



Health and Human Services

Value-Based Payment and Quality Improvement Advisory Committee

November 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:

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- Frank Dominguez, El Paso
- Rachel Hammon, New Braunfels
- Susan Hood, North Richland Hills
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- 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.

2. Consideration of August 18, 2025, draft meeting minutes. The minutes were approved as drafted

3. HHSC staff presentations:

Quality Data Analytics and Reporting: This update focused on work on alternative payment models (APM), with calendar year 2024 reports having been received and under review by the team. Emphasis was placed on collaboration with managed care organizations (MCOs), providers, and community partners to ensure quality improvement strategies align with real-world needs.



Hospital Quality-Based Payment Program and Value-Based Enrollment Overview

In Summary. The hospital quality-based payment program incorporates potentially preventable events (PPEs), focusing on PPRs (readmissions) and PPCs (complications) within the hospital setting.

Annual reports produced by the EQRO at the University of Florida determine rate adjustments that take effect in the following fiscal cycle; the adjustment process was temporarily paused due to data issues related to provider re-enrollment.

It was clarified that HHSC does not mandate MCOs to pass payment adjustments to hospitals for regulatory reasons, although in practice 100% do and report this activity as an alternative payment model with provider risk.

Questions arose about the availability of detailed PPC/PPR lists and their age breakdown; public resources where these can be accessed were indicated.

Presentation

Senate Bill 7, 82nd Legislature and Senate Bill 7, 83rd Legislature, directed HHSC to implement strategies to reduce potentially preventable events (PPEs) by hospitals and managed care organizations (MCOs). HQBPP focuses on PPEs within the inpatient hospital setting (readmissions and complications) Ties hospital performance to financial risk.

Potentially Preventable Events (PPE)

PPC Potentially Preventable Complication -- A harmful event or negative outcome, such as an infection or surgical complication, that occurs during a hospital admission and may have resulted from processes of care and treatment rather than from natural progression of the underlying illness.

PPR Potentially Preventable Readmission-- A return hospitalization within a specified time interval that is clinically related to the initial hospital admission.

Program Layout

Reports follow the state fiscal year (SFY) • Produced by the EQRO

Full-year reports published June of each year

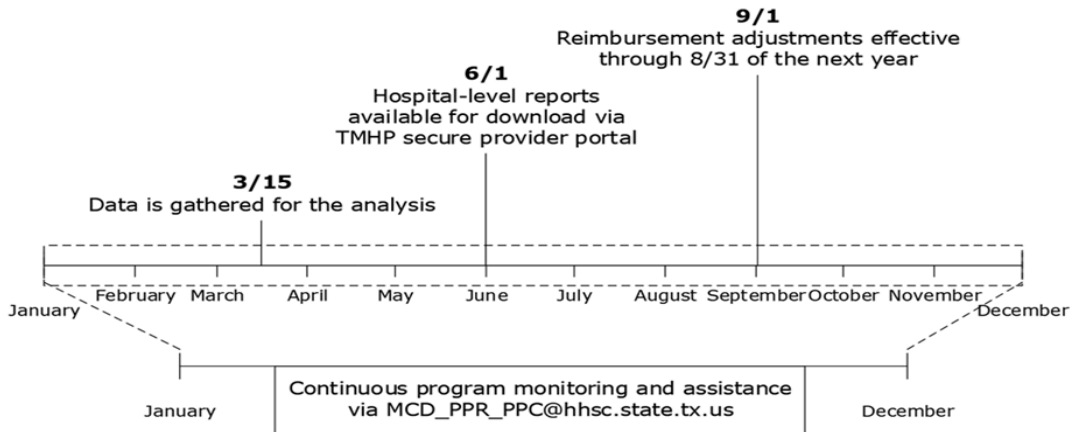
Tied to rate adjustments

Rate adjustments made through MCO capitation and FFS claims

Mid-year reports provided in August
Informational only



Full-year Report Timeline



Rate Adjustment Schedule	Current	Upcoming
Measurement Period	SFY 2024 (Sept. 1, 2023 to Aug. 31, 2024)	SFY 2025 (Sept. 1, 2024 to Aug. 31, 2025)
Adjustment Period	SFY 2026 (Sept. 1, 2025 to Aug. 31, 2026)	SFY 2027 (Sept. 1, 2026 to Aug. 31, 2027)

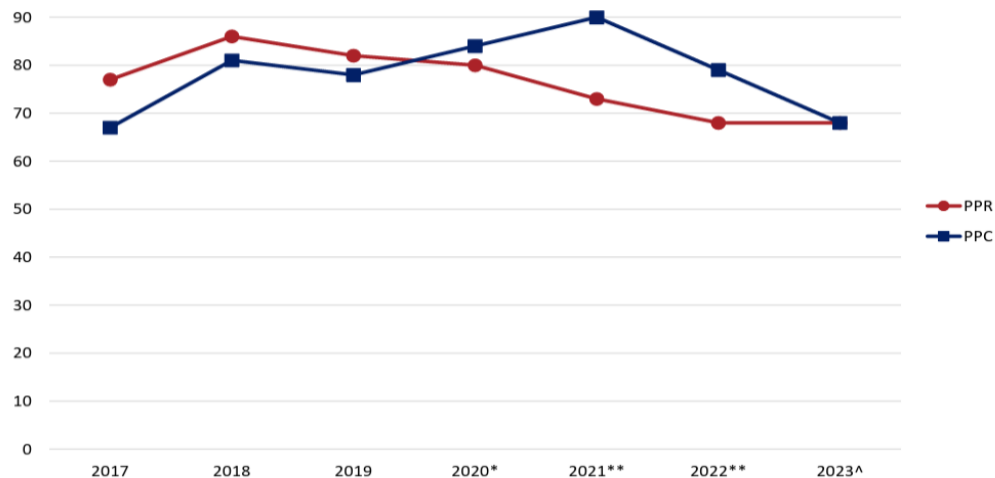
Hospital Performance,

- Several categories of each PPE across Medicaid/CHIP inpatient admissions
- Results may be weighted for resource utilization
 - □ Weighted for PPCs
 - □ Unweighted for PPRs
- The Actual-to-Expected Ratio
 - □ Risk-adjusted to case mix
 - □ Hospital performance vs state norms

Hospital Performance

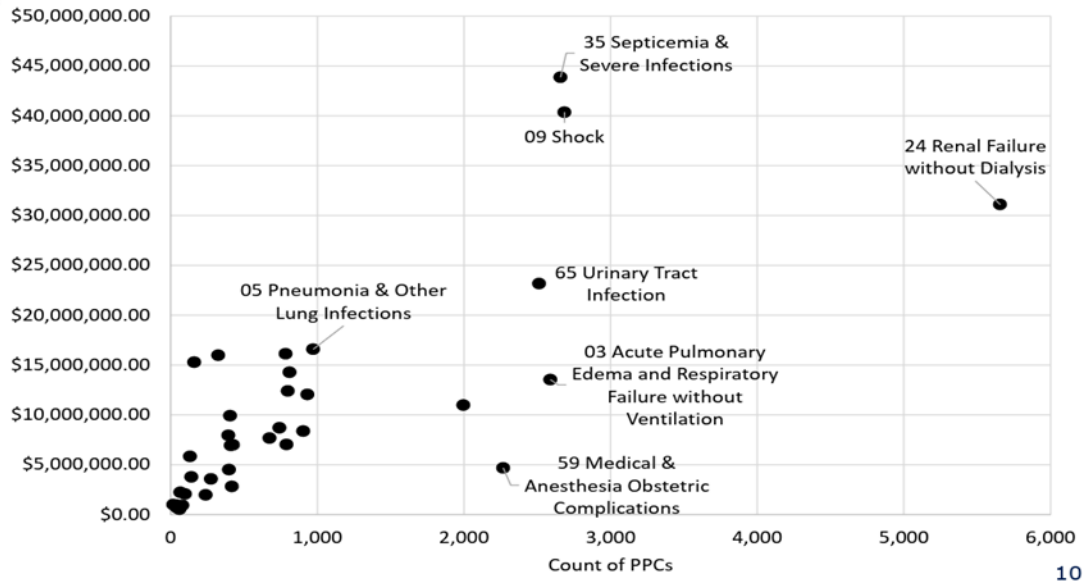
	Actual-to-Expected Ratio		
	Satisfactory	Unsatisfactory	
	Less than 1.10	1.10 to 1.24	1.25 and Greater
PPCs	No Penalty	LOW Penalty: -2.0%	HIGH Penalty: -2.5%
PPRs	No Penalty	LOW Penalty: -1.0%	HIGH Penalty: -2.0%

Number of Hospitals with a Payment Adjustment for PPE Results



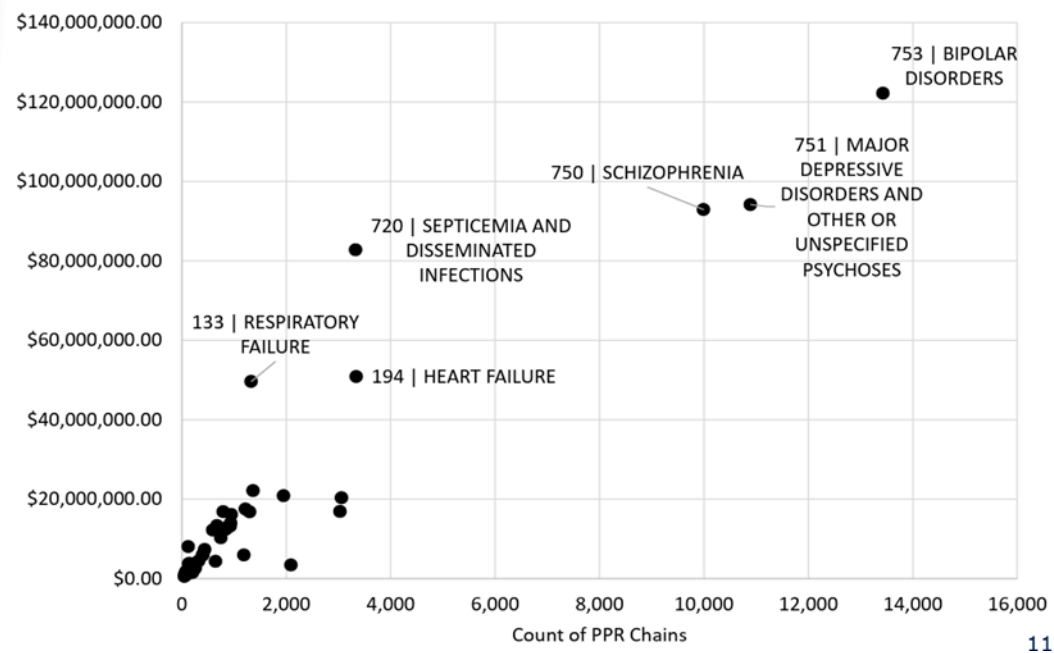
Statewide Hospital PPC Data

Estimated PPC Expenditures by Frequency, SFYs 2018 - 2024



Statewide Hospital PPR Data

Estimated PPR Expenditures by Frequency among APR DRGs, SFYs 2018 - 2024





SFY 2024 Reporting Reports were delayed, distributed 8/29/2025 due to concerns with provider enrollment gaps in SFY 2024 and claims reprocessing. Reimbursement adjustments are temporarily paused, pending additional data quality checks and HHSC will notify MCOs when the pause in adjustments ends

Alternative Payment Models (APMs) HHSC does not require that MCOs pass down rate adjustments, however, MCOs can report the HQBPP as an APM if they pass on adjustments. The HQBPP constitutes downside risk for providers based on annual performance of quality metrics

Resources.

[Potentially Preventable Events | Texas Health and Human Services](#)

[Texas Healthcare Learning Collaborative](#)

[Retroactive Enrollment Periods and Claims Reprocessing | TMHP](#)

Discussion.

Is trending down of the PPE a good thing? Staff stated it reflects the number of hospitals receiving penalties. There aren't any badly performing hospitals. They are all in line.

Is there a list of PPCs that are used? Are they broken out by adult and pediatric hospitals? On the resources slide the PPE website is listed. There is a statewide data file and there are breakouts by PPC category. They are also broken out by age for total PPCs. There are technical notes included in the website data.

Can you explain why the MCOs are not directed to pass on incentives to hospitals? Staff stated that there are specific rules around what HHSC can direct MCOs to do. To do that would require an in depth discussion with CMS. HHSCV believed this is the most efficient way. The MCOs have a rate adjustment so they have a second incentive to pass on the penalties.

What is the proportion of MCOs that do pass on the penalties/incentives. HHSC stated that it is 100%.

When payment reductions are unpaused, will that be retroactive to 9/1? HHSC stated there is not a final decision, but the initial thought is going forward and not retroactive



so they will not have to reprocess claims. MCOs will determine for themselves what they will do.

Value-Based Enrollment (VBE)

In Summary. This is the default assignment process for Medicaid clients who do not select a plan. The value-based enrollment incentive program assigns more default enrollments to plans performing better across three areas: quality, cost efficiency, and member experience, using transparent, established metrics.

Currently, this system is paused in some service areas due to provider changes; data updates will be effective starting December 2025.

Questions about the volume of the default-assigned population noted that in STAR it can reach up to a quarter of total at times.

Presentation

Default Enrollments For Medicaid clients who do not select a health plan, the enrollment broker uses an enrollment default methodology to assign these clients to an MCO

This default methodology has two basic steps for Medicaid managed care:

- Calculates health plan default allocations using member choice percentages
- Assigns members to specific health plans using a logic algorithm For Dental Maintenance Organizations (DMOs),

For Dental Maintenance Organizations (DMOs), default allocations are split evenly among the plans statewide

VBE Background Senate Bill 7, 83rd Legislature and House Bill 1 Rider 43, 86th Legislature, directed HHSC to develop and implement an incentive program for default enrollment based on:

- Quality of Care: Potentially Preventable Events
- Cost Efficiency: Risk-adjusted Spending Ratios
- Member Experience: MCO Report Card Scores



VBE Methodology . Health plans are allocated more or fewer default enrollments in a given service area based on several quality dimensions in relation to other plans in the same region. Data are updated annually in the fall.

Dimension	Calculation	STAR		STAR+PLUS	STAR Kids
		Adults	Children		
Cost (40%)	Spending A/E ratio	✓	✓	✓	✓
Quality/Efficiency (20%)	PPV A/E ratio	✓	✓	✓	✓
	PPA A/E ratio		✓	✓	✓
	PPR A/E ratio			✓	
Quality/Enrollee Experience (40%)	Report Card scores	✓	✓	✓	✓

Program Updates The newest VBE update will be effective starting with December 2025 enrollments. VBE remains paused in 8 of 13 service areas for STAR+PLUS where new MCOs arrived.

VBE Update Simulated Results:

Program	Largest Gain	Largest Loss
STAR	14.0%	20.8%
STAR+PLUS	3.0%	3.5%
STAR Kids	12.8%	12.4%

Discussion.

What is the population who have not selected health plans? HHSC stated it varies by service area and MCO. It is greatest in the STAR Program. It is enough to get MCO attention.

4. Stakeholder Presentation: Fostering Managed Care Organization (MCO) and Health Department Collaboration

Sharon Shaw Texas Association of City & County Health Officials

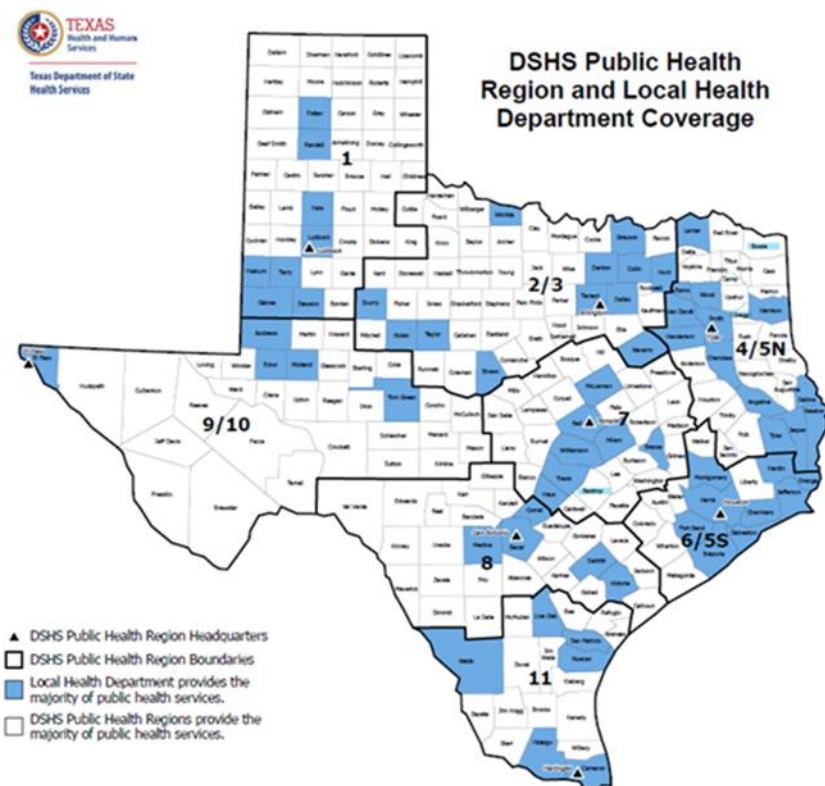
In Summary. The current status of local health departments, affected by federal funding cuts (\$800 million loss and 370 positions) was presented. Departments offer many Medicaid-eligible services but face administrative and knowledge barriers in billing and credentialing. The low proportion of local funding from Medicaid was highlighted despite a significant portion of the clientele being eligible. Partnership with Texas A&M is underway to provide training on Medicaid billing and credentialing processes.

There are opportunities that include the need for greater technical assistance and direct collaboration with MCOs and HHSC to facilitate contracting and billing. There was discussion on the tension between the safety-net role of departments (universal care) and MCOs' interest in capturing data for quality metrics.

Presentation.

Snapshot:

- 254 Counties Texas Public Health
- 50+ Local Health Departments
- DSHS (Central Office - Austin • 8 Public Health Regional Offices)



Critical Public Health Programs at Risk

In 2025, Texas Public Health lost an estimated \$800 million dollars as a result of Federal funding cuts. TACCHO LHD Members report that over 370 staff positions from within their public health workforce eliminated since January 2025.

	Disease response , including investigations of notifiable conditions and public health follow-up for potential measles, congenital syphilis, Ebola, polio, plague, rabies, lead poisoning, and other diseases. These delays could impact hospital systems, schools, prisons, and communities.		Wastewater surveillance , for early detection of H5N1 and other pathogens, lead, controlled substances, and other toxic contaminants.
	Vaccination clinics , which seek to improve vaccination rates and protective coverage against potentially severe and life-threatening vaccine-preventable diseases – one of which is measles – as Texas continues to fight a growing measles outbreak that has already claimed the lives of two children.		Public health data collection and reporting , which contribute to preventing outbreaks, analyzing disease trends, reducing costs, and informing public health policy.
	Food safety inspections , which aim to ensure the safety of food offered to the public and prevent foodborne illnesses.		Health-for-all efforts , which seek to improve access to care and provide supportive services to Texas' most underserved communities.

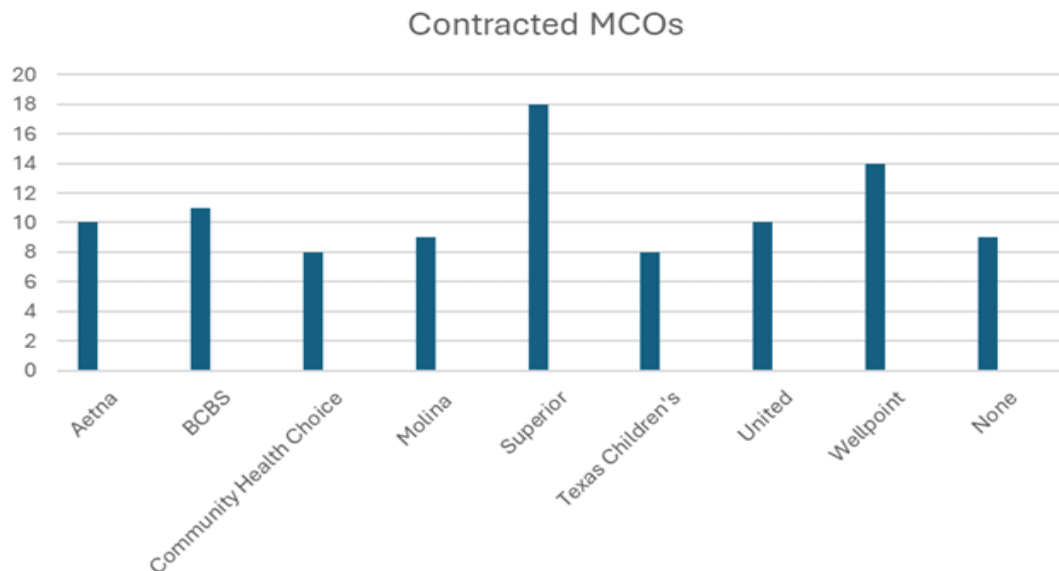
LHD Services – Medicaid Billable

- 91% of LHD's conduct Disease Surveillance
- 88% of LHD's provide Immunization services
- 64% of LHD's provide HIV services
- 40% of LHD's provide Hepatitis C services
- 28% of LHD's provide Primary Health Care

46% of Local Health Departments Provide:

- Medicaid Eligibility Assistance
- Children with Special Healthcare Needs Eligibility Coordination of Personal Care Services
- Coordination of Community First Choice Services
- Community Outreach and Education on Eligibility and Social Services Programs and Services 4
- Community Resource Coordination

Medicaid Managed Care Organizations that LHD's are currently contracted with



Opportunities TACCHO – Supporting The Public Health Future of Texas by exploring strategies for modernizing local public health systems that:

- focus on enhancing billing infrastructure
- identify sustainable models for public health to participate in, and be reimbursed through, the broader healthcare system

Texas Medicaid & MCO's – LHD Collaboration

LHD Challenges

Medicaid Provider Type/Contracting
 MCO Credentialling
 Billing Practices
 Enhancing Billable Services

Discussion

MCOs are interested in improving relationships with local health departments.

What percentage of services qualify for Medicaid. The speaker stated that local public health is a safety net. She stated in her clinic 30=35% of services were for Medicaid eligible individuals and 10% or less funding is Medicaid.



If an MCO wanted to contract with a local health department, how would that work? DSHS regional offices provide some health care services, and they do not bill Medicaid either. Each local health department is unique. MCOs can contract with individual health departments and unique contracts would be needed.

We have talked about balancing tension of the local safety net function of LHDs and the needs of the MCOs for how they provide services. LHDs typically do not ask about Medicaid for some services like immunizations. MCOs have to capture data for quality measures. The speaker stated that there are missed steps at many LHDs and they have to attend to the data collection so they can do it right the first time.

5. Subcommittee updates:

Non-Medical Drivers of Health (NMDOH).

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 data collection.
- Identify next steps based on insights from screening data.
- Explore alternative strategies to support community-based organizations (CBOs).
- Assess the impact of the One Big Beautiful Bill Act (OBBBA) on SNAP coverage for Medicaid populations.

Future Presentations

- Interested in receiving an update on H.B. 113 (88th Leg) implementation.
- Plan to have MCO-led panel discussion concerning H.B. 1575 (88th Leg) implementation.

A suggestion was made to include non-medical drivers of health data from HHSC

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.

Presentations on medical-legal partnerships and plans to gather information on access for complex care populations and HB18 implementation (rural health stabilization and innovation program) are being pursued.

CMS award update might be helpful for the next meeting once HHSC has notification of their rural health stabilization award.

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.
- Interested in having future subcommittee presentations concerning the data collection process for the APM Performance Framework, ATLIS, OBBBA, and evaluation results for the TORCH/TACHC CINs.

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.

6. Public comment. No public comment was offered

7. 2026 Legislative Report policy priorities discussion. The work groups have to come up with their recommendations through meetings before the following meeting. LAR request information is being collected by HHSC also at this time.

8. Action items for staff and member follow-up.

Feb 23 and May 18, are the next two meeting proposal dates.

There was an extension to the new member solicitation and early in 2026 new member selection should be announced.

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

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