



Texas Value-Based Payment and Quality Improvement Advisory Committee Recommendations to the 88th Texas Legislature

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

**Texas Health and Human
Services Commission
December 2022**



TEXAS
Health and Human
Services

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 2022

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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, which is due by December 1, 2022. Our diverse committee includes representatives from Texas health care providers, 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.

The Texas Medicaid program has been actively transitioning to a value-based model over the past 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 connect people to appropriate clinical and nonclinical services. Alternative payment models (APM) 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, access to timely shared data is critical to the successful implementation of value-based care. Third, reimbursement methods in Texas Medicaid must encourage long-term investment in payment and care models to adequately recognize and reward improved health.

Our Committee reached a unanimous consensus on the recommendations in this report. We considered the latest research, lessons learned from the novel coronavirus (COVID-19) federal public health emergency (PHE), the Delivery System Reform Incentive Payment (DSRIP) program transition, and value-based care initiatives across the country. This report extends the Committee's prior work and focuses on four key areas for advancing value-based care and payment in Texas Medicaid:

- Strengthening the home health and pharmacy infrastructure to support value-based payment (VBP) models.
- Leveraging available mechanisms within the Medicaid program to address nonmedical drivers of health (NDOH).
- Advancing and improving the alignment of APM contractual requirements for Medicaid managed care organizations (MCO).
- Enhancing opportunities for secure and timely data sharing to support value-based care.

I would like to personally thank the members of the Committee for their time, contributions, and dedication to this effort. We also appreciate the Texas Health and Human Services Commission (HHSC) 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 as we 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

About the Committee

The 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 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 with the Executive Commissioner and Texas Legislature to help Texas achieve the highest value for health care in the nation. The 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 Plan (CHIP).
- HHSC and 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 Health and Human Services (HHS) Executive Commissioner and represent a variety of stakeholders, including:

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

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

Voting Members

Carol Huber, DrPH, MBA, Chair

University Health, San Antonio

Dana Danaher, DrPH

Huron Consulting Group, Austin

Frank J. Dominguez

Aetna Better Health of Texas, Dallas/San Antonio

Janet Hurley, MD

CHRISTUS Trinity Clinic, Tyler

Daverick Isaac

Community First Health Plans, San Antonio

Andy Keller, PhD

Meadows Mental Health Policy Institute, Dallas

Kathy Lee

Coryell Memorial Healthcare System, Gatesville

Melissa Matlock

Northwest Texas Healthcare System, Canyon

Benjamin McNabb, PharmD

Community Pharmacy Enhanced Services Network (CPESN) Texas, Eastland

Binita Patel, MD

Baylor College of Medicine, Texas Children's Hospital, Houston

Rachana Patwa

UnitedHealthcare Community Plan, Missouri City

Mary Dale Peterson, MD, MHA

Driscoll Health System, Corpus Christi

Alejandra Posada

Mental Health America of Greater Houston, Inc., Houston

Joseph Ramon, III, RPh

HHA/Health Care Unlimited, Inc., McAllen

Michael Stanley, MD

PEDIATRIX, Fort Worth

Ex Officio Representatives

Lisa C. Kirsch, Vice-Chair

Dell Medical School, University of Texas at Austin

C. Mark Chassay, MD, MEd, MBA

BlueCross BlueShield of Texas, Richardson

Shayna Spurlin

Rural & Community Health Institute, Texas A&M University Health Science Center,
Bryan/College Station

Acknowledgements

The Committee would like to thank the Center for Health Care Strategies, Texas Medical Association, Texas Hospital Association, Texas Association for Home Care and Hospice, Texas Medical Equipment Providers Association, and National Association for Home Care and Hospice for their expertise and support to develop this report.

The Committee would also like to welcome the following new members who were appointed in September 2022.

Voting Members

Rachel Hammon

Texas Association for Home Care and Hospice, New Braunfels

Karen Love

Cook Children's Health Plan, Fort Worth

Shao-Chee Sim, PhD

Episcopal Health Foundation, Missouri City

Roberto Villarreal, MD

University Health, Seguin

David Weden

Integral Care, Buda

Ex Officio Representative

Mike Ragain, MD

Texas Tech University Health Sciences Center and University Medical Center, Lubbock

Executive Summary

As health care costs in the United States continue to increase, there is momentum in Texas and nationwide to achieve higher value by changing how we pay for and deliver care. Throughout this report, the terms “value-based payment” (VBP) and “alternative payment model” (APM) are used to describe strategies to improve quality and outcomes for patients while reducing cost trends. These value-based approaches incentivize high-quality and cost-efficiency by linking health care payments to measures of value.

In 2016, the Texas Health and Human Services 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 HHSC and the Legislature that will optimize Texas’ health care system.

The Committee released its first biennial report in 2018.¹ The 2018 recommendations included implementing a comprehensive informatics strategy, making data more readily available to support value-based initiatives, addressing patients’ nonclinical 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, nonmedical drivers of health (NDOH), 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 <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

² <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/value-based-payment-qual-improvement-recommendations-dec-2020.pdf>

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

Building on these past reports, the Committee is pleased to present its third biennial report, which includes recommendations related to APMs in Medicaid, value-based care in home health and pharmacy, NDOH, and timely, actionable data.

The Committee unanimously adopted these recommendations which reflect many of the same themes that have informed its work since 2016. For example, successful VBP initiatives require broad stakeholder engagement, timely integrated data, minimal administrative burden, and aligned incentives for Managed Care Organizations (MCO) and providers. This year's report advances these ideas from prior years to include specific actions Texas legislators, policy makers, and other leaders can and should take to achieve efficient high-quality care and improved health outcomes, particularly in Medicaid and the Children's Health Insurance Program (CHIP).

2022 Recommendations

APMs in Texas Medicaid

- HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement.
 - 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 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 accountability for quality and total cost of care.
 - For Texas to work toward this goal, it would be beneficial for HHSC to endorse a standard primary care health home model that MCOs may adopt for some providers, possibly starting with alignment with the CMS

Primary Care First model, a pregnancy medical home model, and/or key Texas Health Steps (THSteps) measures.

- ▶ In addition, HHSC should consider a more formal structure for dissemination of best practices of VBP models.

Value-Based Care in Home Health and Pharmacy

Home Health

- HHSC should work with MCOs, home health agencies, and stakeholders to:
 - ▶ Define, measure, and publicly report quality, experience, and cost-efficiency for Medicaid providers of in-home care/attendant services.
 - ▶ Identify new or expanded training and reporting requirements for home care attendants to improve the care experience and health outcomes for the Medicaid population.
 - ▶ Analyze enrollee movement between home health agencies to identify patterns, trends, and opportunities for improvement.
 - ▶ Identify and develop VBP models specific to community-based Long-Term Services and Supports (LTSS) delivered through the STAR+PLUS and STAR Kids programs. These models should reward high performing agencies and attendants and offer creative solutions to help address workforce shortages to provide needed home-based care for enrollees in these programs.

Pharmacy

- HHSC should establish standards and a working definition for an Accountable Pharmacy Organization (APO), and work with stakeholders to increase engagement with APOs.
 - ▶ Defining an APO provides clarity when discussing the types of pharmacy organizations involved in VBP contracting. The concept of an APO is distinct from other pharmacy contracting entities (i.e., pharmacy services administrative organization or PSAO).
 - ▶ Increasing VBP arrangements with APOs should improve patient outcomes. Pharmacists will be incentivized to longitudinally engage patients when paid to produce outcomes and lower costs.

- HHSC should develop guidance for MCOs to reimburse pharmacists for services within a pharmacist’s scope of practice.
 - It would be helpful if HHSC could provide additional clarity and guidance to MCOs for paying pharmacists for services under the medical benefit like all other providers. While MCOs could pay pharmacists today, low utilization may indicate a lack of knowledge about these payment options.
 - It would be helpful for HHSC to provide a list of services that fall within a pharmacist’s scope which may be reimbursable by MCOs.

Nonmedical Drivers of Health (NDOH)

- The Legislature should direct HHSC to approve at least one service that addresses NDOH as an in-lieu-of service (ILOS) under 42 C.F.R. §438.3(e)(2). HHSC should consider, at a minimum, the following services as potential ILOS:
 - Asthma remediation;
 - Food is Medicine interventions; and/or
 - Services designed to support existing housing programs.
- The Legislature should direct HHSC to create an incentive arrangement that rewards MCOs that partner with community-based organizations, other MCOs, network providers, and local government agencies to offer ILOS that address NDOH and build related capacity. The Legislature should authorize HHSC to use a portion of amounts received by the state under Texas Government Code §533.014 ³(i.e., “experience rebates”) for this purpose.

Timely and Actionable Data

- HHSC should educate key Texas Medicaid staff and stakeholders about the admit, discharge, and transfer (ADT) and Consolidated Clinical Document Architecture (C-CDA) data it receives from the Texas Health Services Authority (THSA) and establish an annual process to prioritize implementation of new use cases to leverage the data to improve the Medicaid program in light of evolving operational needs.

³ <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.533.htm>

- HHSC should assess options for how to securely share additional data with Medicaid providers about their patients to help inform their participation in more advanced APMs and identify strategies to support providers' use of that data.
- HHSC should conduct a six-month review of the Clinical Management for Behavioral Health Services (CMBHS) system to determine how the system can share data with MCOs and all Medicaid Mental Health Targeted Case Management and Rehabilitative Service providers; and how aggregate data can be easily shared with the public. The review workgroup must include members from the Committee, the Texas Council of Community Centers, MCOs, providers and other stakeholders.
- HHSC should help support the development of a modernized data system at the county level that would permit rapid access to data related to deaths by suicide for researchers and the public while protecting individual privacy. The infrastructure could be developed through several initiatives:
 - ▶ All Texas counties create a publicly available suicide data system in which data are derived directly from the medical examiner or justice of the peace electronic records. This would be modeled after the Tarrant County system with identifying information redacted.⁴
 - ▶ All Texas counties feed suicide data (including provisional data) into a publicly available state-level system that is updated more frequently than the federal data systems.
 - ▶ Create linkages between vital records/mortality data and other public health and health care databases maintained by the Department of State Health Services (DSHS), such as the Texas Health Care Information Collection (THCIC).

⁴ <https://mepublic.tarrantcounty.com>

Introduction

Since its creation in August 2016, the 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 Executive Commissioner of the Health and Human Services system 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.”⁵ As defined in the Committee’s first report, value-based payments (VBP), 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.⁶

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 risk 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 connect people to appropriate clinical and nonclinical services. APMs have great potential to transform the health care system, shift more accountability directly to providers and promote population-wide strategies to improve outcomes. Value-based care, operationalized through effective APMs, benefits patients, providers, payers, suppliers, and society.⁷

The Texas Medicaid program has been transitioning to a value-based model for some time now. Over the past 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 controlling costs and improving quality. Ninety-four percent of Texans (4.1 million) currently

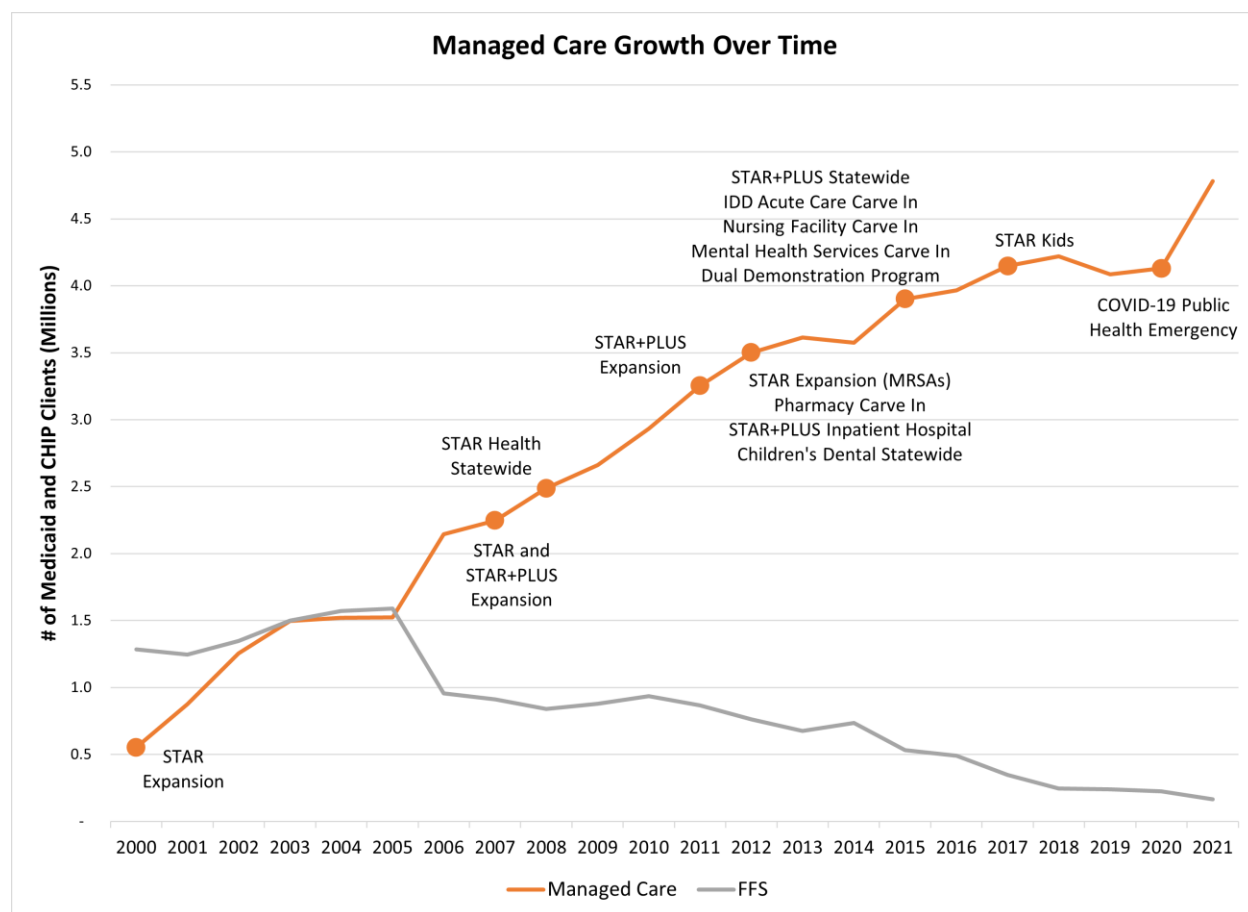
⁵ <https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558>

⁶ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

⁷ <https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558>

enrolled in Medicaid and CHIP receive services through managed care (Figure 1). Increased enrollment and improved access to preventive services within managed care help keep Texas Medicaid costs an estimated 13 percent lower than the U.S. national average.⁸

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



The state's Healthcare Transformation and Quality Improvement Waiver 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

⁸ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/medicaid-chip-perspective-13th-edition/13th-edition-complete.pdf>

reform and advance value in the Medicaid program.”⁹ Between 2012 and 2021, DSRIP providers, including hospitals, community mental health centers, public health entities, 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.

Other statewide initiatives aimed at increasing value in Medicaid and CHIP include: the Medical and Dental Pay for Quality (P4Q) Program; Managed Care Report Cards; Program Improvement Projects (PIPs); Hospital Quality-Based Payment Program; Directed Payment Programs (DPP) such as the Quality Incentive Payment Program (QIPP); and Value-Based Enrollment. These programs are described in HHSC’s Annual Report on Quality Measures and Value-Based Payments¹⁰ and summarized in Table 1.

⁹ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/hb1-provider-perf-dsrip-dy7and8-dec-2020.pdf>

¹⁰ <https://www.hhs.texas.gov/sites/default/files/documents/annual-report-on-quality-measures-and-vbp-dec-2021.pdf>

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

Value-Based Care Initiatives	Priority Population, Provider Type, and/or Payer	Brief Description
Delivery System Reform Incentive Payment (DSRIP) Program	Safety net providers, including hospitals, community mental health centers, and local health departments.	Provides incentive payments to participating providers to improve health outcomes. ¹¹
Directed Payment Programs (DPP)	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. ^{12,13}
Hospital Quality-Based Payment Program	Hospitals	Incentivizes hospitals to reduce potentially preventable hospital readmissions and complications. ¹⁴

¹¹ <https://www.hhs.texas.gov/regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources>

¹² <https://www.hhs.texas.gov/providers/medicaid-supplemental-payment-directed-payment-programs>

¹³ <https://www.hhs.texas.gov/providers/medicaid-supplemental-payment-directed-payment-programs/directed-payment-programs>

¹⁴ <https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/potentially-preventable-events>

Value-Based Care Initiatives	Priority Population, Provider Type, and/or Payer	Brief Description
Pay for Quality (P4Q)	Managed Care Organizations	Incentivizes performance improvement using financial risks and rewards, coupled with performance and improvement targets on quality measures. ¹⁵
Managed Care Report Cards	Managed Care Organizations	Empowers prospective enrollees to make informed choices about Medicaid and CHIP MCOs in their service area. ¹⁶
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. ¹⁷
Value-Based Enrollment	Managed Care Organizations	Adjusts auto-enrollment for Medicaid managed care organizations based on measures of quality and efficiency. ¹⁸

¹⁵ <https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/pay-quality-p4q-programs>

¹⁶ <https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/managed-care-report-cards>

¹⁷ <https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/performance-improvement-projects>

¹⁸ <https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/value-based-care>

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. The 2021 targets were extended 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. Certain exceptions are allowed for high-performing MCOs.

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.¹⁹ 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 APM framework; and 6) rewarding success.

Progress Since the Committee's 2020 Report

The Committee's 2020 recommendations²⁰ focused on maternal and newborn health, multi-payer data, NDOH, advancing APMs in Medicaid, and lessons learned from the federal PHE. Many of these recommendations emphasized information gathering, such as conducting landscape assessments of current programs, barriers, and tools for VBP. Additionally, the recommendations underscored the importance of convening stakeholders to review and identify standardized performance measures and best practice models.

The Committee's 2020 recommendations helped inform subsequent state initiatives, including legislation passed in 2021 and many of the milestones in the DSRIP Program Transition Plan which Texas submitted to CMS.

¹⁹ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/value-based-payment-roadmap.pdf>

²⁰ <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2019/value-based-payment-qual-improvement-recommendations-nov-2018.pdf>

Ongoing State Initiatives and Legislation in the Texas 87th Legislature, Regular Session, 2021

The Texas legislature sets the requirements and direction for HHSC's value-based care strategy. During its regular session, the 87th Legislature enacted several bills and riders that impact the trajectory of value-based care:

- [Rider 20](#) (Senate Bill (SB) 1, 87th Legislature, Regular Session, 2021, Article II, HHSC) requires HHSC to develop quality of care and cost efficiency benchmarks for MCOs participating in Medicaid and CHIP by September 1, 2022.
- [Special Provision 10.06](#) (SB 1, 87th Legislature, Regular Session, 2021, Article IX) extends the requirement for cross-agency²¹ coordination of health care strategies and measures supported by the University of Texas Health Science Center - Houston, Center for Health Care Data (UT Data Center). A required report describes cross-agency coordination activities, efficiencies identified, individual agency policies and practices that have been improved due to the data coordination and analysis, and recommendations on ways to reduce cost and improve quality of care in the healthcare systems of the five participating agencies (HHSC, TRS, ERS, TDCJ, DSHS). The report was submitted to the Legislature on September 1, 2022.²²
- [House Bill \(HB\) 2090](#) (87th Legislature, Regular Session, 2021) authorizes the Texas Department of Insurance to establish an all-payer claims database (APCD) to increase public transparency of health care information and improve the quality of health care in Texas. This law also requires the UT Data Center to administer the database and manage the information submitted for inclusion in the database. Medicaid is represented on a stakeholder advisory group created to provide input on this database.
- [S.B. 1136](#) (87th Legislature, Regular Session, 2021) requires HHSC to coordinate with hospitals and other providers that receive uncompensated care (UC) pool payments and to identify and implement initiatives to address

²¹ There are five agencies involved in the collaboration: DSHS, Employee Retirement System (ERS), Teacher Retirement System (TRS), Texas Department of Criminal Justice (TDCJ) and HHSC.

²² <https://www.hhs.texas.gov/sites/default/files/documents/cross-agency-coord-healthcare-strat-measures-sep-2022.pdf>

potentially preventable emergency department visits (PPVs) among Medicaid members. This law also requires HHSC to encourage Medicaid providers to continue implementing DSRIP-informed effective interventions and best practices. Two reports have been submitted to the Legislature that illustrate the current state of ED use in Medicaid and provide information on initiatives to reduce ED use and improve health outcomes for the Medicaid population.^{23, 24}

- [HB 2658](#) (87th Legislature, Regular Session, 2021) establishes nursing facilities' minimum performance standards, adopts rules for establishing standards and monitoring provider performance, and sharing data regarding the requirements of the bill with the MCOs, and adds requirements to QIPP for improving nursing facility staff-to-patient ratios by January 1, 2025.

DSRIP Program Transition Plan

The DSRIP program in Texas' Healthcare Transformation and Quality Improvement Program 1115 Waiver was designed to increase the quality and cost-effectiveness of care and improve the health of patients and families. The DSRIP program ended October 1, 2021. DSRIP was an effective incubator for testing how flexible payment models can support patient-centered care and clinical innovation. The DSRIP program structure, beginning in federal fiscal year 2012, evolved from a focus on projects and project-level reporting to targeted measure bundles (or measures, depending on performing provider type). Required reporting for DSRIP performing providers included progress on Core Activities, APMs, Costs and Savings, and Collaborative Activities.

The state's DSRIP Transition Plan²⁵ included milestones that are laying the groundwork to develop strategies, programs, and policies to sustain successful initiatives and support emerging areas of innovation in health care. The DSRIP Transition Plan, approved by CMS, supported the following goals for continued delivery system reform:

²³ <https://www.hhs.texas.gov/reports/2022/03/biannual-report-initiatives-reduce-avoidable-emergency-room-utilization-improve-health-outcomes> March 2022.

²⁴ <https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-medicaid-aug-2022.pdf>

²⁵ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/dsrip-transition-plan.pdf>

- Advance APMs that target specific quality improvements;
- Support further delivery system reform that builds on the successes of the 1115 Transformation Waiver and includes current priorities in health care;
- Explore innovative financing models;
- Develop cross-focus areas such as NDOH that use the latest national data and analysis to continue to innovate in Texas; and
- Strengthen supporting infrastructure for increased access to health care and improved health for Texans.

The DSRIP Transition Plan milestones aligned with many of this Committee's current and past recommendations, including:

- Data sharing and transparency to advance value-based care;
- Focus on key populations served through Medicaid such as the population with serious mental illness and maternal and newborn health;
- The need for additional guidance on allowable quality improvement costs in Medicaid managed care to help sustain innovative activities that improve health but are not Medicaid billable services; and
- Screening for and addressing NDOH.

Policy Issues, Recommendations, and Discussion

Throughout 2021 and 2022, the Committee heard invited testimony from numerous health care professionals, subject-matter experts, and stakeholders. The Committee reviewed a wide array of relevant research to develop the new recommendations for 2022. The current Texas health care environment, including the federal PHE and the DSRIP transition, also informed the Committee's work. Above all, the Committee was guided by Texas' health care quality goals:²⁶

- **Promoting optimal health for Texans** at every stage of life through prevention and by engaging individuals, families, communities, and the health care system to address root causes of poor health;
- **Strengthening person and family engagement** as partners in their care to enhance respect for individual's values, preferences, and expressed needs; Keeping patients free from harm by building a safer health care system that limits human error;
- **Providing the right care in the right place at the right time** to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate;
- **Promoting 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; and
- **Attracting and retaining high-performing Medicaid providers**, including medical, behavioral health, dental, and LTSS providers to participate in team-based, collaborative, and high-value care.

During this review, the Committee identified key themes, including the importance of stakeholder engagement, timely data, and aligned incentives. The consensus recommendations that follow, all adopted by unanimous vote of the Committee's multi-stakeholder membership, reflect these themes, and offer solutions to further

²⁶ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/Waivers/medicaid-1115-waiver/value-based-payment-roadmap.pdf>

advance implementation of VBP to achieve improved care and health for patients and families served by the Texas Medicaid program.

Policy Issue: Alternative Payment Models in the Texas Medicaid Program

The first two biennial reports from this Committee focused on APMs as a key strategy to achieve value-based care in Texas Medicaid. Starting in calendar year 2018, Texas HHSC established APM percentage targets for Medicaid MCOs. Over the last four years, HHSC has reported aggregate data on MCO performance against these targets and shared information on MCO-specific models to promote collaborative learning. The following two recommendations focus on strategic improvements to the framework and alignment with national initiatives aimed at improving quality and outcomes.

Recommendation 1

HHSC should adopt a more comprehensive contractual APM framework to assess MCO achievement:

- 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.

Recommendation 2

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 accountability for quality and total cost of care.

- For Texas to work toward this goal, it would be beneficial for HHSC to endorse a standard primary care health home model that MCOs may adopt for some providers, possibly starting with alignment with the CMS Primary Care First model, a pregnancy medical home model, and/or key Texas Health Steps (THSteps) measures.

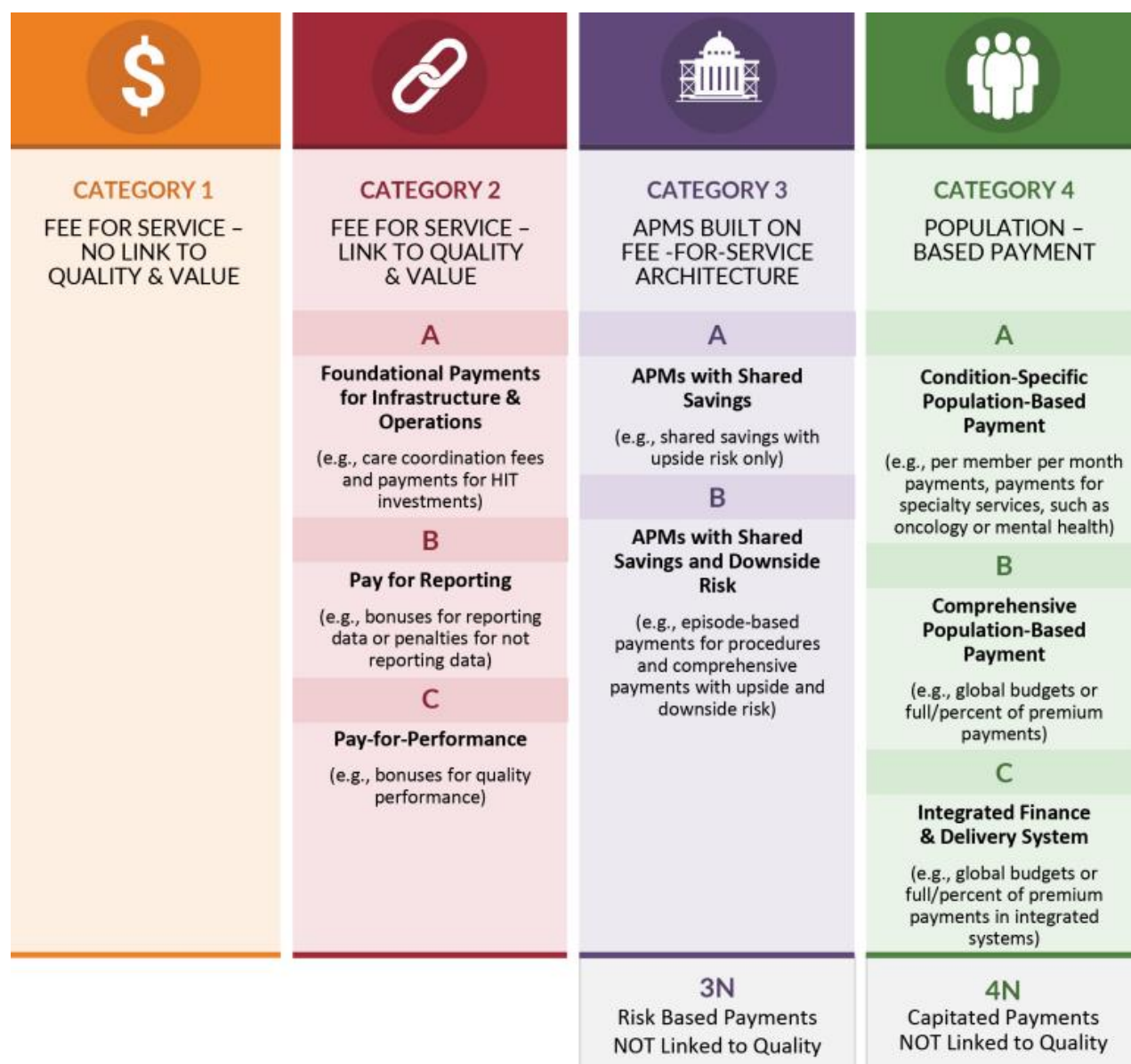
- In addition, HHSC should consider a more formal structure for dissemination of best practices of VBP models.

Discussion

APM Framework

The Health Care Payment Learning & Action Network (HCP-LAN) framework outlines categories of APMs (Figure 2) designed to achieve value-based care. The HCP-LAN seeks both 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.

7Figure 2: Health Care Payment Learning & Action Network Framework²⁷



The Texas Medicaid APM requirements and targets are based on the HCP-LAN concepts, including the advancement of risk-based APMs. The current APM framework set MCO targets beginning in calendar year 2018 (Table 2). HHSC has extended calendar year 2021 targets through calendar year 2022 due to the federal PHE. There are minimum targets for overall APMs and risk-based APMs.

²⁷ <https://hcp-lan.org/workproducts/apm-figure-1-final.pdf>

Table 2: Texas Medicaid MCO Contract Targets for APMs²⁸

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%

By calendar year 2021 (extended to calendar year 2022), MCOs are contractually required to have at least 50 percent of total provider payments for medical and prescription expenses in APMs, and at least 25 percent of the total payments must be in risk-based APMs. 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.²⁹

The Committee is recommending that HHSC adopt a more comprehensive framework for APMs wherein the percentage targets remain at the 2021 level but MCOs may also get credit for undertaking relevant activities that further advance value-based care. These activities will be specified on a “menu,” and HHSC can assign higher points for activities expected to have the greatest impact. This menu-based framework recognizes MCOs for advancing strategic goals of the Medicaid program and may include:

- Maintaining or improving on current APM targets.
- Implementing APMs in challenging circumstances, such as in rural areas.

²⁸ 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.

²⁹ There are certain allowed exceptions for high-performing plans.

- Improving APM rates for priority sectors with traditionally low APM participation, such as home health, pharmacy, and behavioral health.
- Increasing the amount of dollars providers can earn through APMs.
- Monitoring provider satisfaction or establishing other formal provider outreach mechanisms related to APMs, including processes for provider engagement in APMs.
- Sharing timely data with providers through health information exchanges (HIE), including hospital ADT data for a provider's patients or claims.
- Sharing performance reports and best practices with providers.
- Improving on quality measures or documenting processes that describe outcomes achieved and improvements that can be made in future years.
- Developing innovative APM approaches to address NDOH.
- Leveraging VBP to reduce health disparities and incentivize equity.
- Developing a formal strategic plan for advancing APMs.
- Collaborating with other MCOs within a service area (or region) on standard measures and APM models.
- Establishing formal APM evaluation criteria and reporting on evaluation results for key APMs.

Further, the contractually required MCO reporting tool is also an important part of the framework. To reduce administrative burden, the Committee recommends HHSC update the reporting tool to a more streamlined format and only collect data that can be effectively used to describe progress in meeting strategic goals related to APMs.

As of the writing of this report, the Texas HHSC is moving forward with Medicaid Uniform Managed Care Contract (UMCC) and Uniform Managed Care Manual (UMCM) processes to incorporate core elements of these recommendations into the state's APM framework.

High-Value Primary Care and Dissemination of Best Practices

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 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”.³⁰

There is national attention on higher value primary care. In the U.S., only about six percent of total health care expenditures are for primary care activities, compared to an average of 14 percent in peer countries. This represents an underinvestment that leads to poor and inequitable health outcomes. According to the National Academies of Sciences, Engineering, and Medicine, “high-quality primary care requires committing to pay primary care more and differently given its capacity to improve population health and health equity.”³¹ The National Academies further explain that:

High-quality primary care is the foundation of the health care system. It provides continuous, person-centered, relationship-based care that considers the needs and preferences of individuals, families, and communities. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to Emergency Departments increase, preventive care lags, and health care spending soars to unsustainable levels.

In calendar year 2020, 41 percent of Texas’ APMs between Medicaid MCOs and providers were in primary care, which decreased to 38 percent in 2021. Although a high percentage of Texas Medicaid MCO APMs focus on primary care providers, they are often at a basic level: FFS plus quality bonuses (HCP-LAN Category 2), rather than more advanced APMs with shared savings or risk (HCP-LAN Category 3) or population-based payment (HCP-LAN Category 4). Also, because of the administrative effort required to engage in APMs and meet the contractual targets, MCOs tend to prioritize large providers that care for a greater share of their enrolled members. While this helps expand APMs more efficiently, it also reduces opportunities for small or rural providers to participate in APMs.

Texas Medicaid’s focus on APMs in managed care has not yet incorporated an evaluation of the effectiveness of existing APMs. The Center for Health Care

³⁰ <https://innovation.cms.gov/strategic-direction>

³¹ https://www.chcs.org/investing-in-primary-care-is-essential-to-achieve-state-goals-and-how-investments-are-structured-is-crucial/?utm_source=CHCS%2BEmail%2BUpdates&utm_campaign=17dcb9358f-PCI%2BSpending_5%2F19%2F2022&utm_medium=email&utm_term=0_bbced451bf-17dcb9358f-157223226

Strategies recommends that increasing funds available through APMs that require strong advanced primary care standards with a focus on health equity can “help ensure that investments lead to better care, not just more or more expensive care.”³²

SB 1136³³ (87th Legislature, Regular Session, 2021) focuses on reducing PPVs, which are defined as emergency treatment for a condition that could have been treated or prevented by a physician or other health care provider in a nonemergency setting. SB 1136 requires HHSC to explore models that may reduce PPVs and sustain the following DSRIP best practices:

- Improve patient navigation and care coordination through practices such as pre-visit planning and providing culturally and linguistically appropriate care.
- Sustain and expand access to critical health care services, including through telehealth
- Integrate or co-locate primary care with specialty care and psychiatric services.
- Leverage care teams that include a care coordination role such as community health workers and social workers.³⁴

High-value primary care can also include behavioral health integration. The Committee’s 2020 legislative report included a recommendation to review strong models related to maternal and newborn health, behavioral health, and opioid and other substance use identification and treatment. An area of advancement since that report is the inclusion of the Collaborative Care Model in Texas Medicaid as a benefit, beginning June 1, 2022, which enables greater integration of behavioral health care into primary care and could be a component of a standard model of high-value primary care:

The Collaborative Care Model is a systematic approach to the treatment of behavioral health conditions (mental health and/or substance use) in primary

³² https://www.chcs.org/investing-in-primary-care-is-essential-to-achieve-state-goals-and-how-investments-are-structured-is-crucial/?utm_source=CHCS%2BEmail%2BUpdates&utm_campaign=17dcb9358f-PCI%2BSpending_5%2F19%2F2022&utm_medium=email&utm_term=0_bbc451bf-17dcb9358f-157223226

³³ <https://capitol.texas.gov/tlodocs/87R/billtext/html/SB01136S.HTM>

³⁴ <https://www.hhs.texas.gov/sites/default/files/documents/initiatives-reduce-avoidable-er-utilization-improve-health-outcomes-report.pdf>

care settings. The model integrates the services of behavioral health care managers and consulting psychiatrists with primary care provider oversight to proactively manage behavioral health conditions as chronic diseases, rather than treating acute symptoms.³⁵

For Texas to work toward this goal, HHSC may endorse a standard primary care health home APM that MCOs can adopt for some providers, possibly aligning with the CMS Primary Care First model, a focus on THSteps (for children under 21) and/or a pregnancy medical home model.

- **Primary Care First.** Based on lessons learned from its previous demonstration models, the CMS Innovation Center has introduced a next generation APM in Medicare called Primary Care First. It is designed as a multi-payer model. Twenty-six states are in the first two cohorts for this model that rewards value and quality by offering an innovative payment structure to support the delivery of advanced primary care. Primary Care First is a new model based on the principles underlying the existing Comprehensive Primary Care Plus (CPC+) model design: prioritizing the clinician-patient relationship, enhancing care for patients with complex chronic needs, and focusing financial incentives on improved health outcomes.³⁶

Although Texas is not one of the states participating in the first two cohorts of Primary Care First, it could use the model as a framework to have a model endorsed by the state that multiple MCOs can offer to primary care providers. Endorsing this standard model specific to primary care could help MCOs engage smaller primary care practices, as well as safety net providers, such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), that may not have the same capacity or infrastructure as larger primary care practices. In designing a standard model, HHSC should identify opportunities to build capacity for all primary care providers to advance care relationships with accountability for quality and total cost of care by 2030, as envisioned by CMS.

- **Texas Health Steps.** THSteps provides health care for children birth through age 20 who have Medicaid and is an important focus area for HHSC

³⁵ <https://www.hhs.texas.gov/sites/default/files/documents/collaborative-care-model-draft-public-comment.pdf>

³⁶ <https://innovation.cms.gov/innovation-models/primary-care-first-model-options>

and MCOs. THSteps timely checkup rates continue to be low. APMs focused on timely THSteps checkups could help to improve the rates. THSteps checkups are considered timely if the checkup occurs within 90 days after enrollment for new members; and annually within 364 days for those older than 36 months. HHSC calculates timely checkup rates using claims data, for which there is a two year lag. State fiscal year 2020 and 2021 data submitted by the plans to HHSC annually will be impacted by the federal PHE.

- **Pregnancy Medical Home.**³⁷ A pregnancy medical home model is also recommended as a potential focus area for high-value primary care. Since 2013, the Texas Legislature has required HHSC to evaluate the potential of these models. In 2019, the Texas Legislature directed HHSC to implement a Pregnancy Medical Home Pilot (SB 748, 86th Legislature, Regular Session, 2019) which represented, in part, an expansion of the Pregnancy Medical Home Pilot Program required by HB 1605 (83rd Legislature, Regular Session, 2013). The focus of the Pregnancy Medical Home Pilot Program required by SB 748 was to test the replicability of findings from the previous Pregnancy Medical Home Pilot Program, and to explore expansion of the delivery model across Medicaid.

HHSC plans to offer all STAR MCOs the opportunity to participate in the pilot programs. The success of the pilot programs hinges upon the working relationship between the MCOs and the pilot providers. For example, pilot providers must adjust their practices to meet pilot requirements as described in the bill. MCOs would be charged with establishing pilot sites and must provide data to aid HHSC in linking the mother-infant dyad for the pilot evaluations. Therefore, HHSC will seek joint proposals from both providers and MCOs.³⁸ Texas Medicaid has also focused on maternity care in performance improvement projects.

The Texas Medical Association (TMA) recommended HHSC consider a more formal structure for the dissemination of best practices. Across the state, physicians and MCOs have vital expertise and lessons learned about APM designs and strategies. Currently, there is no central repository of information or formal, ongoing learning

³⁷ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/maternal-teleservices-pregnancy-med-home-pilot-prgms-jan-2021.pdf>

³⁸ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/maternal-teleservices-pregnancy-med-home-pilot-prgms-jan-2021.pdf>

collaborative from which physicians and MCOs can benefit from that expertise. There are challenges with marketplace competitors and the ability to share proprietary design information. However, there is a risk to “reinvent the wheel” for practices new to APMs or for other MCOs. Establishing a more formal structure for sharing experiences can help practices new to APMs and those ready to advance to higher level APMs. TMA also references that this approach would help facilitate development and implementation of strategies to address NDOH, as an evolving focus area within APMs.³⁹

Providers have expressed that the wide variety of APMs and non-standard performance reports employed by MCOs are a barrier to their participation in APMs. Increasing the standardization of models, performance measures, and reports will reduce barriers to provider participation in APMs. Enhanced standardization will also facilitate a broader evaluation of APMs to help stakeholders discern the quantitative and qualitative aspects of APMs that are correlated with better health outcomes and improved cost-efficiency.

³⁹ Texas Medical Association letter to HHSC. Final Comments on Potential Medicaid APM Revisions. March 28, 2022.

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

[CMS Letter to State Medicaid Directors Re: Value-Based Care Opportunities in Medicaid \(Sept 15, 2020\)](#)

[Assessment of Financial Incentives for Alternative Payment Models: Texas Delivery System Reform Incentive Payment Program Transition Plan. Texas Health and Human Services Commission \(June 2021\)](#)

[Innovation Center Strategy Refresh. Centers for Medicare and Medicaid Services \(2021\)](#)

[State Medicaid Managed Care Advisory Committee Annual Report \(December 2021\)](#)

[Annual Report on Quality Measures and Value Based Payments \(December 2021\)](#)

[Biannual Report in Initiatives to Reduce Avoidable Emergency Utilization and Improve Health Outcomes in Medicaid \(March 2022\)](#)

Policy Issue: Value-Based Care in Home Health and Pharmacy

Value-Based Care in Home Health

Individuals with disabilities or chronic conditions often receive LTSS to assist with activities of daily living and instrumental activities of daily living. It is projected that over 27 million Americans will need these services by 2050.⁴⁰ Over 300,000 Texans currently receive services from community attendants through LTSS programs.⁴¹

HHSC and MCOs are limited in their abilities to assess performance of a home health agency or attendant. For example, it is difficult to compare agencies or attendants on measures of fall prevention, medication adherence, emergency department utilization, hospitalizations, health outcomes, and cost trends. As a result, patients find it challenging to select an agency that is best for them. The following recommendations focus on strategic improvements to enhance quality measurement, attendant training, and APM development for home health providers serving the Texas Medicaid program.

Recommendation: Home Health

HHSC should work with MCOs, home health agencies, and stakeholders to:

- Define, measure, and publicly report quality, experience, and cost-efficiency for Medicaid providers of in-home care/attendant services.
- Identify new or expanded training and reporting requirements for home care attendants to improve the care experience and health outcomes for the Medicaid population.
- Analyze enrollee movement between home health agencies to identify patterns, trends, and opportunities for improvement.
- Identify and develop VBP models specific to community-based Long-Term Services and Supports (LTSS) delivered through the STAR+PLUS and STAR

⁴⁰ <https://aspe.hhs.gov/reports/overview-long-term-services-supports-medicaid-final-report-0>

⁴¹ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/rider-157-ca-workforce-dev-strat-plan-nov-2020.pdf>

Kids programs. These models should reward high performing agencies and attendants and offer creative solutions to help address workforce shortages to provide needed home-based care for enrollees in these programs.

Discussion

Measuring Quality in Home Health

In June 2018, the Medicaid and CHIP Payment Access Committee reported on the status of state adoption of managed long-term services and supports (MLTSS) and areas of program evolution. The committee noted:

As states gain MLTSS experience, attention is turning to program outcomes. Although there is modest evidence of some successes, there are many unanswered questions. Limited baseline data and insufficient targeted quality measures have made evaluation difficult. Efforts to implement new quality measures and collect better encounter data may improve monitoring and oversight of MLTSS in the future.⁴²

CMS studies suggest that a ratings system for agencies helps members select the appropriate agencies to meet their needs.

The core sets allow states, the public, and CMS to monitor trends in performance on standardized indicators of quality of care provided to Medicaid and CHIP beneficiaries under both FFS and managed care arrangements and examine performance across states. The goals of the core sets are to facilitate standardized reporting by states on a uniform set of performance measures and encourage states to use results to drive quality improvement.⁴³

The Home Health Care Compare website publishes patient survey and performance data obtained through a standardized data set used by home health care agencies for Medicare patients. The patient survey asks patients (or their family or friends) about their home health care and if they would recommend the agency to someone else. Using a five-star scale, obtained from both the survey responses and the standardized data set, the quality rating shows how a home health care agency

⁴² <https://www.macpac.gov/publication/june-2018-report-to-congress-on-medicaid-and-chip/>

⁴³ <https://www.macpac.gov/subtopic/quality-measures-used-in-medicaid/>.

compares to others on measurements of their performance, such as how often the agency began their patient's care in a timely manner, or how often a patient improved at walking around. A rating of 3 to 3.5 stars means the agency performed about the same as most agencies. No standardized data set currently exists for home health care services delivered to Medicaid LTSS patients.

On July 21, 2022, CMS published a letter providing State Medicaid Directors with information on a set of nationally standardized quality measures for Medicaid-funded Home and Community-Based Services (HCBS). This measure set is intended to “promote more common and consistent use within and across states of such nationally standardized quality measures in HCBS programs, create opportunities for CMS and states to have comparative quality data on HCBS programs, and drive improvement in quality of care and outcomes for people receiving HCBS”.⁴⁴

The proposed list of measures includes detailed information on selection criteria, measures specifications, and considerations for implementation. Measures were selected based on the availability of evidence that they will drive significant gains in quality, scientific acceptability of the measures, feasibility of reporting, usability, and extent to which there are related or competing measures. A forthcoming guidance document will describe how states can incorporate these measures into quality improvement activities and promote equity.

The Committee encourages HHSC and the Texas Legislature to study this measure set and partner with stakeholders to identify ways to achieve improved comparative reporting of quality, experience, cost trends, and outcomes in the Texas Medicaid program.

Attendant Workforce

In November 2020, HHSC’s Community Attendant Workforce Development Strategic Plan⁴⁵ reported on strategies and data related to the community attendant workforce. The report defined an attendant as a “person who assists people with their personal care and household tasks”. Individuals requiring the services of community attendants often have physical disabilities, chronic illness, cognitive impairment, or other complex needs. The use of attendants helps individuals remain in their homes and community-based settings and also helps reduce more

⁴⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf>

⁴⁵ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/rider-157-ca-workforce-dev-strat-plan-nov-2020.pdf>

costly use of institutional care settings such as nursing facilities and state-supported living centers.

Texas currently has a ratio of 11 people with disabilities per community attendant worker. Due to projected population growth, particularly in older age groups, Texas's attendant workforce needs are estimated to be as high as 484,000 in 2031 compared to a 2022 workforce of 301,000. These workers often earn wages of \$10.10 per hour. Only a small percentage of providers reported offering medical benefits, mileage reimbursement, or paid sick leave to these employees. Yet, these workers help lower cost trends and improve quality of life for the patients they serve. HHSC estimates that in fiscal year 2019, nursing facility care costs were 227 percent higher than community care.

Often, attendants serve patients with high medical and behavioral health needs that require specialized training, which the Community Attendant Workforce Development Strategic Plan identified as having a key impact on access to care. Behavioral health conditions, in particular, are of serious concern. These may present occupational safety hazards, such as the potential for verbal and physical abuse and stress related to client aggression, violence, and other behavioral issues.⁴⁶ Focus groups conducted with community attendants and conversations with key informants have found home care aides: ⁴⁷

- Feel scared and unsure how to respond to aggressive behavior or displays of paranoia.
- Find it difficult to assist clients when behaviors limit their ability to provide personal care services.
- Have not received training on mental health and are unprepared to manage behaviors.
- Often develop skills "on the job" and use their intuition to respond to challenging situations.
- Struggle to maintain strong boundaries and cope emotionally with demands of providing care to clients with behavioral health needs.

⁴⁶ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00021>

⁴⁷ https://commcorp.org/wp-content/uploads/2016/07/hcwtf-planning-grants_home-care-aide-council-report.pdf

Training to develop specialized expertise in caring for patients with behavioral health conditions could create opportunities for new career pathways, so long as the training is not prohibitively expensive to home health agencies or individual workers.⁴⁸ Training should focus on “practical tips and information on how to successfully respond to difficult client behaviors”.⁴⁹

This Committee’s recommendations are aligned with the goals presented in the Community Attendant Workforce Development Strategic Plan, including:

- Provide a living wage, with flexibility to offer benefits and reward training with pay incentives.
- Reduce administrative burden, including streamlining the orientation process and improving criminal background checks.
- Workforce development, including expanding funding for certification programs, expanding workforce development opportunities, increasing access to resources, and elevating the role of attendant work.
- Data collection, including completing studies on return on investment, quality, outcomes, and pay equity.
- Pursue alternative sources of revenue, including APMs.

Texas’s Direct Service Workforce Development Taskforce is currently meeting six times per year to monitor implementation efforts and obtain feedback on the strategic plan.

Alternative Payment Models

In calendar year 2020, only five percent of APMs reported by Medicaid MCOs involved home health care providers. APMs may present an opportunity to address many of the issues described above. One model that may be used as a pathway for developing APMs for Medicaid home care providers is the CMS Home Health Value-Based Purchasing (HHVBP) Model being tested with Medicare populations served by 1,907 home health agencies in nine states. Key findings after five years include:⁵⁰

⁴⁸ <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00021>

⁴⁹ https://commcorp.org/wp-content/uploads/2016/07/hcwtf-planning-grants_home-care-aide-council-report.pdf

⁵⁰ <https://innovation.cms.gov/data-and-reports/2022/hhvpb-fifthann-rpt-fg>

- Total Performance Scores for home health agencies were seven percent higher among HHVBP states than non-HHVBP states
- The model improved home health patients' mobility and self-care.
- The model generated Medicare savings of \$942.9 million over five years.

Value-Based Care in Home Health: Key Reports and Other Resources

[CMS Letter to State Medicaid Directors Re: Home and Community-Based Services Quality Measurement Set \(July 21, 2022\)](#)

[Quality Measurement for Home and Community Based Services \(HCBS\) and Behavioral Health in Medicaid \(Dec 2016\)](#)

[Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement \(Sept 2016\)](#)

[Community Attendant Workforce Development Strategic Plan \(November 2020\)](#)

Value-Based Care in Pharmacy

Texas has 411 primary care health professional shortage areas (HPSAs) and only 58 percent of primary care needs in those areas are currently being met.⁵¹

Pharmacists can fill gaps in care helping to alleviate these provider shortages. The following recommendations focus on establishing standards for Accountable Pharmacy Organizations and guidance for reimbursement of pharmacy services.

Recommendation 1: Pharmacy

HHSC should establish standards and a working definition for an Accountable Pharmacy Organization (APO), and work with stakeholders to increase engagement with APOs.

- Defining an APO provides clarity when discussing the types of pharmacy organizations involved in VBP contracting. The concept of an APO is distinct from other pharmacy contracting entities (i.e., pharmacy services administrative organization or PSAO).
- Increasing VBP arrangements with APOs should improve patient outcomes. Pharmacists will be incentivized to longitudinally engage patients when paid to produce outcomes and lower costs.

Recommendation 2: Pharmacy

HHSC should develop guidance for MCOs to reimburse pharmacists for services within a pharmacist's scope of practice.

- It would be helpful if HHSC could provide additional clarity and guidance to MCOs for paying pharmacists for services under the medical benefit like all other providers. While MCOs could pay pharmacists today, low utilization may indicate a lack of knowledge about these payment options.
- It would be helpful for HHSC to provide a list of services that fall within a pharmacist's scope which may be reimbursable by MCOs.

⁵¹<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>

Discussion

Non-Dispensing Services

We have seen firsthand the vital role of pharmacists during the federal PHE. The Centers for Disease Control and Prevention (CDC) recently reported that 70 percent of COVID-19 vaccines nationwide were administered by pharmacists, including 60 percent of all COVID-19 vaccinations administered to adolescents. Texas was no different, as shown in Tables 3 and 4. Patients clearly are taking advantage of these pharmacy services, which has significantly reduced the burden on primary care clinics and other health care settings, thus allowing them to perform other important health care functions.

Table 3: Percent of COVID-19 Vaccinations Administered by Pharmacists in Texas, By Age Group⁵²

Age Group	Percent
Ages 5-11	54.09%
Ages 12-17	63.82%
Ages 18 +	45.59%

Table 4: Percent of COVID-19 Vaccinations Administered by Pharmacists in Texas, First vs Second Booster, All Ages⁵³

Booster COVID-19 Vaccines (All Ages)	Percent
First Boosters	72.19%
Second Boosters	79.01%

Beyond vaccinating, pharmacists have taken on enhanced roles providing COVID-19 testing and administering COVID-19 therapeutic treatments (i.e., monoclonal

⁵² <https://dshs.state.tx.us/immunize/TIC/2022/Day-One/Texas-Pharmacy-Response-to-COVID-19.pdf>

⁵³ <https://dshs.state.tx.us/immunize/TIC/2022/Day-One/Texas-Pharmacy-Response-to-COVID-19.pdf>

antibody treatment). These new non-dispensing pharmacist services are billed to Texas Medicaid MCOs using the traditional medical billing framework, demonstrating that the infrastructure needed to reimburse pharmacists for medical services exists today in Texas. Paying pharmacists for non-dispensing services is now at the discretion of the Texas Medicaid program and Texas MCOs.

Further, beginning in February 2021, the Texas Medicaid & Healthcare Partnership (TMHP) assumed enrollment processing for the Texas Vendor Drug Program (VDP) through the TMHP Provider Enrollment and Management System (PEMS). This new enrollment process made the National Provider Identification (NPI) numbers of both individual pharmacists and pharmacy organizations directly visible to health plans. As a result, pharmacy is now visible in the same system used for other provider types, removing a significant barrier for payment of non-dispensing services.

Despite great progress over the last few years, pharmacists remain underutilized. There is a significant opportunity to expand access to services beyond COVID-19 testing and monoclonal antibody treatments, especially in rural and medically underserved communities. These services may include payment for other Clinical Laboratory Improvement Amendments (CLIA)-waived point-of-care testing, smoking cessation, Diabetes Self-Management Education and Support (DSMES), Transitions of Care, comprehensive medication reviews, medication therapy management (MTM), and services performed under collaborative practice agreements.

Payment for non-dispensing services would likely 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.
- Payment for a pharmacist to provide transitions of care interventions may be better suited for a single billable action rather than a longitudinal value-based arrangement.
- 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.

Ultimately, FFS payments add more tools and flexibility that can help MCOs find the payment methodologies that work best to meet the needs of their members.

Accountable Pharmacy Organizations

Accountable Care Organizations (ACOs) have emerged as a pay-for-performance and value-based purchasing conduit for medical providers. Similarly, APOs would 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”.^{54,55}

APOs could provide enhanced services subject to performance measurements that determine payment. APO-provided services could be designed to improve the quality of care while reducing the unnecessary use of resources. APO-provided services could be designed to optimize necessary medication use, reduce unnecessary medication use, and improve care coordination, leading to lower health care costs. VBP arrangements that reward APOs that meet predetermined goals and measures create competition among pharmacy groups to produce clinical, humanistic, and cost-saving results.

APOs can be composed of regional pharmacy chains, national pharmacy chains, or Clinically Integrated Networks (CIN) of independent pharmacies. Establishing this standard definition provides clarity for stakeholders as they contract with and increase VBP arrangements with pharmacies.

It is important to note APOs are distinct in form and function from a PSAO, which negotiates fee-for-product drug dispensing contracts on behalf of pharmacy groups with pharmacy benefit managers (PBM). 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 in addition to their existing PSAO contracts.

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

⁵⁴ <https://www.healthcare-economist.com/2020/06/01/accountable-pharmacy-organizations/>

⁵⁵ <https://www.jmcp.org/doi/full/10.18553/jmcp.2020.26.6.705>

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 and/or their adherence is poor. 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.

While VBP models have primarily focused on physicians and hospitals, they are now expanding to include more types of providers. The VBP goal 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. VBP reform has the potential to improve outcomes, enhance care coordination, and create more system efficiencies. The contribution of community pharmacy in helping achieve the goal of VBP models is extremely promising.

Successful outcomes for a VBP model and other coordinated care programs will be dependent 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 will not only increase the overall health of patients but will also result in a decrease in overall health care costs.

Table 5 demonstrates suggested disease management priorities and accompanying measurement sets.

Table 5: 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; ER visit rate
Diabetes	HbA1c Reported; HbA1c <7.0, <8.0, <9.0; HbA1c test completion; Proportion of Days Covered (PDC) >80 percent (Medication Adherence); Completed PeCP
Hypertension	Blood Pressure (mmHg) Reported; mmHg <150/90, <140/90; Completed PeCP; PDC >80 percent
Behavioral Health	Completed Patient Health Questionnaire (PHQ)-2, PHQ-4, PHQ-9, Generalized Anxiety Disorder (GAD)-7; Completed PeCP; Referred to Care Team Member

Legislative Progress

The current shortage of primary care providers in Texas leaves patients, especially in underserved and rural communities, without appropriate access to health care. With continued challenges in the future, such as the aging population, the lack of access will be even more problematic. Pharmacy and other health care professionals must be fully utilized to fill this void and expand equitable health care access to all patients.

Recent legislative changes allowing pharmacists to provide this type of health care services can alleviate this growing issue. Effective January 1, 2020, HB 1757⁵⁶ and

⁵⁶ <https://capitol.texas.gov/tlodocs/86R/billtext/html/HB01757F.HTM>

HB 3441⁵⁷ (86th Legislature) amended the Insurance Code for commercial health plans in Texas. It added pharmacists to the list of health care practitioners and allowed an insured beneficiary to select a pharmacist to provide the services in the health insurance policy that are within the pharmacist's scope of practice. By doing so, it prohibited a health benefit plan issuer or PBM of a health benefit plan from denying reimbursement to a pharmacist for the provision of a service or procedure within the scope of the pharmacist's license that would be covered by the insurance policy or other coverage agreement if the service or procedure were provided by a physician, an advanced practice nurse, or a physician assistant. This means pharmacists may now be in provider networks and be reimbursed for services that are within their scope of practice; and an insurer may not discriminate against pharmacists for payment or reimbursement for services performed in the scope of that pharmacist's license if the same services or procedures are provided and covered by another listed health care practitioner.

Other states, like Ohio, Iowa, and North Carolina, are implementing similar measures to reimburse pharmacists for non-dispensing services in their Medicaid programs. On May 26, 2022, Oklahoma Governor Kevin Stitt signed HB 2322 into law, recognizing pharmacists as essential community providers and requiring the state Medicaid program to reimburse pharmacists for health care services at the same rate as other providers. This legislation will increase patients' access to valuable services provided by pharmacists.

Value-Based Care in Pharmacy: Key Reports and Other Resources

[Community Care of North Carolina: Clinical Program Analysis \(May 2015\)](#)

⁵⁷ <https://capitol.texas.gov/tlodocs/86R/billtext/html/HB03441I.htm>

Policy Issue: Nonmedical Drivers of Health⁵⁸

A 2007 study estimated access to care accounted for ten percent of what makes us healthy. Another 20 percent of a person's health is dependent on their environment. Half of a person's health is dependent upon their health behaviors, such as what they eat, if they exercise, and whether or not they smoke or use other addictive substances (Figure 3). But only four percent of the health care dollar is spent on addressing health behaviors.⁵⁹

If we were to do a similar study in Texas today, we would likely see similar results. While it is important for Texans to have access to high quality health care when they need it, we spend the vast majority of the health care dollar treating conditions, rather than preventing disease. In order to establish a sustainable health care infrastructure for Texas, we must change this imbalance.

Nonmedical drivers of health (NDOH) are those health behaviors and environmental factors that impact a person's well-being. Historically these factors have been ill-addressed by insurers and health care systems, and have not been well reimbursed, if at all. Medicaid MCOs in Texas often consider spending toward these initiatives as administrative costs, which can impact the MCOs' rate setting the following year.

An alternative funding mechanism would help enable MCOs to do more meaningful work on NDOH that will not penalize them in subsequent year rate setting. Our Committee has investigated a funding mechanism called In Lieu of Services (ILOS) that enables an MCO to pay for addressing NDOH in-lieu-of traditional Medicaid covered services.

⁵⁸ 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 (<https://www.episcopalhealth.org/research-report/moving-upstream-how-medicaid-in-texas-could-use-in-lieu-of-services-to-address-non-medical-drivers-of-health/>).

⁵⁹ <https://www.nehi-us.org/publications/32-the-boston-paradox-lots-of-health-care-not-enough-health/view>

Figure 3: Healthy Behaviors vs. Health Care Spending⁶⁰



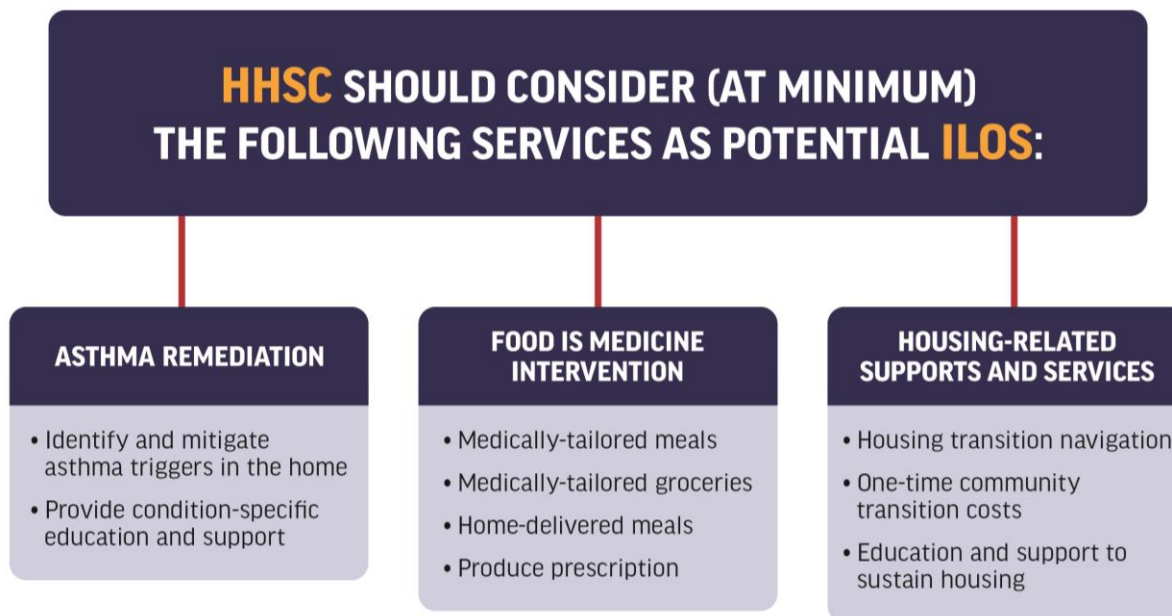
Recommendation 1

The Legislature should direct HHSC to approve at least one service that addresses NDOH as an ILOS under 42 C.F.R. §438.3(e)(2). HHSC should consider, at a minimum, the following services as potential ILOS (Figure 4):

- Asthma remediation;
- Food is Medicine interventions; and/or
- Services designed to support existing housing programs.

⁶⁰ <https://www.nehi-us.org/publications/32-the-boston-paradox-lots-of-health-care-not-enough-health/view>

Figure 4: ILOS Considerations



Specific examples of each of these interventions with case studies showing return on investment can be found in the report *In Lieu of Services to Address Nonmedical Drivers of Health: Three Potential Interventions and Related Evidence* published by the Center for Health Care Strategies.⁶¹

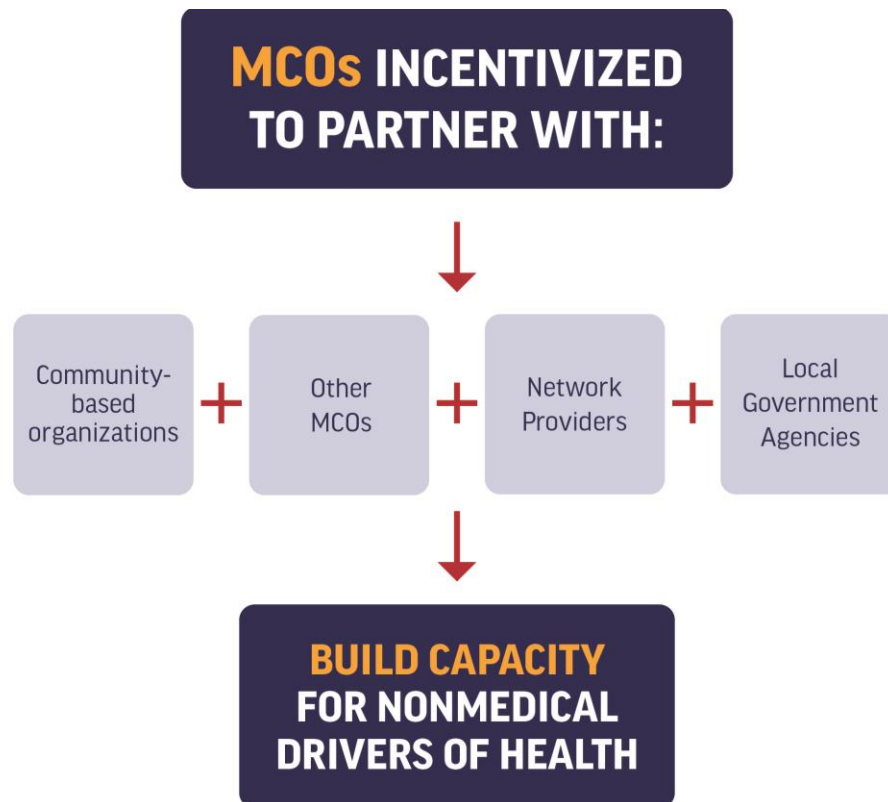
Recommendation 2

The Legislature should direct HHSC to create an incentive arrangement that rewards MCOs that partner with community-based organizations, other MCOs, network providers, and local government agencies to offer ILOS that address NDOH and build related capacity (Figure 5). The Legislature should authorize HHSC to use a portion of amounts received by the state under Texas Government Code §533.014⁶² (i.e., “experience rebates”) for this purpose.

⁶¹ <https://www.episcopalhealth.org/research-report/moving-upstream-how-medicaid-in-texas-could-use-in-lieu-of-services-to-address-non-medical-drivers-of-health/>

⁶² <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.533.htm>

Figure 5: Building Capacity to Address NDOH



Discussion

Positive health outcomes are driven by more than health care alone. What happens in homes and communities matters at least as much. The best available evidence indicates that particularly for many low-income individuals, addressing significant nonclinical needs can lead to real savings for the medical system and improvements in health.

NDOH are the conditions in which people live, work, play, and age that influence their health. NDOH can dramatically impact health outcomes. As a result, 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*⁶³ explored the impact of NDOH on Texas Medicaid and CHIP populations. This study found that NDOH 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 NDOH, and outcomes among pregnant women were also meaningfully associated with some NDOH factors. As a result, the *Focus Study* recommends that policymakers consider how they can prioritize interventions to address NDOH for Medicaid and CHIP members.

ILOS and NDOH

MCOs have the flexibility to provide services that are not formal Medicaid benefits. This flexibility has allowed MCOs to experiment with pilot programs that improve the quality and cost-effectiveness of their members' care. However, MCO payment rates do not typically fully 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 categorizing certain services as ILOS, a category defined in federal rule. This designation allows states to consider the cost and utilization of these services when setting rates for MCOs.

The use of ILOS is not new in Texas; in fact, the state is currently negotiating behavioral health ILOS with CMS.⁶⁴ ILOS have typically been used to substitute one medical service for another (e.g., providing a prenatal home visit in place of an office visit for a high-risk pregnancy). Its application to NDOH was theoretical and not widely implemented. An MCO may cover, for enrollees, services or settings that are ILOS, or settings covered under the State plan as follows:

- The State determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the State plan;
- The enrollee is not required by the MCO to use the alternative service or setting;

⁶³ Texas Managed Care Focus Study: Social Determinants of Health and their Impact on Health Care Quality Measures

⁶⁴ <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/medicaid-bh-lieu-services-annual-report-nov-2020.pdf>

- The approved ILOS are authorized and identified in the MCO contract, and will be offered to enrollees at the option of the MCO;
- The utilization and actual cost of ILOS is considered in developing the component of the capitation rates that represents the covered State plan services unless a statute or regulation explicitly requires otherwise.

Recent developments have shown that CMS is open to a broader definition of ILOS that includes covering evidence-based interventions addressing NDOH like food and housing insecurity. In 2022, California’s Medicaid program gave its health plans the option to provide 14 Community Supports, including services such as medically supportive food and meals, housing related services and supports, and asthma remediation. For example, asthma remediation can be used to minimize asthma triggers in the home of a Medicaid enrollee, resulting in decreased emergency department utilization related to asthma attacks.⁶⁵ CMS approved 12 of these community supports as ILOS; the remaining two Community Supports (short-term post-hospitalization housing and medical respite) were approved under the state’s 1115 demonstration.⁶⁶ Every six months, MCOs can update their county-specific selections to provide additional ILOS.

Forthcoming CMS guidance on ILOS

Dan Tsai, deputy administrator and director of CMS, has shared that CMS is excited about this new, broader view of ILOS and is planning to release detailed guidance to states that are interested in pursuing the use of ILOS to support interventions addressing NDOH. Detailed guidance will explore how states can pursue the ILOS authority and what evidence is needed to support their request. This guidance would be based on CMS’ approval of California’s program. Key criteria for approval include that ILOS are:⁶⁷

- Cost-effective when evaluated at the aggregate level;
- Evidence-based;
- Defined, clinically oriented service linked to Medicaid’s objectives; and
- Designed to serve a defined Medicaid population.

⁶⁵ <https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices>

⁶⁶ <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-Approval-Letter.pdf>

⁶⁷ <https://www.manatt.com/insights/webinars/meeting-health-related-social-needs-through-medica>

Based on this precedent-setting approval and upcoming guidance, states across the country, including Texas, can consider if and how to use the ILOS authority to support interventions designed to address NDOH for Medicaid enrollees and whether other options for Medicaid coverage (e.g., a state plan amendment authorizing a covered benefit, or a demonstration pilot program in certain geographic areas) may be more appropriate.

Implementation Considerations

The Committee also recommends incenting MCOs to take up and expand access to services that address NDOH. This section discusses how HHSC can financially and logistically support MCOs and community partners as they work to build the infrastructure, capacity, and partnerships needed to deliver ILOS that address NDOH, related to these two recommendations.

- **Ask for feedback.** HHSC should seek input from community members, community-based organizations, MCOs, and health systems to ensure that ILOS definitions, eligibility criteria, and related guidance are clear and effective. HHSC can explore a range of options, including advisory committees, requests for information, and listening and roadshow sessions in communities across Texas. HHSC can particularly look at opportunities to strengthen and not duplicate existing pilots and programs.
- **Strengthen community capacity.** Implementing ILOS will require close partnerships with community-based organizations that have traditionally been underfunded and not formally integrated into the health care system. HHSC should consider how to prepare community-based organizations for these new partnerships with Medicaid MCOs and providers, and explore the role of emerging and existing Community Care Hubs and community-based organization networks. Sources of funding for these capacity-building efforts could include: MCO incentive arrangements, VBP arrangements with upfront seed money or capacity-building funds, and new federal flexibilities under the American Rescue Plan Act for Home and Community-Based Services (HCBS) spending plans.⁶⁸ These Medicaid funds would be intended to supplement, and not supplant, other non-Medicaid resources, such as public health funds

⁶⁸ <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html>

and grants associated with COVID-19 (e.g., a \$45.2 million grant focused on health disparities in Texas⁶⁹).

The Committee recommends an MCO incentive arrangement to support these capacity-building efforts. Currently, HHSC has existing authority under Texas Government Code §533.014(c) to create incentive arrangements using excess MCO profits returned to the state.⁷⁰ MCOs must pay these excess profits (“experience rebates”) back to the state if the MCO’s net income before taxes is greater than a certain percentage of total revenue for the period. An ILOS-focused incentive arrangement is consistent with the statutory goals enumerated in Texas Government Code §533.014(c). The statute explicitly mentions cost-effectiveness (a key feature of ILOS) and notes that HHSC can “provide incentives to specific MCOs to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.”⁷¹

- **Allow flexibility to tailor ILOS to local community needs, preferences, and assets.** Texas is a large, diverse state with many urban and rural areas. HHSC should encourage interventions that are codesigned with individuals who have experienced nonmedical risk factors, such as food or housing insecurity, in each relevant community or region. This engagement will help develop effective, responsive programs that are tailored to local community needs, preferences, and assets. For example, HHSC should encourage culturally appropriate food and meal services that respect individuals’ dignity and agency to choose the foods they would like to eat, delivered by organizations that they trust in a way that is most convenient to them (e.g., at a community health center, at home, or at a food bank). Taking these steps will help engage Medicaid members and maximize the use and impact of these services.
- **Integrate primary care teams.** Primary care teams can help coordinate and manage care, identify NDOH, and refer eligible members for additional services that address identified needs. HHSC can consider ILOS in tandem with other initiatives seeking to advance whole-person, team-based, person-

⁶⁹ <https://www.dshs.state.tx.us/phfpcommittee/docs/COVID-19-Health-Disparities-Funding-10-12-2021/>

⁷⁰ <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.533.htm>

⁷¹ <https://statutes.capitol.texas.gov/Docs/GV/htm/GV.533.htm>

centered primary care. For example, HHSC can consider value-based care initiatives seeking to expand trauma-informed screenings for risk factors relating to NDOH and leverage the full spectrum of the health care workforce (e.g., community health workers, peer support providers, pharmacists, community paramedics, doulas, and direct care workers). Further, ILOS that address NDOH can help primary care teams address the many factors outside health care that impact health outcomes, bolstering these teams' abilities to succeed under VBP models.

- **Support data sharing and coordination.** To implement ILOS that address NDOH, providers, MCOs, HHSC, and community-based organizations in Texas will have to form partnerships with clear roles and responsibilities for: 1) identifying needs of Medicaid enrollees through social risk factor screening; 2) collecting and recording data from these screenings (e.g., through Z codes); 3) referring enrollees to appropriate interventions; 4) tracking and measuring progress; and 5) sharing data about outcomes or other relevant information across the broad care team. HHSC can consider ways to support the infrastructure needed for community-informed data sharing and coordination across stakeholders, such as developing a closed-loop referral system or community information exchange infrastructure and building on existing strengths of its 2-1-1 system.⁷² HHSC and Medicaid MCOs can encourage referrals to these new ILOS through multiple pathways, including health plans, health systems, primary care teams, community-based organizations, community-based organization networks, and local government entities.
- **Minimize administrative burden.** The Committee often discusses administrative burden as a barrier to provider uptake of VBP. Based on early experiences in California,⁷³ administrative burden can also be a barrier for uptake and implementation of ILOS, particularly for community-based organizations piloting new partnerships with health plans, and medical providers referring individuals to new types of services. Without additional support and resources, community-based organizations may be unable or unwilling to navigate different MCOs' negotiation and vetting processes, portals, claims submission, and data reporting processes. Primary care teams

⁷² <https://www.chcs.org/resource/a-community-centered-approach-to-data-sharing-and-policy-change-lessons-for-advancing-health-equity/>

⁷³ <https://www.chcf.org/publication/launching-calaim-10-observations-ecm-community-supports/#related-links-and-downloads>

may shy away from making referrals to ILOS if each plan in their area has different authorization criteria, and different service offerings. Responding to these concerns, HHSC can consider ways to encourage MCOs in each managed care service area to streamline and standardize technical assistance, capacity-building efforts, authorization criteria, and workflows.

Nonmedical 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 \(January 7, 2021\)](#)

[Housing Choice Plan \(May 2022\)](#)

[Medicaid Behavioral Health In-Lieu-of-Services Annual Report \(November 2021\)](#)

[Texas Medicaid VBP Advisory Committee SDOH Workgroup: In-Lieu-of Services Learning Session \(March 22, 2022\)](#)

[Center for Health Care Strategies In-Lieu-of Services Technical Assistance \(December 3, 2021\)](#)

[Medicaid Behavioral Health In-Lieu-of Services Annual Report \(2019\)](#)

[Community Supports in California \(October 2022\)](#)

Policy Issue: Timely and Actionable Data

Over the past six years, the Committee has focused on the importance of timely, actionable data to enable value-based care and movement toward more advanced care models along the value-based care continuum. MCOs and providers cannot succeed in APMs to better manage population health without necessary data. HHSC, policymakers, and other community partners also need data to make meaningful program improvements. The following recommendations focus on strategic improvements to understand and expand secure and timely data sharing among MCOs, providers, HHSC, and other public agencies.

Recommendation 1

HHSC should educate key Texas Medicaid staff and stakeholders about the admit, discharge, and transfer (ADT) and Consolidated Clinical Document Architecture (C-CDA) data it receives from the Texas Health Services Authority (THSA) and establish an annual process to prioritize implementation of new use cases to leverage the data to improve the Medicaid program in light of evolving operational needs.

Recommendation 2

HHSC should assess options for how to securely share additional data with Medicaid providers about their patients to help inform their participation in more advanced APMs and identify strategies to support providers' use of that data.

Recommendation 3

HHSC should conduct a six-month review of the Clinical Management for Behavioral Health Services (CMBHS) system to determine how the system can share data with MCOs and all Medicaid Mental Health Targeted Case Management and Rehabilitative Service providers; and how aggregate data can be easily shared with the public. The review workgroup must include members from the Committee, the Texas Council of Community Centers, MCOs, providers and other stakeholders.

Recommendation 4

HHSC should help support the development of a modernized data system at the county level that would permit rapid access to data related to deaths by suicide for researchers and the public while protecting individual privacy. The infrastructure could be developed through several initiatives:

- All Texas counties create a publicly available suicide data system in which data are derived directly from the medical examiner or justice of the peace electronic records. This would be modeled after the Tarrant County system with identifying information redacted.⁷⁴
- All Texas counties feed suicide data (including provisional data) into a publicly available state-level system that is updated more frequently than the federal data systems.
- Create linkages between vital records/mortality data and other public health and health care databases maintained by the Department of State Health Services (DSHS), such as the Texas Health Care Information Collection (THCIC).

Discussion

Prior Committee reports have extensively highlighted the critical nature of equipping the Texas HHSC, policymakers, MCOs, and providers with timely and actionable data to improve care in Medicaid and advance value-based care. The 2018 Committee Report recommended that HHSC develop a comprehensive initiative to leverage enhanced federal matching funds to maximize the usability of the United States Department of Health and Human Services system data resources, including by building capacity to integrate clinical and health risk data available through electronic health records (EHR) systems with Medicaid claims, pharmacy, and other administrative data sets. Some of the key data-related recommendations to the Texas 87th Legislature in 2020 included a statewide de-identified mother-baby database and expansion of use cases for the Texas Healthcare Learning Collaborative (THLC) Portal data in conjunction with other available data sources. Additionally, a recommendation was made to encourage cross-agency collaboration in the integration and use of health care data from many state and commercial payer sources administered by the UT Data Center.

The 87th Texas Legislature solidified the state's commitment to the use of multi-payer data through passage of HB 2090, which built upon this cross-agency collaboration to formally establish a Texas all-payer claims database (APCD) administered by the UT Data Center.⁷⁵ This database is intended to increase public transparency of health care information and improve the quality of health care.

⁷⁴ <https://mepublic.tarrantcounty.com>

⁷⁵ <https://9/13/2022.texas.gov/tlodocs/87R/billtext/pdf/HB02090F.pdf#navpanes=0>,

Among other provisions relating to the database, the bill provides for a portal that allows the public to easily access and navigate aggregated information in the database.

The 87th Legislature also focused on how to take important next steps for data sharing and care coordination related to the behavioral health needs of Texas Medicaid enrollees through the enactment of SB 640.⁷⁶ The bill requires HHSC to study the interoperability needs and technology readiness of behavioral health service providers. Based on the results of the study, HHSC is required to submit a report that includes a state plan and proposed timeline for aligning the interoperability and technological capabilities in the provision of behavioral health services with applicable law.

Regarding suicide surveillance, the 86th Legislature passed HB 3980, which required that the Statewide Behavioral Health Coordinating Council prepare a report regarding suicide rates in this state and state efforts to prevent suicides.⁷⁷ The report is required to include statewide and regional data on the prevalence rates of suicidal thoughts, suicide attempts, and deaths from suicide between 2000 and 2020; rates of death from suicide disaggregated by county and recognized categories of risk; and demographic correlates of death from suicide, including age, gender, and military status (i.e., active duty at the time of the event or veteran).

Use Cases for ADT and C-CDA Data in Medicaid

The 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.⁷⁸ 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 ADT data for Medicaid members and some related clinical data in C-

⁷⁶ <https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB00640F.pdf>

⁷⁷ <https://capitol.texas.gov/tlodocs/86R/billtext/html/HB03980F.htm>

⁷⁸ <https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=80R&Bill=HB1066>

CDA format.⁷⁹ ADT messages transmit administrative patient data related to patient identification and the patient hospital inpatient or emergency department (ED) visit. C-CDA based clinical data contains information such as patient demographics, encounter diagnoses, procedures, medications, lab values, and care plans.

The final State Medicaid Health Information Technology Plan (SMHP), which HHSC submitted to CMS on March 30, 2022, includes a goal to establish use cases for HIE data in the Medicaid and CHIP Services (MCS) division at HHSC with a target date of spring of 2023, including the use of this information in process workflows, as applicable.

The Committee strongly supports this SMHP recommendation and further recommends that HHSC educate MCS staff on the available data and integrate a process for Texas Medicaid to reassess on an ongoing basis the potential use cases for leveraging the ADT- and C-CDA-based data in light of evolving operational needs and implementation of new projects. These data have enormous potential to improve care and increase efficiency in the Medicaid program. For example, ADT data can be used to enhance care coordination and gain insight into the care coordination efforts by MCOs and their efficacy or for rapid cycle quality improvement projects to reduce PPVs. C-CDA data can be used for predictive analytics to forecast future service needs or assess what preventive and wellness interventions could lead to better health outcomes and potential cost savings.

Additional potential use cases could be considered for the THLC Portal and other data sources. One such use case may be to leverage available data within THLC, the UT Data Center, the THCIC and other data to focus on a specific high-incidence condition like diabetes, not only in Medicaid but also among other state payers. Another use case may be to leverage data in THCIC on uncompensated care provided in hospitals to quantify the care and assess the health of the uninsured population.

The potential use cases developed should be analyzed for the value they bring to advancing health care in Texas, and a strategy should be developed to implement

⁷⁹ 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.

the most valuable and feasible use cases. During this process, Texas should clearly delineate the roles and responsibilities of each data source (i.e., THLC, THCIC, UT Data Center, etc.) so that health care data consumers understand which data source is the access point for each purpose, and ensure there is not duplication of resources. Consideration should be given to the strengths of each existing data source, their existing authorities for data use and dissemination, and how to minimize disruption or confusion among the existing base of consumers for each data source.

Assessment of Options to Get Data to Medicaid Providers for Participation in Advanced APMs

Timely and actionable data is a necessary foundation for providers to engage in more advanced, risk-based APMs and to be stronger partners with Texas Medicaid in improving patient outcomes and reducing the total cost of care. More comprehensive data about health status and the full spectrum of health care utilization for a provider's patients can achieve better care management and coordination, facilitate performance measurement on more meaningful quality metrics, and enable providers to assess areas for performance improvement. All of these are critical pieces to support providers engaging in APMs to take more accountability for their patients' overall health and total cost of care.

Through their enactment of HB 1218 in 2009, the 81st Texas Legislature acknowledged the need for providers and the broader Medicaid system to have data by requiring HHSC to establish the Medicaid Eligibility and Health Information System (MEHIS), which would include an electronic health record (EHR) and "establish a foundation for future HIE for improved efficiency, continuity of care, and health outcomes."⁸⁰ The MEHIS EHR was intended to include key data elements for Medicaid-enrolled clients as they became available, including claims and encounter data, immunization information, prescription drug history, THSteps service information, laboratory data, and other health history information.⁸¹ Ultimately, HHSC has attempted to implement the intent of HB 1218 with resources available through TMHP. Challenges in implementing MEHIS are an example of the need for ongoing consideration of additional means of getting data to providers to help them manage patient care.

⁸⁰ <https://capitol.texas.gov/BillLookup/Text.aspx?LegSess=81R&Bill=HB1218>.

⁸¹ 1 TAC §356.101

HHSC's requirements for MCO APMs with providers, which are further discussed in the section on Next Steps for Alternative Payment Models, have also historically acknowledged the importance of providers receiving data by requiring that MCOs implement processes to share data and performance reports with providers participating in APMs on a regular basis.⁸² Despite this contractual requirement, providers continue to express their need for more timely data on the patients in their own panels, such as information on hospital ED visits and inpatient stays, utilization of specialty care and other services, lab values, and prescribing histories.

The Committee recommends that Texas Medicaid identify data HHSC can share with providers about their own patients, explain why other data cannot be shared, and explore the feasibility and steps necessary to share data. This assessment should include whether and how HHSC can provide historical encounter (utilization) data to providers for their patient panels. Some primary care providers have requested these data from HHSC on their assigned patients to help them engage in more advanced APMs. This assessment should also include consideration of the sharing of available but currently untapped or underutilized data, such as the ADT and C-CDA data discussed in this section, the findings of the SB 640 report on the interoperability of behavioral health data, and any available data on NDOH. HHSC should assess ways to leverage existing tools like the THLC Portal to integrate and share additional data. This initiative will equip providers with the necessary data to participate in APMs that involve more risk and reward them for managing the fuller spectrum of patient care.

The THLC portal is a strong, public-facing tool that provides data on Medicaid MCO and dental maintenance organization (DMO) performance, including on potentially preventable events, medical and dental quality of care measures, and CMS core measures.⁸³ Information is available in dashboards that can be searched by year, program type, MCO, and measure set, and the aggregated data may be downloaded. THLC data are primarily used by HHSC, MCOs, and DMOs, though it can also be accessed directly by providers, enrollees, and other stakeholders.

There is an opportunity to grant providers access to their own outcome data so they may compare their performance to state and regional benchmarks of similar providers, manage patient care, and assess opportunities for value-based

⁸² HHSC *Uniform Managed Care Contract*, 8.1.7.8.2 MCO Alternative Payment Models with Providers

⁸³ <https://thlcportal.com/home>

purchasing. In addition, protected access could be granted for longitudinal, patient-level data that would facilitate continuity of care and care transitions even when patients move or switch MCOs.

Review of the CMBHS System

DSHS developed the CMBHS system, which began operating in December 2009. The system is used across the state with DSHS- and HHSC-contracted substance use disorder and mental health treatment service providers and others who qualify.

Some providers use CMBHS as their EHR and claims payment system, while others mainly use it to submit data to the state to fulfill contract requirements. The system includes clinical tools that standardize the assessment, diagnosis, and level-of-care determination and treatment processes. Providers also use it to document the services provided and send claims directly to the HHS program that processes and pays that claim type.

CMBHS supports data exchange between:

- HHSC and Local Mental Health Authorities (LMHA);
- Contracted substance use disorder and mental health service providers (with client consent as required by law); and
- HHSC and other state agencies to coordinate care and help with oversight of services and claim payments.
- Service providers contracted with Texas HHSC for delivering mental health services or substance use disorder services are the primary users of CMBHS. The requirements for using CMBHS are defined in their contracts.

The carve in of Mental Health Targeted Case Management and Rehabilitative Services into Medicaid managed care (SB 58, 83rd Legislature, Regular Session, 2013) allowed other non-LMHA providers to deliver these services in Medicaid managed care.⁸⁴ Providers of Mental Health Targeted Case Management and Rehabilitative Services must use the CMBHS system in order to be a credentialed provider of these services. However, data are not shared back with providers of

⁸⁴ <https://capitol.texas.gov/tlodocs/83R/billtext/html/SB00058F.htm>

these services and CMBHS does not share data with the Medicaid MCOs. Aggregate data is also not easily shared or reported to stakeholders.

The Committee recommends that HHSC conduct a six-month review of the CMBHS system to determine how the system can share data with all Medicaid Mental Health Targeted Case Management and Rehabilitative Service providers, MCOs; and how aggregate data can more easily be shared with the public. The review workgroup must include members from the Committee, The Texas Council of Community Centers, MCOs, providers and other stakeholders.

Modernized Data System for County-Level Data Related to Suicide

Timely and actionable data is a necessary foundation to inform policy and clinical practice for suicide prevention. The inability to access near real-time data on deaths from suicide and drug overdose has made it impossible to identify potential spikes in suicide and overdose deaths during the federal PHE, or at any time. Instead, reports focus on more readily available information such as patterns in ED presentations for suicide-related injuries and calls to crisis hotlines. Although these are important risk indicators, they are not equivalent to rates of death from suicide and do not provide the essential data needed to inform clinical practice and policy. As a result, interventions and policies to reduce deaths from suicide may not be implemented for three or four years after the increase in deaths has occurred.

Currently, a formal request for mortality data to DSHS to obtain contemporary, patient-level data is required. Because these data are sensitive, the data request process is lengthy, and a request for de-identified, person-level data must be reviewed and approved by both an institutional review board at DSHS and a Committee on Requests for Personal Data.⁸⁵ The release of person-level data for legitimate public health surveillance or research purposes is permissible according to the Texas Administrative Code (25 TAC §181.11)⁸⁶ and has more steps than the federal process for obtaining data at the state and county levels.⁸⁷ Data access and modernization has been prioritized by the CDC. The CDC has begun to generate the software infrastructure needed to enable bidirectional reporting between death

⁸⁵ <https://www.dshs.texas.gov/chs/vstat/RequestProcedures.shtm>

⁸⁶ [https://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=181&rl=11](https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=181&rl=11)

⁸⁷ https://www.cdc.gov/nchs/data_access/vitalstatsonline.htm

certifiers, states, and the CDC. In 2022, the CDC's data initiative highlights modernizing non-infectious disease data (including suicides) as a key initiative, using the infrastructure and lessons learned from the federal PHE.

To remedy these gaps, a data system that relays mortality data from the medical examiner or justice of the peace to DSHS and to other stakeholders (in a predefined deidentified format), including researchers, policy analysts, and public health departments charged with surveilling public health, etc. is needed. Health care data alone cannot be used as a surveillance tool to identify deaths from suicide or drug overdose. Many patient deaths occur outside the health care system and are therefore not monitored or recorded in health care data systems. Vital records information should be made available more routinely to advance knowledge and evidence-informed policy.

Figure 6: Tarrant County Dashboard

2200959	Tarrant			29	1/14/2022	Black	M
Police Department:	Fort Worth Police Department				Police Svc #:		
Deceased Address:					Time Of Death	12:27 AM	
Occurred Location:							
Place Of Death:	Hospital				Prosecutor:		
Place Of Death Address:					Manner Of Death:	SUICIDE	
Cause Of Death:	GUNSHOT WOUND OF HEAD						
EDR #:							
Certificate of Death							
Amendment:							
Ready for Transport:	Released				Report Completed:	No	
Type of Exam:	Autopsy						
2201423	Denton			26	1/19/2022	White	M
Police Department:	Lewisville Police Department				Police Svc #:		
Deceased Address:					Time Of Death	2:41 PM	
Occurred Location:							
Place Of Death:	Hospital				Prosecutor:		
Place Of Death Address:					Manner Of Death:	SUICIDE	
Cause Of Death:	HANGING						
EDR #:							
Certificate of Death							
Amendment:							
Ready for Transport:	Released				Report Completed:	No	
Type of Exam:	Autopsy						

Model jurisdictions providing near real-time data on deaths from suicide exist. The Tarrant County data system permits the release of detailed, death record information for public use. Figure 6 is a redacted screenshot example of the

information that is publicly accessible.⁸⁸ The Oregon Health Authority, Center for Health Statistics provides preliminary death data via a user-friendly dashboard,⁸⁹ including deaths from suicide.⁹⁰ Mortality data lags two months from the current time, with data updated monthly. Orange County Health Care Agency in Orange County, California, maintains a suicide data dashboard based on California Comprehensive Death File data.⁹¹ Preliminary data are available within three months from the current time, with final data availability within six months. New data or corrections to previous data are updated on or before the fifth of each month.

The Committee recommends the development of a modernized data system at the county level that redacts identifiable information (i.e., addresses, dates of birth, names, etc.) to maximize access to death records for researchers and the public as they become available while protecting individual privacy. Each of the three recommendations identified above would expand the availability of mortality data for legitimate public health surveillance purposes without compromising individual privacy. Creating a state-level system to organize and release data (including provisional data) on deaths from suicide streamlines the existing reporting system. The State of Texas and the CDC agree that timely access to data is a priority in modernizing data and tracking health trends. If these data were more readily available, researchers, health officials, policy analysts, and policy makers could identify geographic hot-spots or emergency trends months or years before the official data are released.

Once individual-level data on deaths from suicide are regularly released, analysts could then join data with other state-level databases. Creating linkages with other data and sources of information is vital in saving lives. Data must be systematically combined to provide a complete picture of trends. Other sources, such as the THCIC, could add important information on hospital utilization for behavioral health reasons, including suicidal ideation and attempts. Program planners and decision-

⁸⁸ <https://mepublic.tarrantcounty.com/?AspxAutoDetectCookieSupport=1>

⁸⁹ https://visual-data.dhsoha.state.or.us/t/OHA/views/Year-to-datepreliminarydeathwebtables/Manner?percent3Adisplay_count=n&percent3Aembed=y&percent3AisGuestRedirectFromVizportal=y&percent3Aorigin=viz_share_link&percent3AshowAppBanner=false&percent3AshowVizHome=n

⁹⁰ <https://www.oregon.gov/oha/ph/birthdeathcertificates/pages/index.aspx>

⁹¹ <https://www.ochealthinfo.com/about-hca/mental-health-and-recovery-services/wellness-promotion-prevention/suicide-prevention>

makers can use the comprehensive information to create and adapt suicide prevention efforts and prioritize initiatives in communities with high rates of suicide.

Timely and Actionable Data: Key Reports and Other Resources

[Legislative Report on Suicide and Suicide Prevention in Texas \(December 21, 2020\)](#)

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 improved health outcomes, particularly in Medicaid and CHIP.

Our recommendations related to APMs in Medicaid, value-based care in home health and pharmacy, NDOH, and timely, actionable data, can be implemented and integrated across numerous programs and agencies. We invite and 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
APM	Alternative Payment Model
APO	Accountable Pharmacy Organization
C-CDA	Consolidated Clinical Document Architecture
CDC	US Centers for Disease Control & Prevention
CHIP	Children’s Health Insurance Program
CIN	Clinically Integrated Networks
CMBHS	Clinical Management for Behavioral Health Services
CMS	Centers for Medicare & Medicaid Services
DMO	Dental Maintenance Organization
DPP	Directed Payment Program
DSHS	Texas Department of State Health Services
DSRIP	Delivery System Reform Incentive Payment
ED	Emergency Department
EHR	Electronic Health Record
FFS	Fee-For-Service
HB	House Bill

Acronym	Full Name
HbA1c	Hemoglobin A1c
HCBS	Home and Community-Based Services
HCP-LAN	Health Care Payment Learning & Action Network
HHSC	Texas Health and Human Services Commission
HHVBP	Home Health Value-Based Purchasing
HIE	Health Information Exchange
ILOS	In-Lieu-of Service
LMHA	Local Mental Health Authority
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MEHIS	Medicaid Eligibility and Health Information System
MLTSS	Managed Long-Term Services and Supports
MTM	Medication Therapy Management
NDOH	Nonmedical Drivers (or Determinants) of Health
P4Q	Medical and Dental Pay for Quality
PBM	Pharmacy Benefit Manager
PeCP	Pharmacist eCare Plan
PIP	Project Improvement Plan
PPA	Potentially Preventable Hospital Admissions
PPV	Potentially Preventable Emergency Department Visits
PSAO	Pharmacy Services Administrative Organization

Acronym	Full Name
QIPP	Quality Incentive Payment Program
SB	Senate Bill
SMHP	State Medicaid Health Information Technology Plan
THCIC	Texas Health Care Information Collection
THLC	Texas Healthcare Learning Collaborative Portal
THSA	Texas Health Services Authority
THSteps	Texas Health Steps
TMA	Texas Medical Association
TMHP	Texas Medicaid & Healthcare Partnership
UT Data Center	Center for Health Care Data at The University of Texas Health Science Center at Houston School of Public Health
VBP	Value-Based Payment