TEXAS INSIGHT
HEALTHCARE INTELLIGENCE

Health and Human Services

Value-Based Payment and Quality Improvement Advisory Committee

August 18, 2025

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

Value-Based Payment and Quality Improvement Advisory Committee provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services and the wider health care system. Members:

- Paul Aslin, Beach City
- Dana Danaher, DrPH, Austin
- Frank Dominguez, El Paso
- Rachel Hammon, New Braunfels
- Susan Hood, North Richland Hills
- Carol Huber, Chair, DrPH, San Antonio
- Aliya Hussaini, MD, Austin
- Kathy Lee, Gatesville
- Luming Li, MD, Sugar Land
- Karen Love, Fort Worth
- Benjamin McNabb, Pharm. D., Eastland
- Rachana Patwa, Missouri City
- Joseph Ramon III, RPh, Mission
- Vernicka Sales, DO, Houston
- Shao-Chee Sim, PhD, Missouri City
- Karl Serrao, MD, Corpus Christi
- Michael Stanley, MD, Fort Worth
- Roberto Villarreal, MD, Seguin
- David Weden, Buda

Ex Officio Representatives

- Lisa C. Kirsch, Vice-Chair, Austin
- Mike Ragain, MD, Lubbock
- Shayna Spurlin, College Station

1. Welcome and roll call. The meeting was convened by David Weden, Chair.

2. Consideration of June 3, 2025, draft meeting minutes. The minutes were approved as drafted.

3. HHSC staff update.

Quality and Program Improvement update.

- Updates on the Alternative Payment Model (APM) summary: results are now public, and individual results will be shared with MCOs by month-end.
- Atlas Program (Aligning Technology by Linking Interoperable Systems): all participating MCOs submitted required assessments, no concerns noted, Year 2 framework in development with MCO feedback soon.
- Atlas Year 2 will focus on connectivity growth, early health info exchange usage, workflow integration, and improved barrier management.
- Post-legislative work is ongoing around new quality implementation plans from the 89th session.

House Bill (HB) 1575, 88th Legislature, Regular Session, 2023 Implementation

- Medicaid Managed Care Organizations (MCOs) and Thriving Texas Families (TTF) screen pregnant women for non-medical health-related needs and coordinate services
- Pregnant women must opt-in • MCOs and TTF share results with HHSC
- Community Health Workers (CHW) and Doulas as new providers of Medicaid case management for Children and Pregnant Women (CPW) case management services
- Revised provider training for CPW services • Report sent to the Legislature every two years

non-medical-health-related-needs-certain-pregnant-women-2024.pdf

Summary of MCO Contracts, effective as of Sept. 1, 2024

Medicaid managed care contracts include screening and data sharing requirements:

- Uniform Managed Care Contract (UMCC), Section 8.1.13.3;
- STAR Kids Contract, Section 8.1.39.4;
- STAR Health Contract, Section 2.6.46.5; and
- STAR+PLUS Contract, Section 2.6.59.3.

Uniform Managed Care Manual (UMCM) chapters include final screening questions and text file layout MCOs must use to submit required data to HHSC via TexConnect.

- UMCM Chapter 16.10 , Non-Medical Needs Screening for Pregnant Members
- UMCM Chapter 5.24.14 , Non-Medical Needs Screening Report Text File Layout
- UMCM Chapter 5.0.1 , Deliverable Requirements Matrix

MCO Responsibilities

Complete the Screening For all consenting pregnant members within 30 days of the member's enrollment or after the MCO identifies a pregnant member

Use the Results Determine if the member requires:

- Covered services, like CPW
- Service coordination
- Value-added services

- Referrals to community resources

Report Data First report due Jan. 30, 2025, must include data from Sept. 1, 2024, through Dec. 31, 2024. Subsequent reports will be submitted monthly.

Non-Medical Needs Screening Report: Updates

Highlights

- Each month, 100% of the expected total deliverables have been submitted on time by the MCOs.
- As of today, MCOs have submitted data for 10 total reporting months (Sept 2024 – Jun 2025).
- Provisional data trends suggest the prevalence of non-medical needs are similar to the trends seen in MCO pilot data from Summer 2024.

Data Limitations

- Reporting total pregnant population
- Reporting skip pattern errors, implausible values, and outlies

Next Steps

- HHSC is providing technical assistance to MCOs to:
- Improve accuracy of reported data
- Help share member outreach and screening best practices

Non-Medical Needs among Pregnant Members Screened in Feb 2025		
Non-Medical Need	**Identified Need**	**Want Help***
Food Insecurity	30%	62%
Transportation	10%	72%
Experiencing Homelessness	2%	47%
Housing Insecurity	3%	
Paying Utilities	12%	
Housing Quality	6%	
Child Care	19%	91%

Appendix Table B-2. [Leg Report pg. 34]

Table B-2. Percentage of Medicaid Pregnant Women with Positive Screening Results During the Pilot, Based on Non-Medical Need and Wanting Help with that Type of Need[1,2]

Type of Non-Medical Need	MCO A	MCO B	MCO C	MCO D	MCO E[3]	MCO F	MCO G	MCO H	MCO I	MCO J	MCO K
n	*34*	*145*	*197*	*70*	*3*	*163*	*59*	*259*	*37*	*131*	*61*
Food Insecurity	27%	48%	12%	31%	-	22%	44%	42%	38%	24%	69%
Want Help, Food?[4]	100%	91%	63%	36%	-	50%	46%	78%	57%	69%	67%
Transportation	24%	19%	4%	6%	-	8%	10%	14%	11%	8%	18%
Want Help, Transport?[4]	100%	93%	25%	0%	-	62%	33%	75%	50%	73%	64%
Experiencing Homelessness	0%	2%	2%	3%	-	13%	0%	4%	8%	2%	7%
Housing Insecurity	12%	6%	0%	0%	-	1%	2%	5%	5%	7%	15%
Paying Utilities	24%	7%	8%	6%	-	7%	15%	15%	5%	10%	31%
Housing Quality	3%	10%	4%	14%	-	20%	25%	13%	19%	5%	18%
Want Help, Housing?[4]	73%	57%	43%	0%	-	14%	6%	57%	56%	48%	43%
Child Care	18%	17%	25%	9%	-	17%	19%	26%	30%	18%	33%
Want Help, Child Care?[4]	100%	100%	70%	50%	-	86%	91%	90%	82%	87%	85%

Data Source: MCO pilot data June-July 2024. Analysis by HHSC-DAP.

non-medical-health-related-needs-certain-pregnant-women-2024.pdf

89th Legislature, Regular Session, 2025 update: Quality and Program Improvement bills (Senate Bill (SB) 1 Rider 23, Rider 35, Rider 38, and Special Provision 31; HB 18, HB 26, HB 136, HB 138, SB 926, SB 1188, HB 3940, HB 5155)

Key Bill Topics

- Data sharing and interoperability
- In-Lieu-of Services and Settings (ILOSs)
- Maternal health
- Value-Based payment initiatives
- Rural health
- Medicaid program delivery
- Key takeaways, 2026-27 General Appropriations Act

1604 SAN ANTONIO, AUSTIN, TEXAS 78701 TEL: 512-944-8994 WWW.TXINSIGHT.COM

Data Sharing & Interoperability

Overview of Bills Passed

- **Senate Bill 1188 (Kolkhorst)**
  - Requires HHSC, Texas Medical Board, and TDI to adopt rules with requirements for storage, content, and management of electronic health records
- **House Bill 3940 (Johnson)**
  - Requires HHSC to notify medical providers, hospitals, birthing centers, and managed care organizations that a newborn not yet assigned a Medicaid ID number may use the mother's Medicaid ID

In-Lieu-of Services (ILOS)

Overview of Bills Passed

- **House Bill 26 (Hull)**
  - Requires HHSC to add nutritional counseling as an in-lieu-of service (ILOS)
  - Requires HHSC to implement an ILOS pilot for pregnant women to receive nutritional counseling and medically-tailored meals

Maternal Health

Overview of Bills Passed

- **House Bill 136 (Hull)**
  - Requires HHSC to add lactation consultation as a reimbursable Medicaid benefit
- **House Bill 5155 (Rose)**
  - Continuation and expansion of the Maternal Opioid Misuse (MOM) model pilot

Value-Based Payment Initiatives

Overview of Bills Passed

- **Senate Bill 926 (Hancock)**
  - Allows an MCO, including Medicaid and CHIP MCOs, to provide incentives to use services from a particular physician or provider
  - MCOs must comply with federal rules that ensure provider incentive plans are not for the purpose of limiting medically necessary services or lowering the quality of care

1604 SAN ANTONIO, AUSTIN, TEXAS 78701 TEL: 512-944-8994 WWW.TXINSIGHT.COM

Rural Health

Overview of Bills Passed

- **House Bill 18 (VanDeaver)**
  - Establishes and administrators' certain programs and services providing health care services to rural counties

Medicaid Program Delivery

Overview of Bills Passed

- **House Bill 138 (Dean)**
  - Establishes a Health Impact, Cost, and Coverage Analysis Program at the Center for Health Care Data at UTHealth Houston.

2026-27 General Appropriations Act: Key Takeaways

Reimbursement Rates/Increases

- **Rider 23**
  - Attendant wage increases and impacts to the attendant care rate enhancement programs

Program Impacts

- **Rider 35**
  - Nutritional counseling and instructional services as in-lieu-of services
- **Rider 38**
  - Evaluate feasibility of creating a diabetes prevention program
- **Special Provision 31**
  - Requires development of service coordination protocols in STAR Health

23. Base Wage Increase for Personal Attendant Services.
(a) Included in the amounts appropriated above in Goal A, Medicaid Client Services, Strategy D.2.3, Behavioral Health Waiver & Amendment, and Strategy F.1.2, Non-Medicaid Services, is $470,883,027 from the General Revenue Fund and $716,822,548 from Federal Funds ($1,187,705,575 from All Funds) in fiscal year 2026 and

$494,762,919 from the General Revenue Fund and $753,159,237 from Federal Funds ($1,247,922,156 from All Funds) in fiscal year 2027 to increase the base wage for personal attendant services to $13.00 per hour, increase the associated payroll costs, taxes, and benefits percentage to 15.0 percent for services provided in residential settings and 14.0 percent for services provided in non-residential settings, and increase the associated administrative rate by $0.24 per hour.

(b) The Health and Human Services Commission (HHSC) shall utilize any funds that were previously expended for the attendant compensation rate enhancement programs for the base wage increase described in subsection (a) and shall discontinue the attendant compensation rate enhancement programs for community care services, intermediate care facility services, and intellectual and developmental disability services.

(c) Out of funds appropriated in Strategy B.1.1, Medicaid & CHIP Contracts and Administration, HHSC shall continue to collect biennial cost reports from providers to monitor the average hourly wage and associated payroll costs, taxes, and benefits. HHSC shall calculate for each provider the total amount that was paid to the provider that is attributable to the direct care wages, payroll costs, taxes, and benefits, the amount expended by the provider for that purpose, and the ratio of expenses to revenue to determine a direct care wage and benefits expense ratio. HHSC shall report to the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House of Representatives, and the Office of the Governor on an annual basis by November 1 of each year on the findings, including a list of providers whose calculated direct care staff wage and benefits expense ratio is less than 0.90.

35. Nutritional Support Services. Out of funds appropriated above, the Health and Human Services Commission (HHSC) may permit a managed care organization to offer nutritional support services in lieu of a service or setting covered under the state plan. The nutritional support services must be clinically appropriate and a cost-effective substitute for a covered Medicaid service.

In determining nutritional support services to include in the contract with managed care organizations, HHSC shall take into consideration nutrition counseling and instruction services, tailored to health risk or demonstrated outcome improvement.

38. Diabetes Prevention Program.
(a) Out of amounts appropriated above to the Health and Human Services Commission (HHSC) that are available for that purpose, the commission shall conduct a study, in consultation with the Department of State Health Services, to evaluate the cost-effectiveness and feasibility of implementing and administering a diabetes

prevention program for Medicaid recipients, including alternative interventions for Medicaid recipients at risk of developing Type 2 diabetes.

(b) Not later than November 1, 2026, HHSC shall submit to the Governor, the Legislative Budget Board, the Senate Finance Committee, the House Appropriations Committee, and each standing committee of the Legislature with jurisdiction over health and human services a written report containing the findings of the study conducted under this rider and any recommendations for legislative or other action based on those findings.

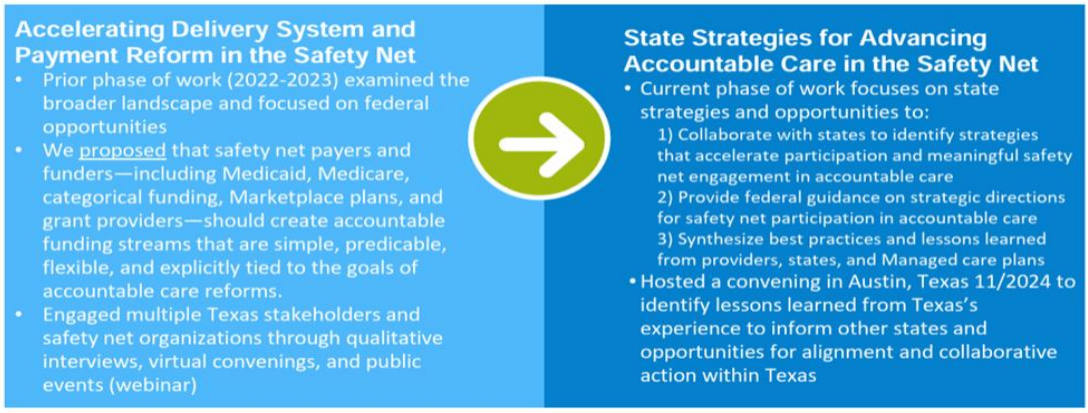
Special Provisions Sec. 31. STAR Health Services Coordination. Not later than August 31, 2026, the Health and Human Services Commission shall, in collaboration with the STAR Health managed care organization and the Department of Family and Protective Services, develop written protocols to operationalize the service coordination requirements in the STAR Health Medicaid managed care contract. The written protocols should, at a minimum, define a process through which a STAR Health service coordinator participates in the development of the Child's Plan of Service and defines the service coordinator's role in facilitating access to all STAR Health covered services identified in the plan.

Discussion. No discussi0on

4. Stakeholder presentation: Duke-Margolis Institute for Health Policy, Center for Medicare and Medicaid Innovation Strategic Direction Refresh

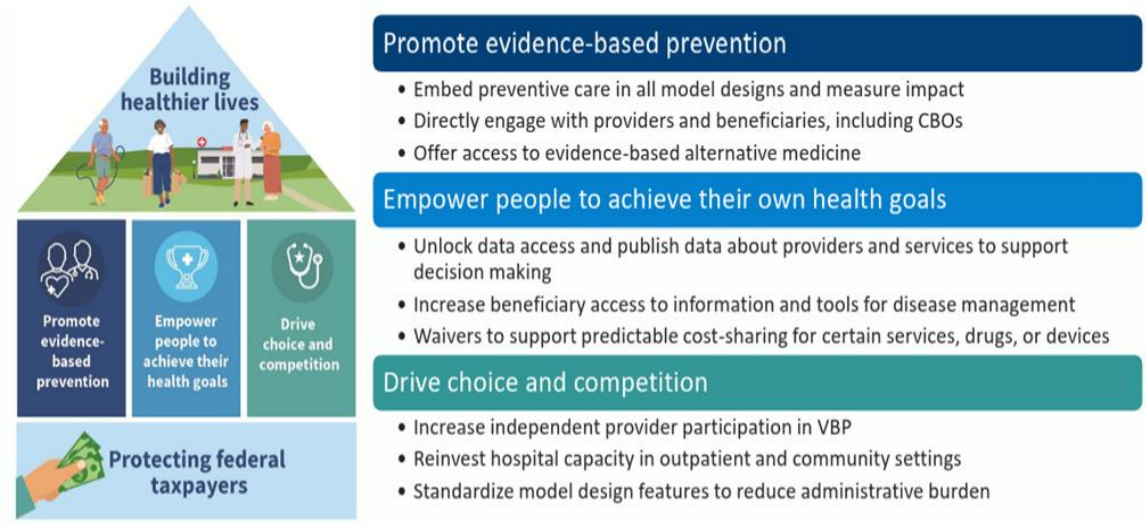
Mission: To improve health, health equity, and the value of health care through practical, innovative, and evidence-based policy solutions.

Duke-Margolis's continued health care transformation efforts in Texas to advance the health care safety net.



Overview of Recent CMS Priorities and Actions

CMMI Strategy to Make America Healthy Again



Health Care Payment Learning & Action Network (LAN) Launches Four Strategic Initiatives. HCPLAN is reaffirming its commitment to value-based care, aligning with CMMI's "Make America Healthy Again" strategy. The organization is shifting focus to strengthen public-private partnerships, accelerate innovation, reduce costs, and explore new, cost-effective approaches to improve data access and care management.

CMMI Pillars are Underpinned by CMS' Commitment to Advancing a Health Technology Ecosystem

On July 30, 2025, CMS Announced an Interoperability Framework defining data sharing principles and five criteria:

I. Patient Access & Empowerment CMS is also partnering with tech companies for patient-facing apps for three use cases:

II. Provider Access & Delegation

III. Data Availability & Standards Compliance

IV. Network Connectivity & Transparency

V. Identity, Security & Trust

CMS is also partnering with tech companies for patient-facing apps for three use cases

Early Actions from CMS to Leverage Technology

CMS & ASTP/ONC RFI on Digital Health Innovation

- **Seeking input to:**
- Accelerate adoption of digital health and care navigation tools
- Strengthen interoperability via open, secure standards
- Address barriers to seamless health data exchange
- Reduce administrative burden to support patient-centered care

HHS & CMS Prior Authorization Reform

- Standardize electronic prior auth using FHIR® APIs
- Reduce services requiring prior auth by 2026
- Ensure continuity of care during coverage transitions
- Improve transparency and appeals processes
- Expand real-time approvals by 2027
- Require clinical review for all denials

WISeR (Wasteful and Inappropriate Service Reduction) Model

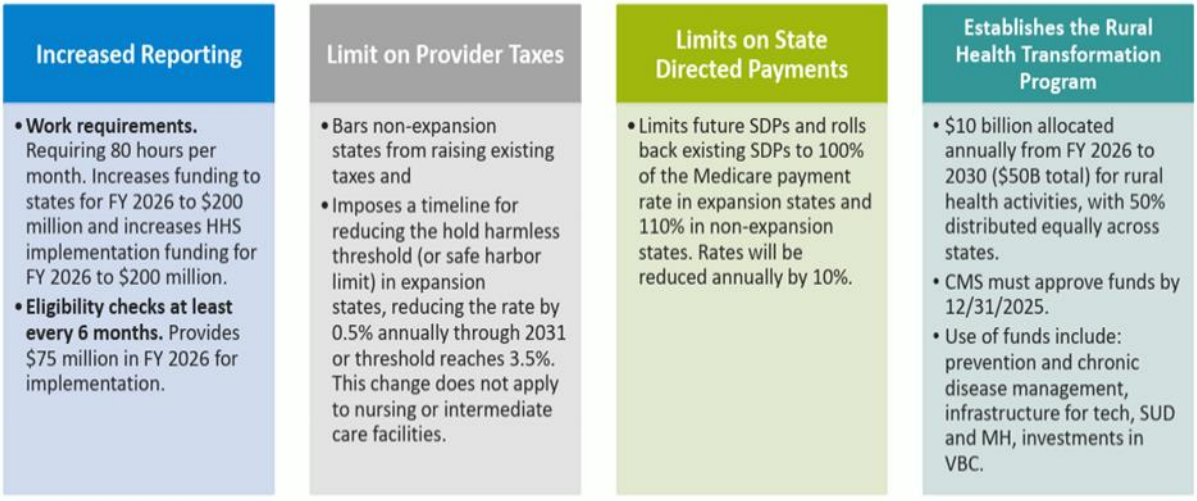
- Reducing fraud, waste, and abuse and targeting low-value care
- Leveraging advanced tools (AI and Machine Learning) to streamline and improve accuracy in prior authorization
- Ensuring licensed clinicians review all denial decisions
- Improving transparency in data reporting and appeals tracking

HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System | HHS.gov

CY2026 Payment Policies in the Physician Fee Schedule

- Medicare Shared Savings Program: Move ACOs inexperienced with risk into risk-based arrangements sooner, reducing the time ACOs can stay in a one-sided risk arrangement from 7 to 5 years. Provide flexibility in reaching 5,000 assigned beneficiaries (Y3).
- Enhanced Care Management and Behavioral Health: Create add-on Advanced Primary Care Management (APCM) services for complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM) services, but without time-based requirements. Safety net providers (FQHCs and RHCs) permitted to use new codes.
- Prevention and Management of Chronic Disease RFI seeking input on services not adequately captured by PFS, services to address social isolation and loneliness, services to improve physical activity and lifestyle interventions
- Establishes the Ambulatory Specialty Model (ASM), which would be mandatory for specialists commonly treating heart failure or low back pain, to improve prevention and upstream chronic disease management. Participating specialists required to enter into agreements with PCPs to support coordination and evidence-based prevention efforts. TEAMs also finalized in IPPS. ASM (Ambulatory Specialty Model) | CMS

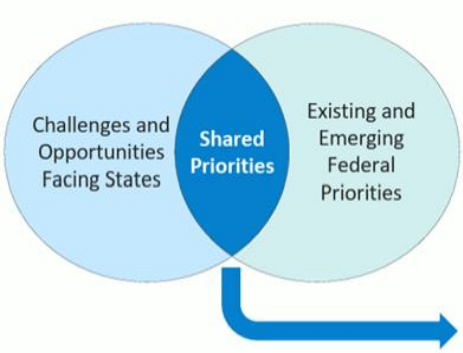
Key Provisions of H.R.1, One Big Beautiful Bill Act



Text - H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act | Congress.gov | Library of Congress

Areas of Alignment for Health Care Transformation in Texas

State-Federal Synergies: Navigating Challenges and Advancing Shared Priorities

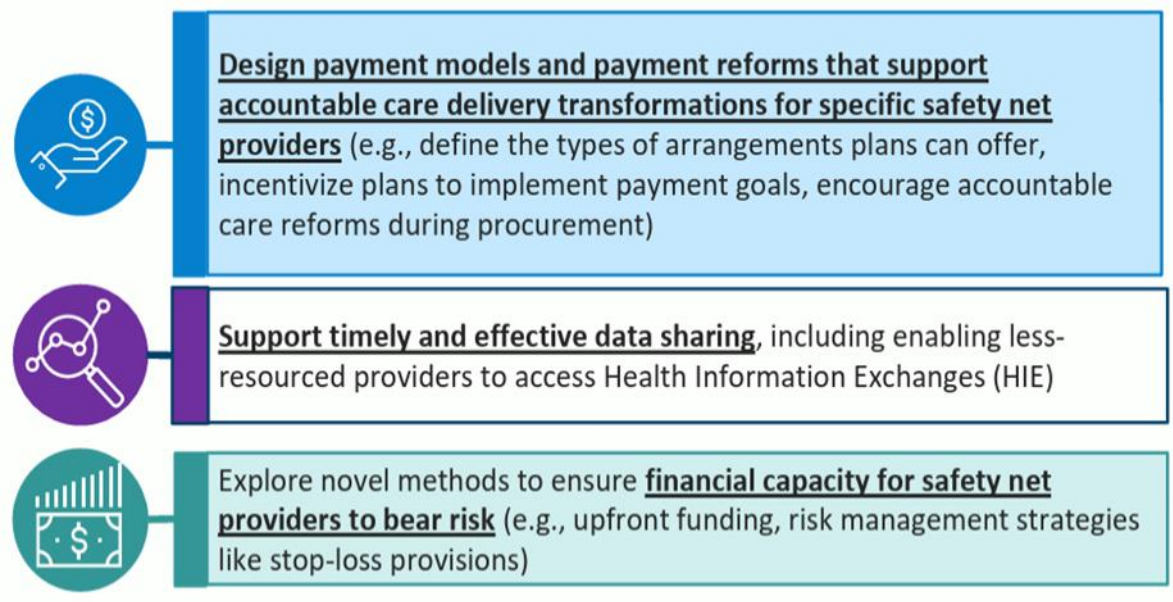


Shared priorities and opportunities:

- Promote evidence-based prevention and primary care
- Increase independent provider participation in accountable care
- Enhance timely and effective data sharing for vulnerable populations to improve care coordination
- Move more providers into risk bearing arrangements
- Advance the financially sustainability of the health care system
- Ensure federal dollars are tied to stronger primary care and there is longitudinal management of the patient across their care journey

Progress in Innovative, Value-Based Health Care for the Most Vulnerable Texans

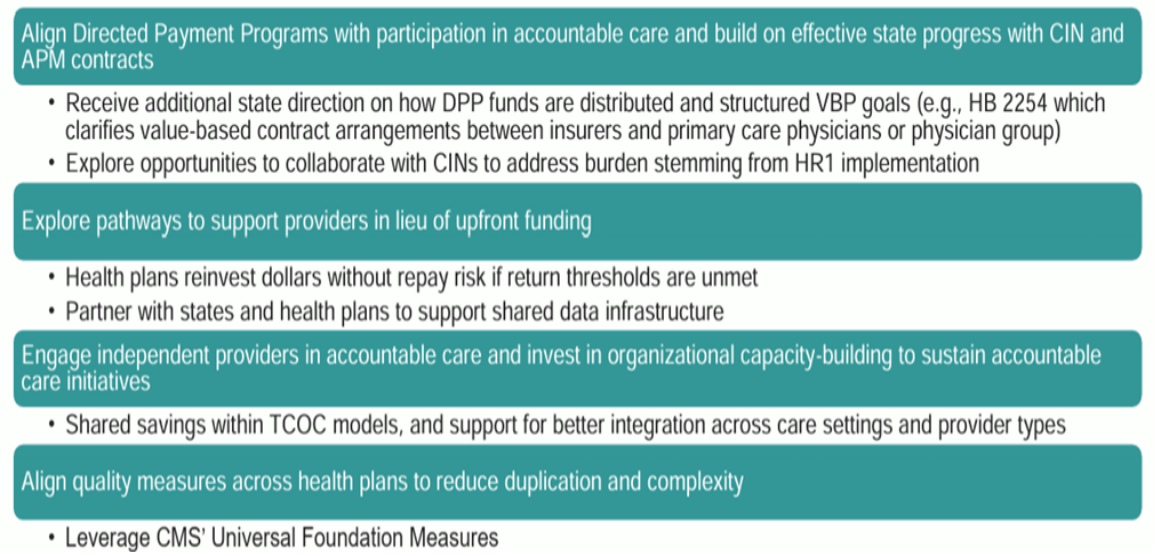
Nov 2024 Roundtable: Texas Stakeholders Identified Priorities to Improve Care for Communities Served by the Safety Net



Texas Priorities that Align with Promoting Evidence Based Prevention

Texas Priorities that Align with Empowering People to Achieve their Health Goals through Timely and Effective Data Sharing

Texas Priorities that Align with Driving Choice and Competition through Ensuring Safety Net Providers can Bear Risk



Discussion.

The "Kill the Clipboard" initiative and other federal efforts highlight API adoption, national provider directories, real-time credentialing, and prior authorization reform.

Forthcoming payment policy changes will push ACOs faster toward risk-based models, and increase focus on prevention and care management, and introduce new mandatory specialty care models.

Federal budget drivers will impact Medicaid financing, with considerations for rural transformation and administrative burden which Texas is already addressing.

Clear alignment opportunities exist and highlighted between new federal directions and recent Texas legislative activity. These are , especially in diabetes prevention and non-medical drivers of health.

5. Subcommittee updates:

Non-Medical Drivers of Health. Areas of Interest

- Evaluate pathways to reimburse providers for NMDOH screening.
- Learn more about evidence-based NMDOH interventions and models.
- Interest in H.B. 26 (89th Leg) implementation.
- Broaden the scope of H.B. 1575 (88th Leg).
    - Improve the quality and efficiency of H.B. 1575 data collection.
    - Identify next steps based on insights from H.B. 1575 screening data.
- Explore alternative strategies to support community-based organizations (CBOs).
    - Strengthen CBO capacity to contract with managed care organizations (MCOs).
- Assess the impact of the One Big Beautiful Bill Act (OBBBA) on SNAP coverage for Medicaid populations.
- Learn about the data collected by HHSC as part of H.B. 113 (88th Leg) implementation.

Value-Based Care in Rural Texas. Areas of Interest

- Managed care organizations (MCOs) continue to face challenges surrounding workforce, reimbursement, and access to care.

- Explore opportunities to improve access to care for individuals with complex chronic care needs.
- Community alternatives to address the nursing workforce shortage in rural areas.
- Consider rural health initiatives from other states.

Alternative Payment Models in Texas Medicaid. Areas of Interest

- Evaluate the performance of prominent clinically integrated networks (CINs) within Texas.
- Expand CIN participation among safety net providers.
- Determine next steps based on results from the Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot Program.
- Identify APM opportunities that address chronic disease prevention rather than chronic disease treatment.

Timely and Actionable Data. Areas of Interest

- Follow up on Emergency Department Encounter Notification (EDEN) system use cases. (Assess quality of EDEN data).
- Support hospitals in prioritizing EDEN connectivity.
- Determine how to advance the Aligning Technology by Linking Interoperable Systems (ATLIS) program and improve patient care.
- Look to other states for strategies to address health information exchange (HIE) and data-sharing issues.
- Continued interest in utilization of the Medicaid collaborative care benefit.
- Request update from the Texas All-Payor Claims Database (TX-APCD) staff concerning future activities.
- Better understand how to align with other screening s occurring across the state.

6. 2026 Legislative Report policy priorities discussion.

Work groups were requested to finalize recommendations by early summer for 2026 report due to long approval/timeline requirements.

7. Public comment. No public comment was offered

8. Action items for staff and member follow-up. Next meeting November 18th.

Topics and Follow up.

- New member solicitation process and two week extension result. Update on member selection will be discussed
- Begin draft recommendation language discussion in subcommittees
- Update on HB1575 (Dual eligible portion), HB18 and HB 113
- Required Bylaws review
- Members were encouraged to suggest speakers or staff for policy briefings.

Possible items for the committee to consider

- Continue technical support with MCOs to improve non-medical needs screening data accuracy.
- Share updates from the next legislative report and rural health transformation efforts at future meetings.
- Invite presentations and agency updates on recent and upcoming legislation (notably on rural health and diabetes prevention).

9. Adjourn. There being no further business, the meeting was adjourned.