TEXAS INSIGHT
HEALTHCARE INTELLIGENCE

Health and Human Services

Value-Based Payment and Quality Improvement Advisory Committee

May 18, 2026

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.

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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
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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

Learn about the Health and Human Services value-based payment initiative at Value-Based Care.

1. Welcome and roll call. The meeting was convened by David Weden, Chair. A quorum was not immediately present.

2. Consideration of February 23, 2026, draft meeting minutes. The minutes were approved as drafted.

3. Stakeholder Presentation: **Guiding Principles for a Health Data Utility to Support Value-Based Payment Models. Staff from Connxus made the presentation. Tables and charts are from Connxus.**

Summary. Core framing: HIEs uniquely support aggregation and real-time push of data, governed by participants with strict privacy/security policies and federal/state law compliance. Health Data Utility (HDU) concept extends HIE capabilities by integrating additional data (including social care data and public health/government data).
Key HIE/HDU services and assets include: master patient index and longitudinal record, real-time alerts, robust ingestion/linking/harmonization, and extensive legal agreements

and policies enabling treatment and payment operations and sometimes public health research.

National and Texas landscape: 70+ HIEs; Texas currently has five HIEs, with significant "white space" (uncovered regions). The national exchange networks don't necessarily aggregate data or provide real-time data.

The Patient-Centered Data Home is a ZIP-code-based "data repatriation," routing encounter data back to a patient's home community to support timely notifications and cross-state continuity.

Connxus established (1997) a large longitudinal dataset (2M+ patients, hundreds of thousands of encounters per year. It provided coverage across many hospitals and provider types and was an opt-out model for TPO under HIPAA and emphasized security participation in federal interoperability initiatives.

Value-based payment essentials: lessons from Oklahoma. David Kendrick described Oklahoma's experience using HIE/HDU infrastructure to enable value-based models, emphasizing that "technology for technology's sake" won't drive participation but demonstrating practical value does. Oklahoma engaged in multiple CMMI models (e.g., Comprehensive Primary Care Initiative), emphasizing multi-payer alignment, common performance requirements including paperwork, and care management investments.

Medicare outcomes: 6% average annual savings over four years using real-time admit and discharge alerts and between-visit care management. These were all major drivers.

Key operational challenge is fragmentation of data across many organizations and EHR vendors. Claims data was described as broad but shallow while clinical data is deep but narrow, and true patient care spans many locations.

Fragmentation . There is very low likelihood a care site has "all the data" at point of care leaving fragmentation of the date which undermines quality measurement (e.g., using the most recent A1c within the measure window across sources is methodologically necessary). Providers bear the integration workload and privacy state-law compliance risk (including sensitive data and 42 CFR Part 2) A central HDU can enforce laws/consent and reduce provider complexity.

Connxus described a Central Texas implementations to support social needs screening and referral workflows. Dell Seton / Dell Children's provided real-time identification of eligible patients but were limited to certain populations. CHW Call lists were generated from discharge events, consent workflow, warm handoffs to community resources, and follow-up over ~6 months were all part of the effort.

Operational results were shared from the study period (July 1, 2024–June 30, 2025): 10,000 identified patients; 3,300 reached by four CHWs; high screening and navigation rates among consented participants (94–95%); closed-loop performance reached the 80% goal. It showed meaningful impact for pediatric patients (about one preventable ED visit prevented per child on average), with less clear outcomes for adults due to overlapping programs.

A New Ascension pilot provides post-discharge text-based screening that returns the top three referrals via phone. A dashboard will track engagement and completion metrics with the initial focus being on pediatric patients in Hays and Travis counties.

David Kendrick shared Oklahoma's AHC screening scale with millions of screening offers, substantial needs detection (Medicaid 40–45%, uninsured >50%, commercial >17%), and demonstrated final RTI results indicating 7% Medicaid savings across participating sites.

Inclosing multiple uncoordinated social care programs can lead to repeated outreach for some people and none for others. There is a need for harmonized data to target highest-risk populations and understand geographic "pockets" of need.

Presentation

Background

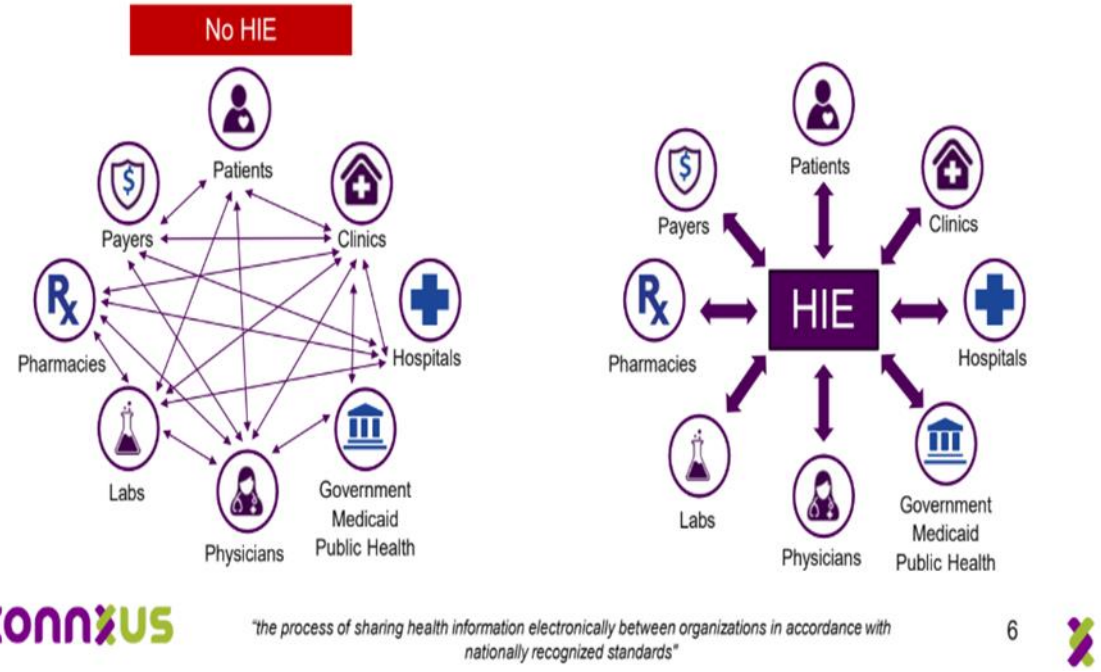
Electronic Medical Record Systems

1. 2004 – G. W. Bush, $100M in demonstration projects
2. 2009 – Obama, HITECH and ARRA $27B in incentives
3. 2017 - 86% adoption (hospitals, PCPs)

Health Information Exchanges

1. Early implementations in 1990s
2. Surged after 2009 HITECH support ($564 million), critical infrastructure
3. Aggregation and real-time push model
4. Governed by Participants with strict policies and compliance with health laws

Health Information Exchange



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"the process of sharing health information electronically between organizations in accordance with nationally recognized standards"

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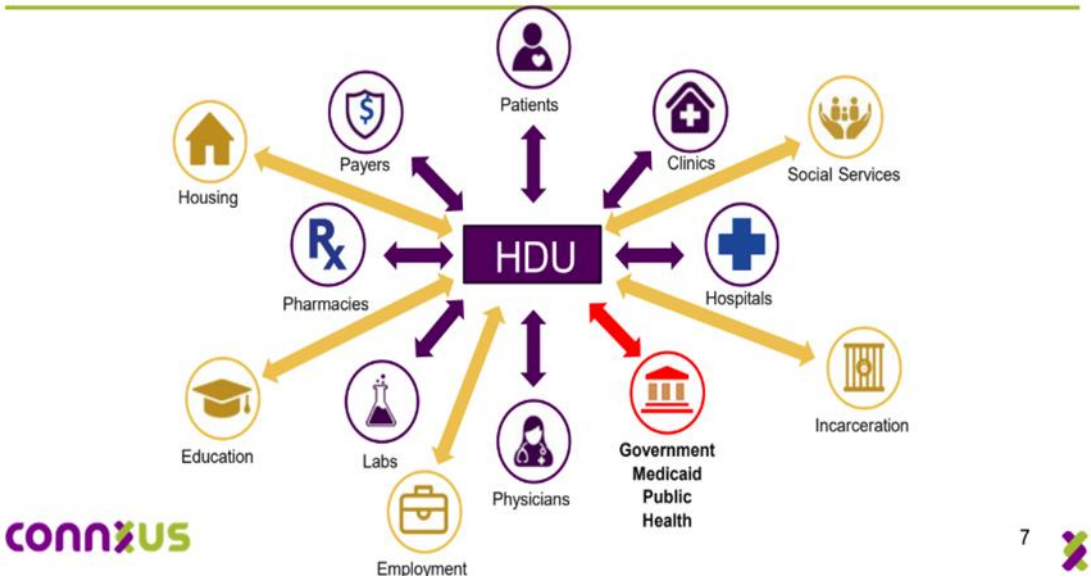
Health Data Utility (HDU)



HDU Core Services and Features

- Capabilities to ingest any data from any source
- Master Patient Index – Community ID
- Longitudinal Patient History
- Consent Management
- Audit Trail
- Provider Clinical Record Portal
- Single Sign-on
- Interstate Exchange
- ED/IP Reporting, Alerts and Notifications
- Data Release Protocols for: prep-to-research,
- research, QI/QA, public health reporting

Key Assets

Legal agreements with participating organizations allowing for the exchange of data for Treatment, Payment and Operations (TPO)

Robust technology platform that ingests, links, aggregates and allow access to data.

Policies designed to govern data access as allowed by law and by its participating

organizations for cases other than TPO (e.g., Public Health, Research, etc.).

Procedures, technologies, and policies to guarantee the security and privacy of data.

HIEs and HDUs in the USA

- Over 70 HIEs nationally (excluding private ones) covering over 90% of the population
- eHealth Exchange – public-private network in all 50 states cover over 120 million patients
- TEFCA – US Government Initiative. Comparable to eHealth Exchange in functionality

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Patient-Centered Data Home (PCDH)

- Coordinated by Civitas for Health – 74 HIEs
- As of 2021 had 45 HIEs connected and covering over 177,000,000 patients
- Notify providers of a care event occurred outside of the patient's "home" HIE, based on the patient's zip code
- Transmits all relevant clinical data from "away" care event to the "home" HIE to complete longitudinal patient record.

Connxus

15+ years of data with 2 million patients with at least one encounter in last 5 years and an average 350,000 encounters per year

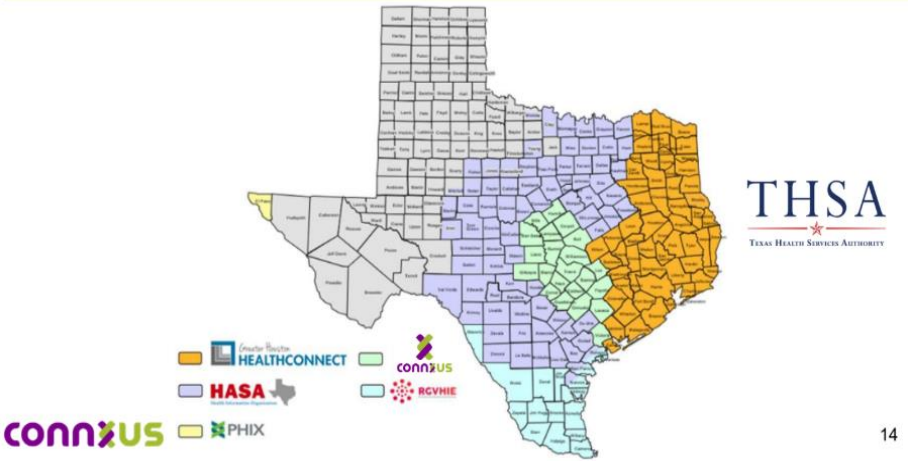
Covers about 80% of all hospital (Seton, St. David's, CHRISTUS) utilization in the region for Medicaid, Medicare and uninsured patients

Includes behavioral health, EMS and FQHCs and PCPs

Opt-out model (no patient authorization required)

Texas HIEs in 2014

Texas HIEs Today

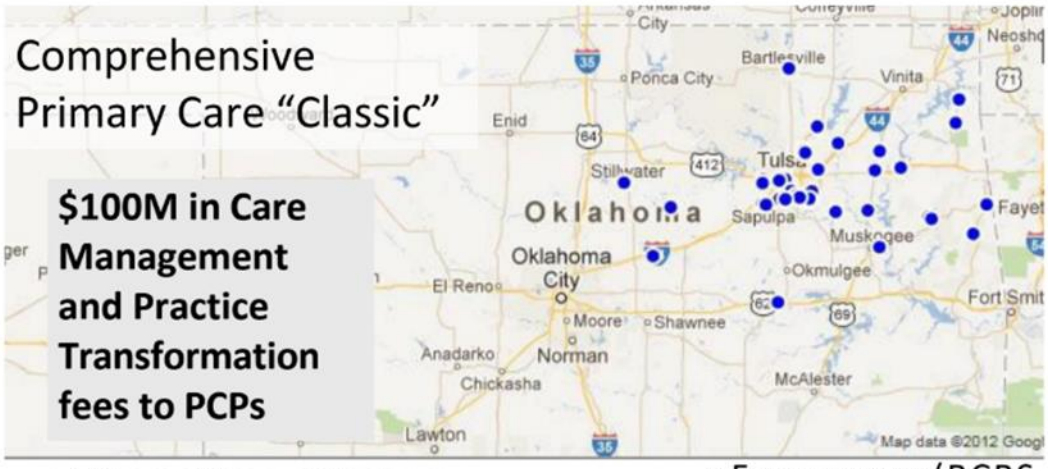


- HiTrust and TX-RAMP certified system

- CMS Aligned Network and Kill the Clipboard
- Improved Care Coordination & Efficiency
    - Enhanced Assessment
    - Close Gaps in Care
    - Enable better Follow-up
    - Enhance Care Management
- Reduced Costs of Care
- Address Non-Medical Needs

Data Essentials for Value Based Payment Models

$$Value = \frac{Quality}{Cost}$$



- 68 practices, 265 docs
- OK Payers require MyHealth Participation
- >30 hospitals affiliated

- Four payers (BCBS, CCOK, Medicaid, Medicare)
- >90% of covered lives
- Shared savings Y3-4

CMS Experience CPC:

56-60 practices, ~50,000 Medicare pts

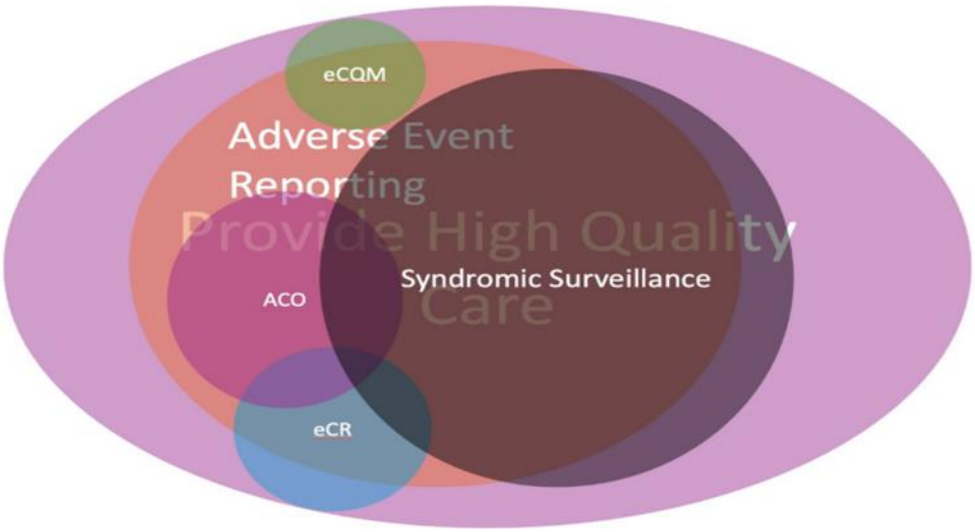
Oklahoma CMS Shared Savings					
Year	**Gross Savings**	**% Gross Savings**	**Net Savings**	**Net Savings Percentage**	**Dollars shared with practices**
2013	~$30 M	7%	~$21 M	5%	1st year no payments
2014	~$20M	4.7%	~$11 M	2.4%	$900,000
2015	$33M	7.1%	$25 M	5.4%	$10,800,000
2016	$26 M	5.7%	$18 M	4.0%	$9,127,320
Totals	~$110 M	6.1%	**~$65M**	~5%	**$21,827,320**

+ **$56M** in Care Management Payments over 4 years

Quality Measures: Exceeded Benchmarks for all three measures

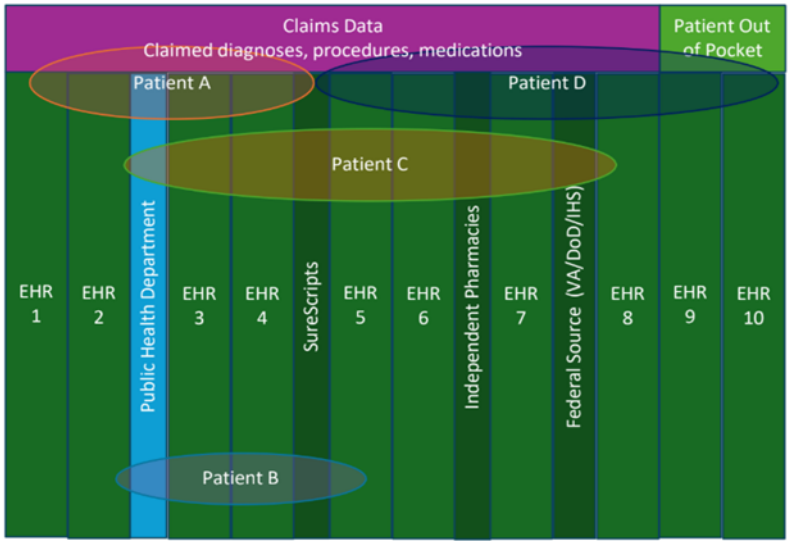
- All Cause Readmissions: Highest Benchmark
- CHF Admissions: First Benchmark
- COPD Admissions: First Benchmark

Many Programs, Common Deliverables = Provider Burden



Data Fragmentation

Scope of Data (Fragmentation must be addressed)



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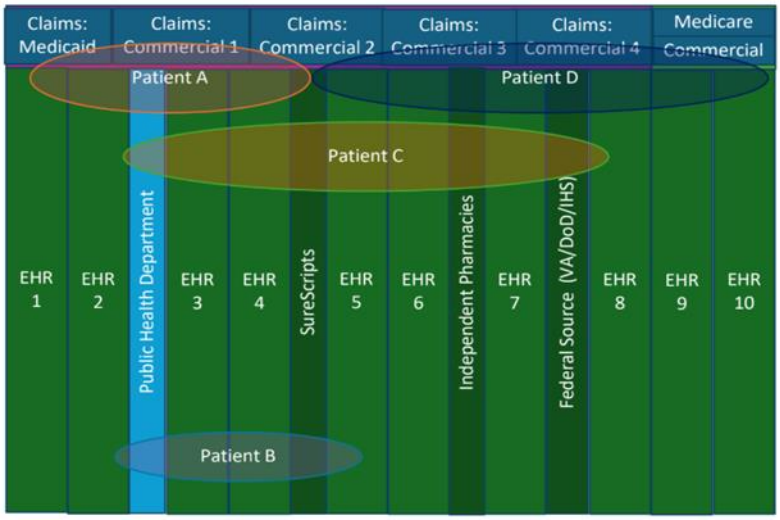

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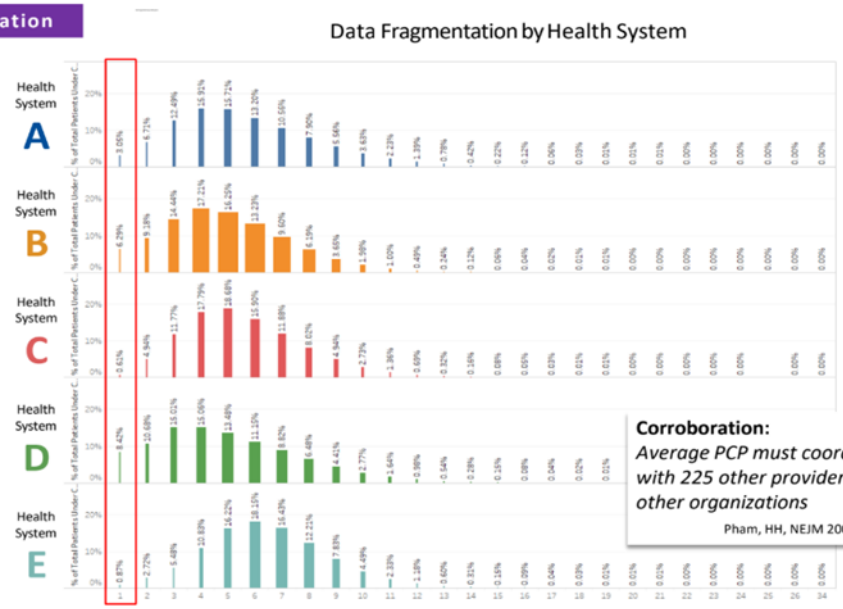

Corroboration:
Average PCP must coordinate care with 225 other providers in 117 other organizations

Pham, HH, NEJM 2007; 356: 1130-1139

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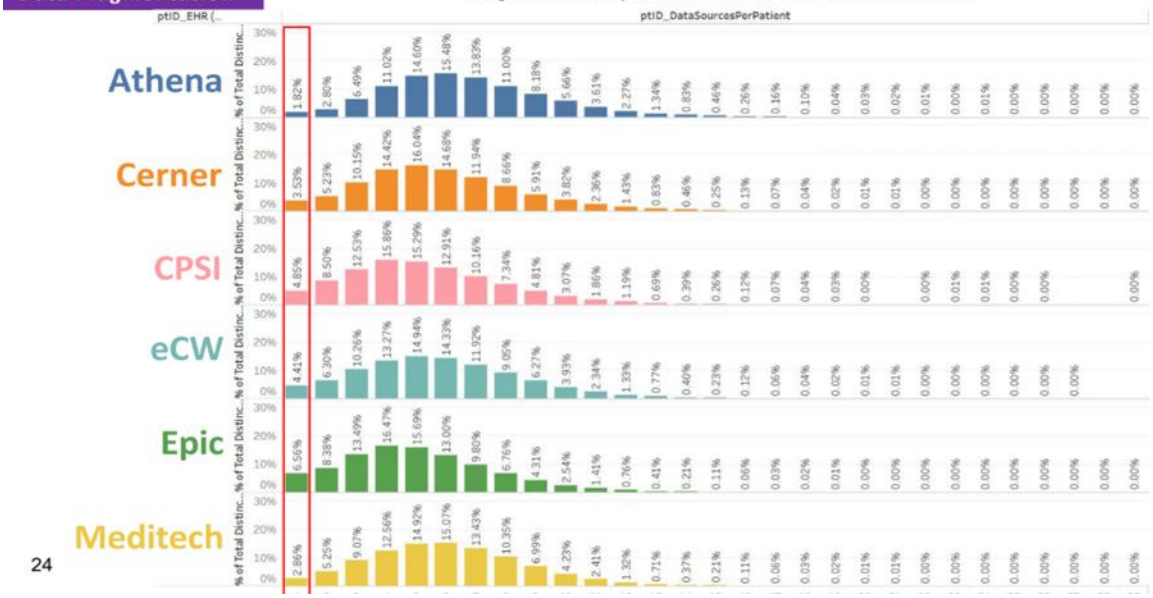
Data Fragmentation



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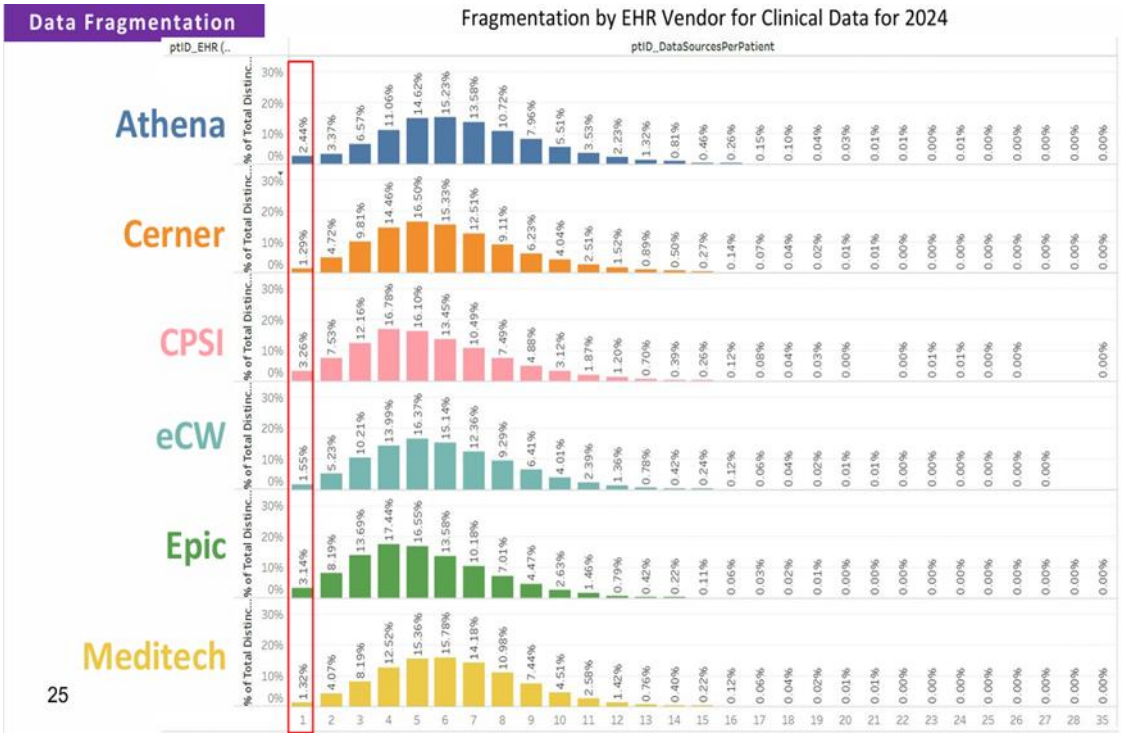
Data Fragmentation



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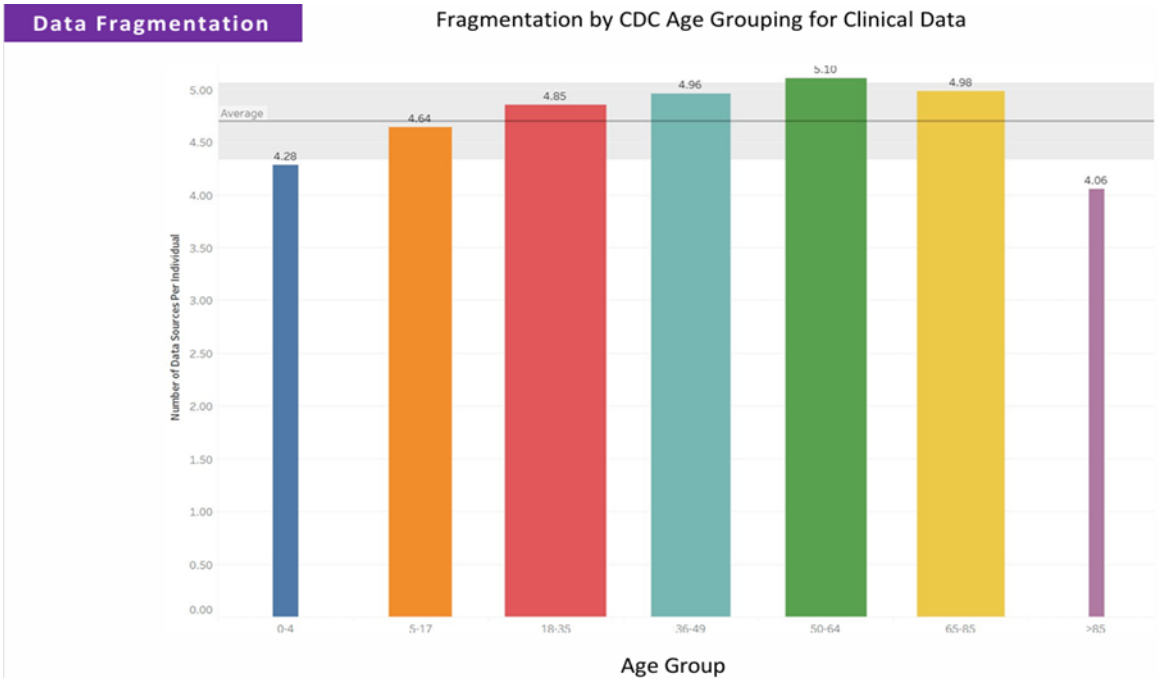
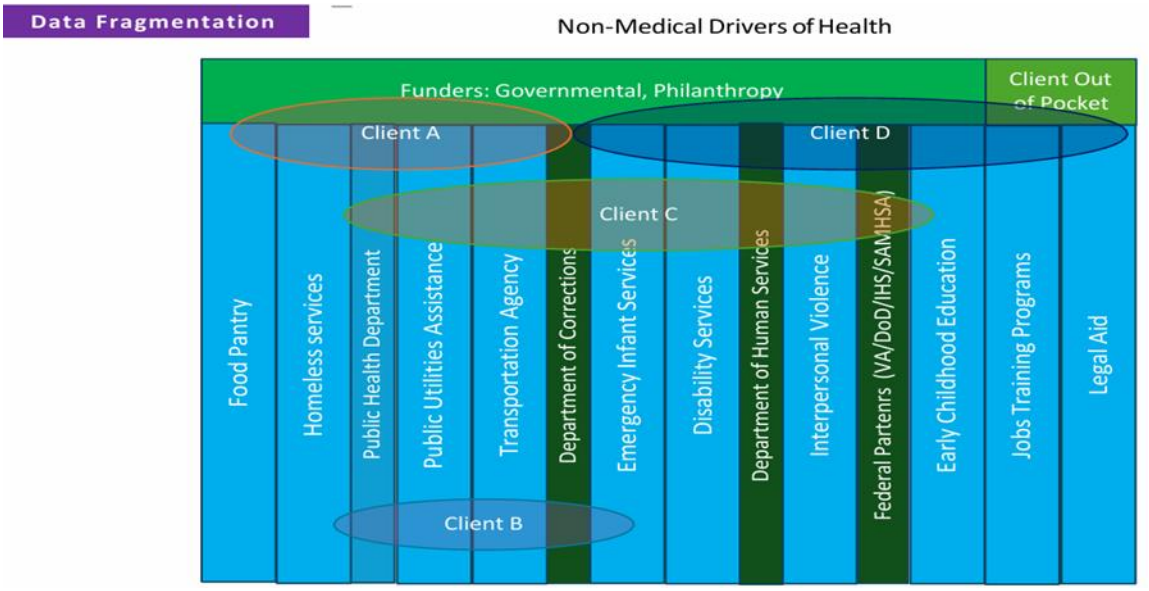
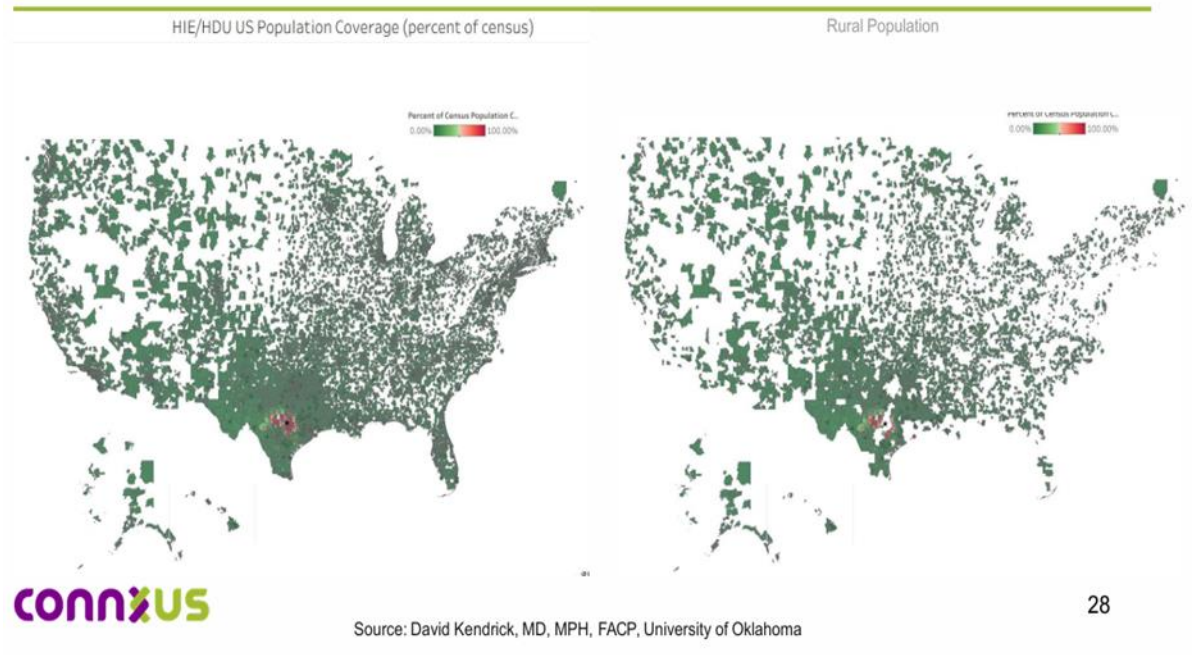
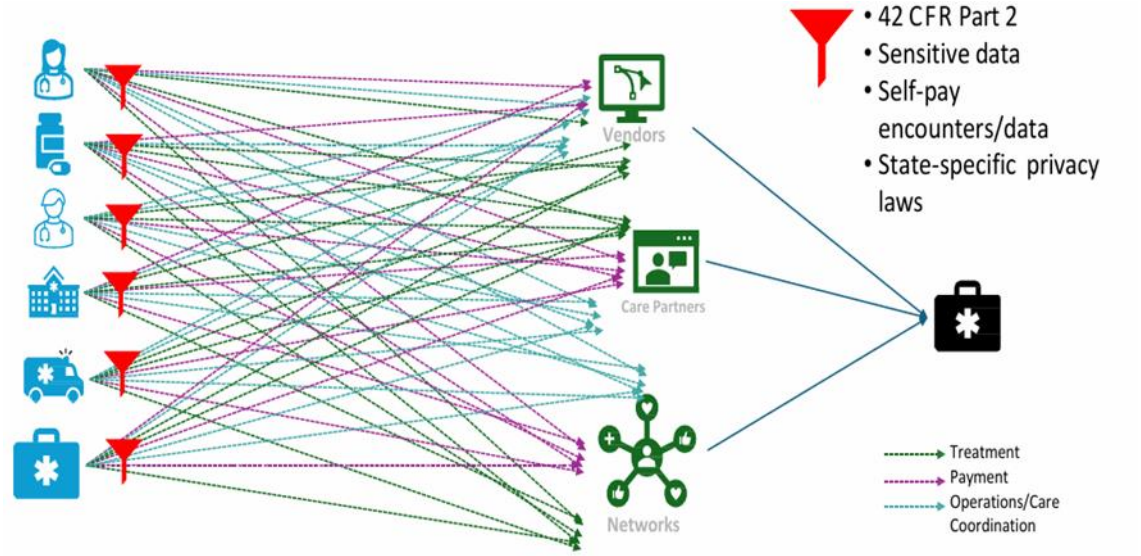




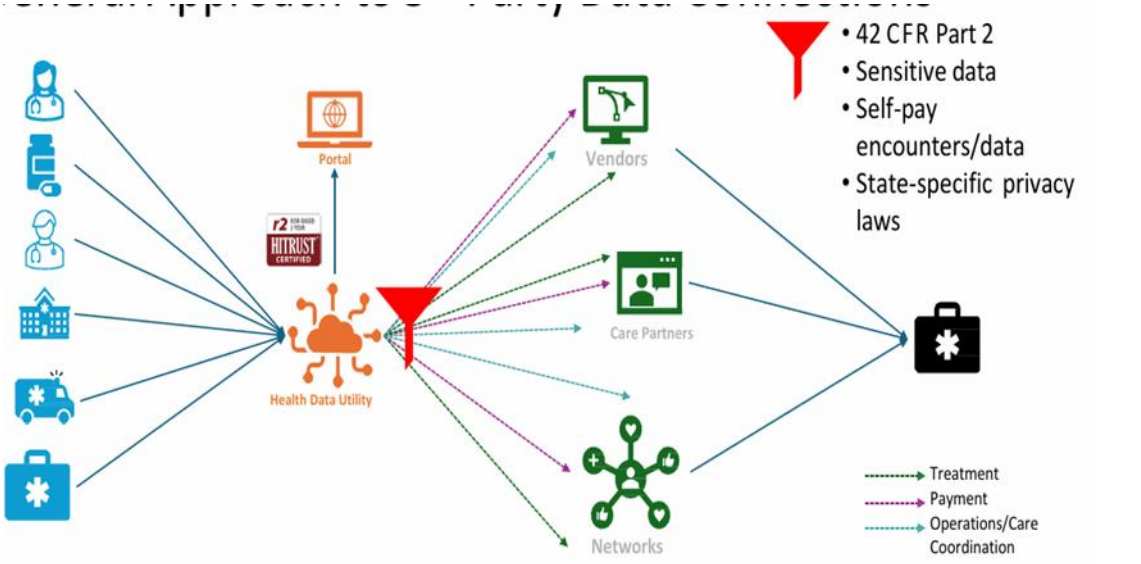
Connxus Fragmentation (urban and rural)



Providers Face Daunting Connectivity Expectations



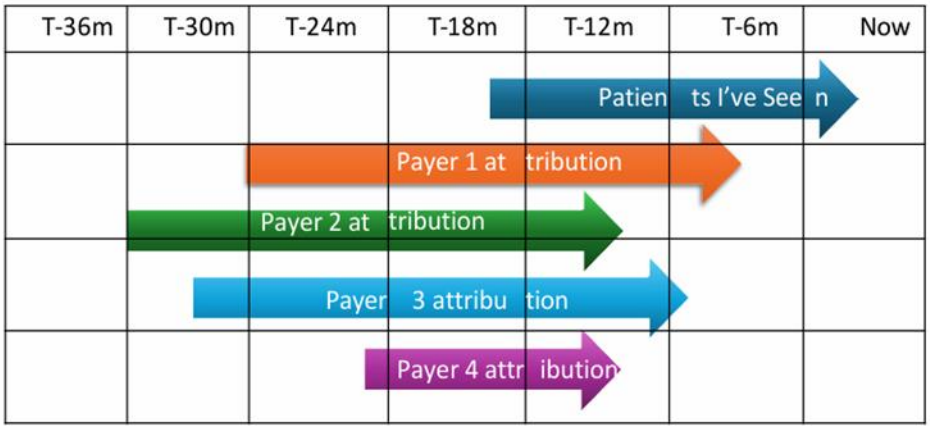
General Approach to 3rd Party Data Connections



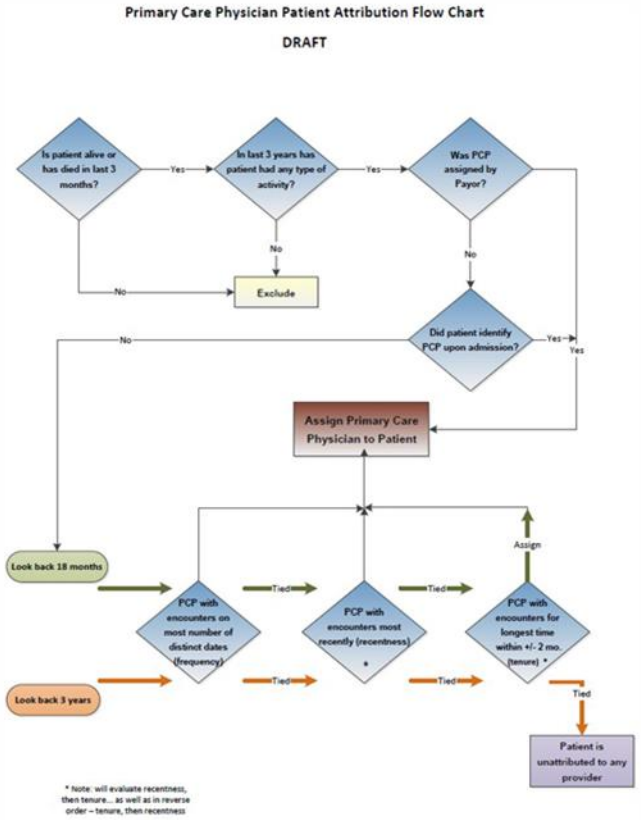
Health Data Utility: Rich Clinical, Claims, NMDoH Data

- Diagnoses
- Medications
- Allergies
- Vital signs
- Clinical documents
  - H&P
  - D/C summary
  - Operative/Procedure notes
  - Progress notes
  - POLST/MOLST
  - Advanced Directives/Powers of Atty
- Labs/Observations/Assessments
- Insurance
- Dispensed Medications
- Equipment Devices
- Related Persons
- Social History
- Family History
- Radiology
- Care Team
- Goals of treatment

Who Are My Patients? Attribution can be confusing, but is critical to understand . . .

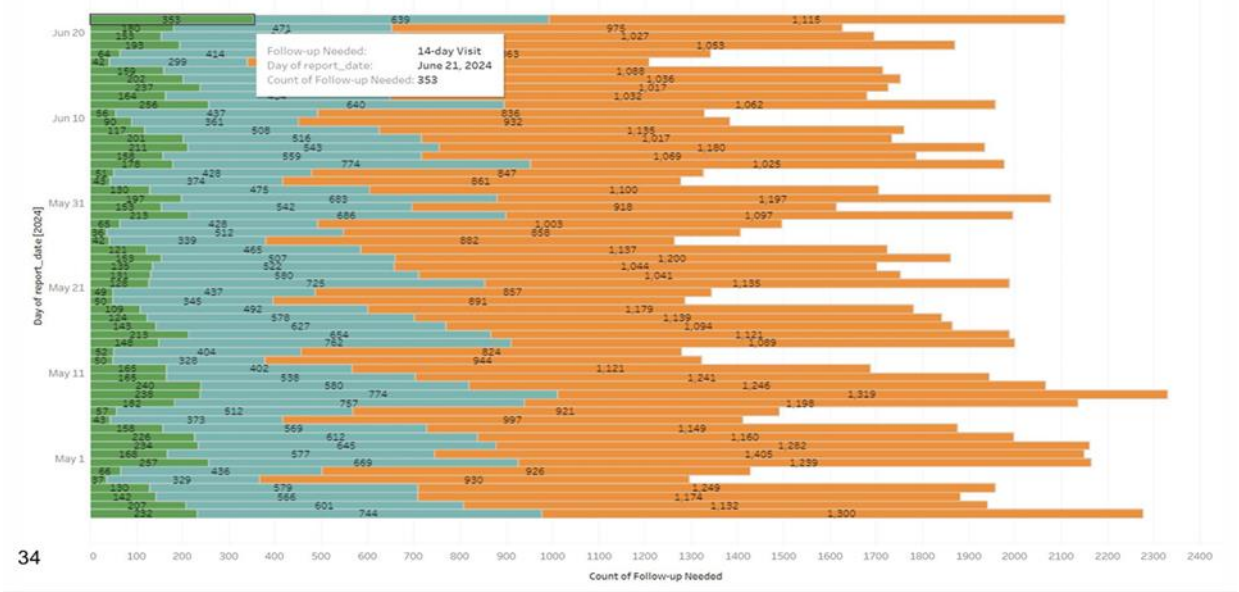


Patient Attribution

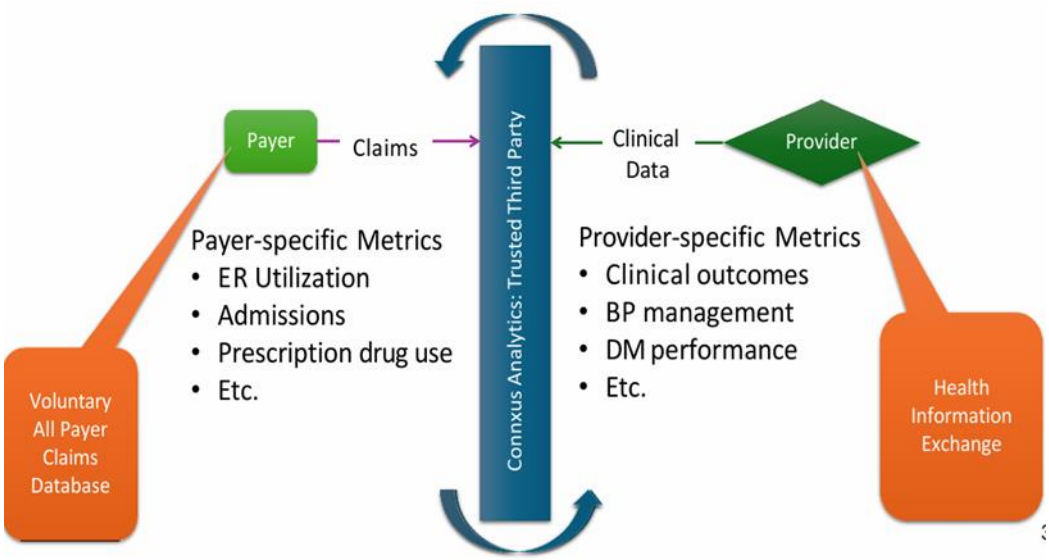


Action Alerting

Opportunity for Timely Follow Up: **All** for Medicare Age & Not Medicare Age

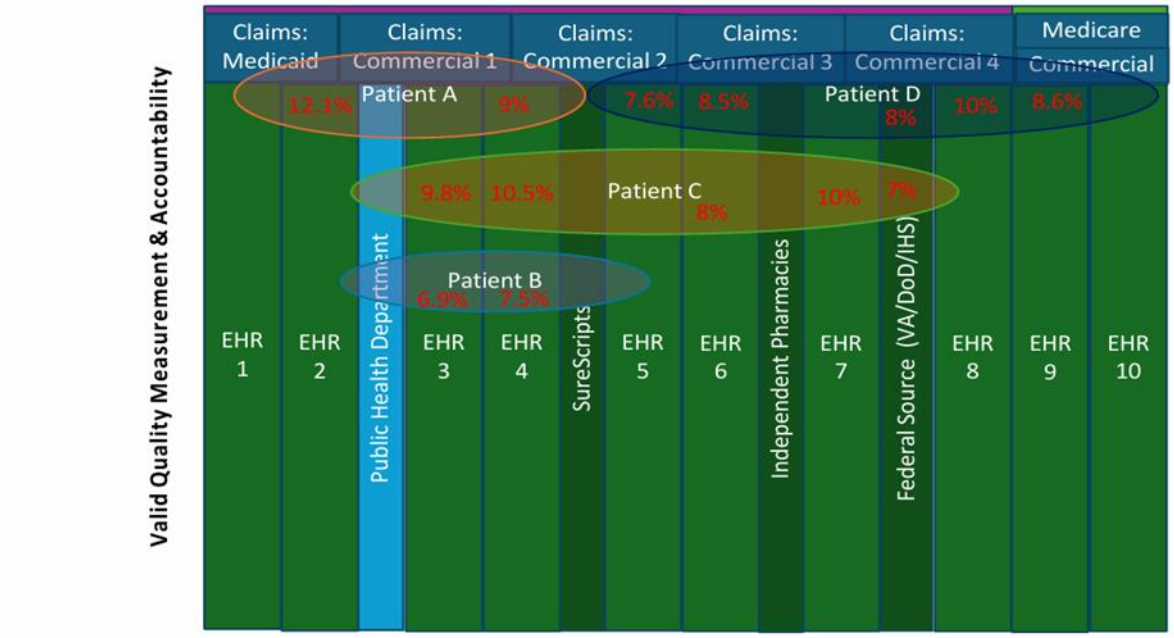


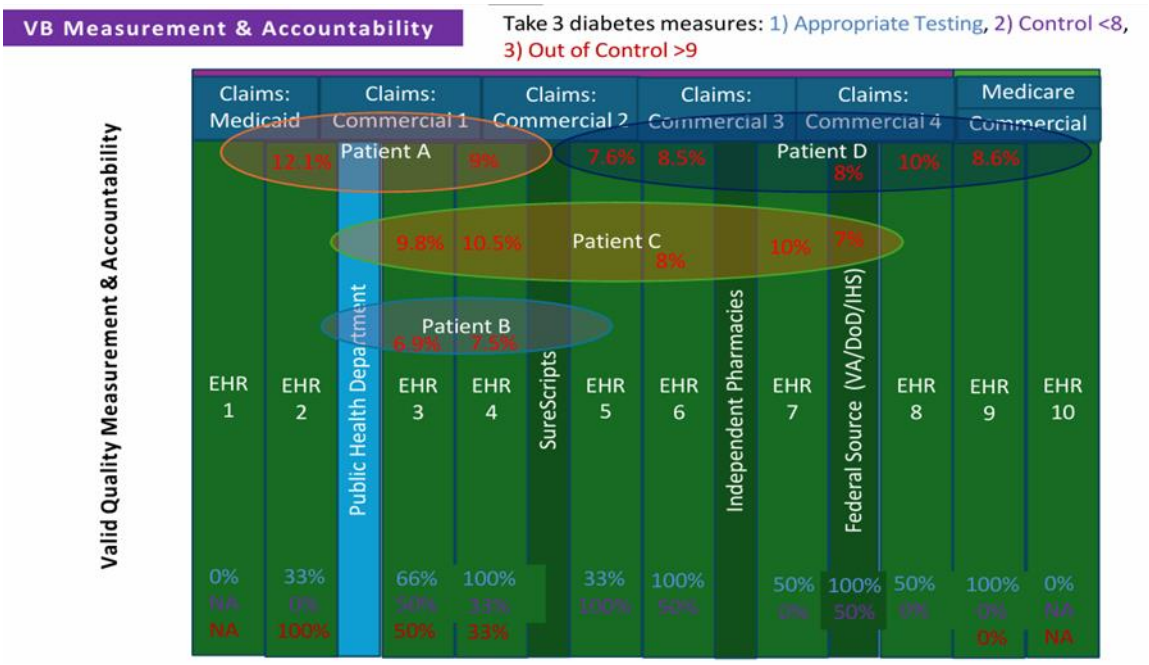
Trusted 3rd Party for Measurement



VB Measurement & Accountability

Example: HbA1c control– what is the correct answer for each provider? Patient? Payer?





Take 3 Diabetes Measures:

Source	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
EHR 1	0%	NA	NA
EHR 2	100%	0%	100%
EHR 3	66%	50%	50%
EHR 4	100%	33%	33%
EHR 5	33%	100%	0%
EHR 6	100%	50%	0%
EHR 7	50%	0%	100%
EHR 8	50%	0%	100%
EHR 9	100%	0%	0%
EHR 10	0%	NA	NA
VA/DoD/IHS	100%	50%	50%
Population:	?	?	?

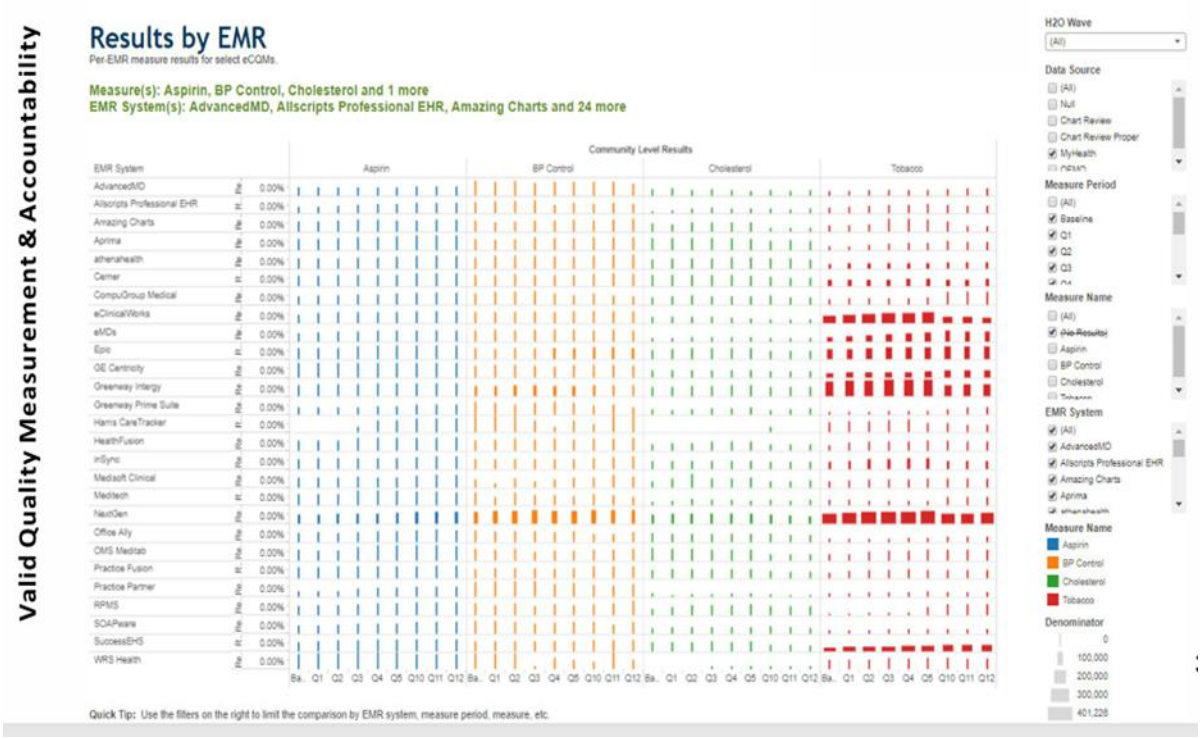
Payers will get multiple scores on the same patient– what do they do with that?

Looking at populations, we cannot roll these up . . .

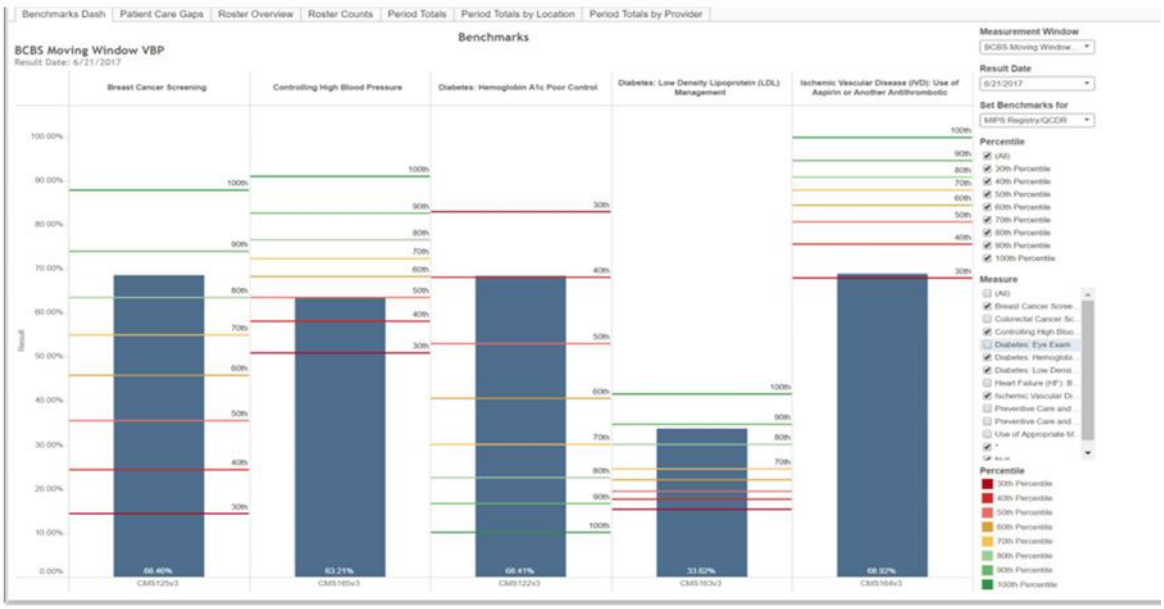
Isn't this what we *really* want to know?

Patient	Appropriate HbA1c Testing	DM in control (A1c<8)	DM out of control (A1c>9)
Patient A:	100%	0%	0%
Patient B:	100%	100%	0%
Patient C:	100%	100%	0%
Patient D:	100%	0%	0%
Population:	**100%**	**50%**	**0%**

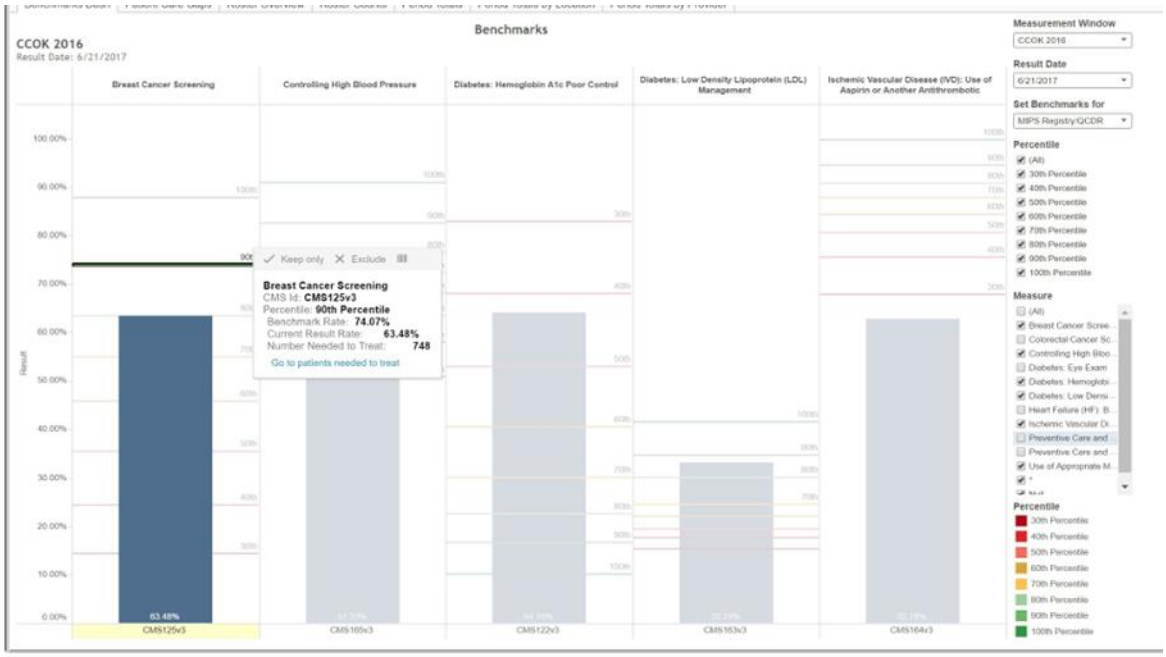
Measure Performance Across Systems and EHRs



MIPS View of Quality Measures



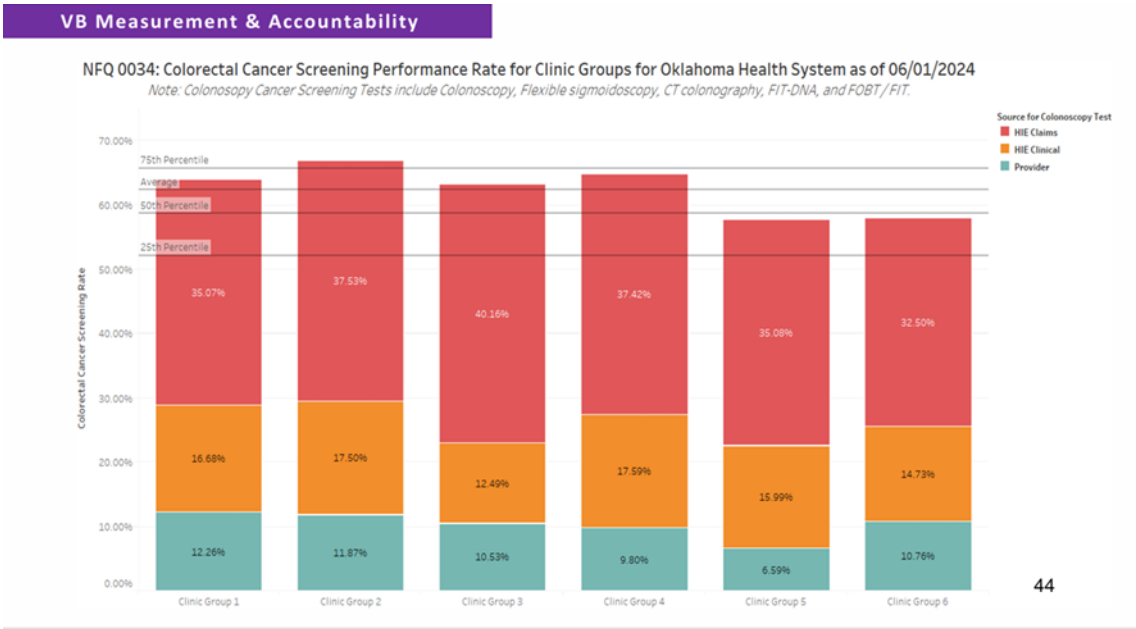
Actionable: Number Needed to Treat



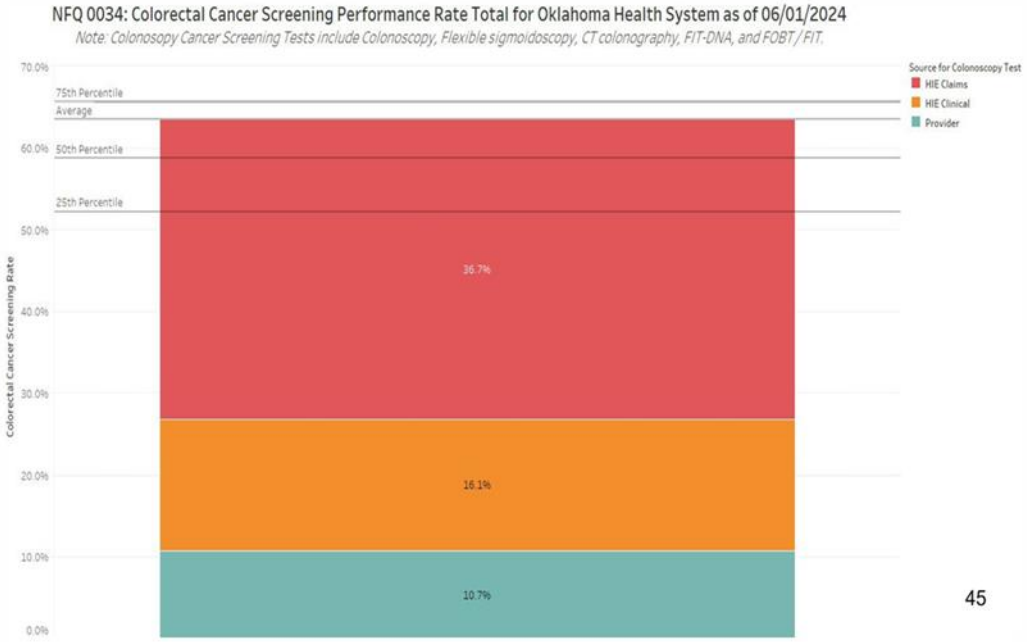
Care Gap Closure = Better Performance

Predicting Performance Guides Activity

VB Measurement & Accountability



VB Measurement & Accountability



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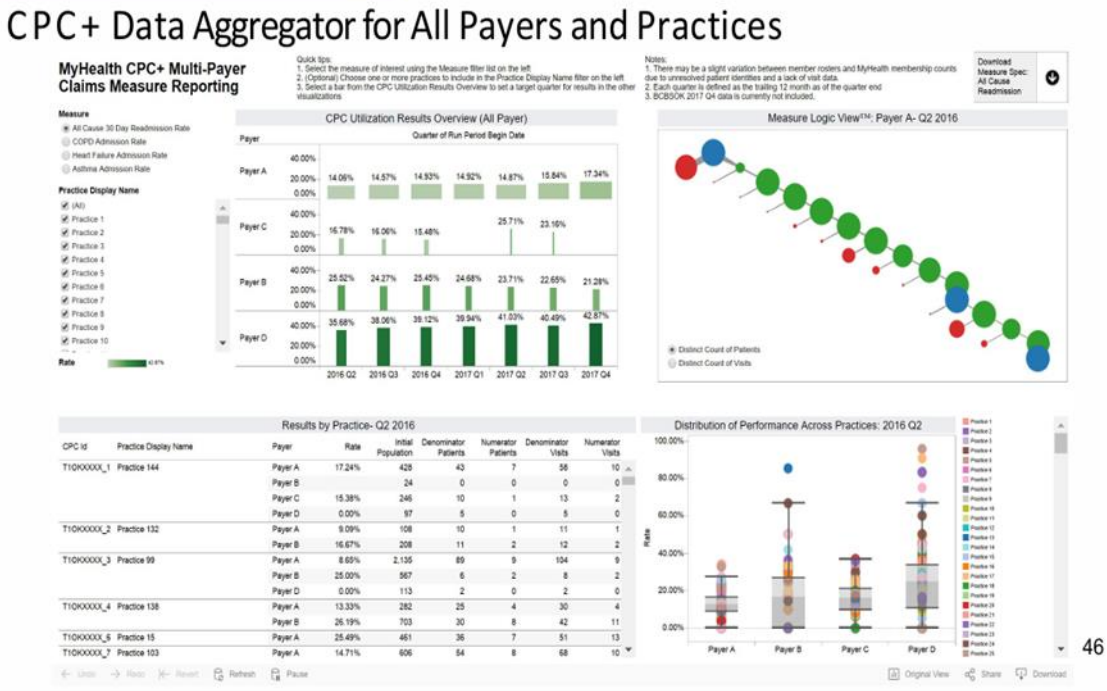
VB Measurement & Accountability



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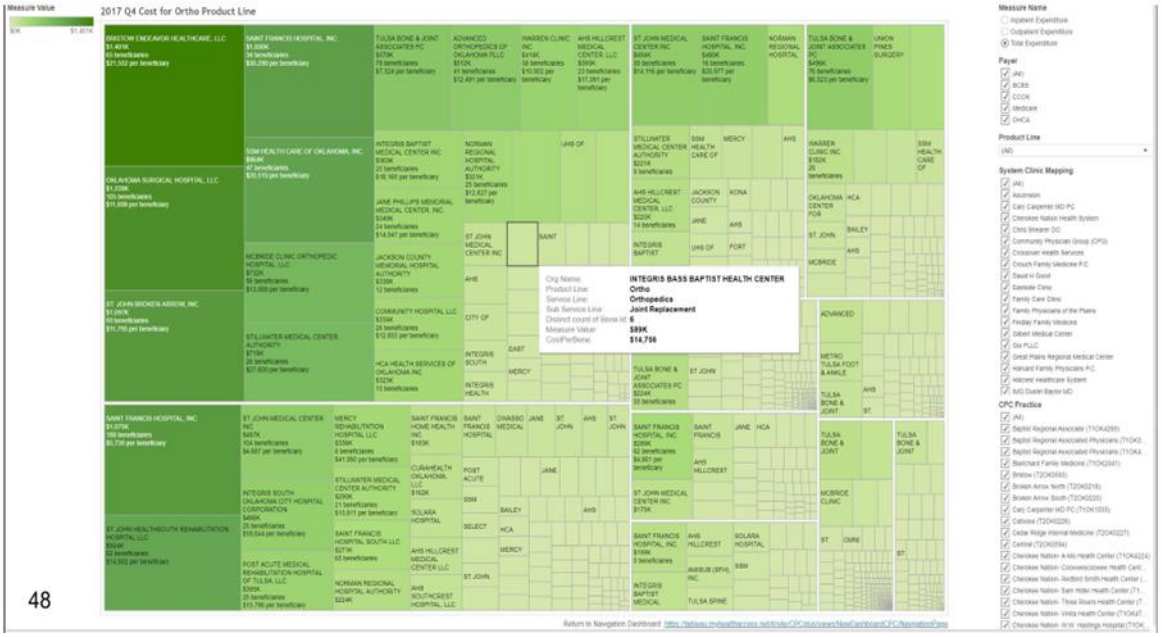
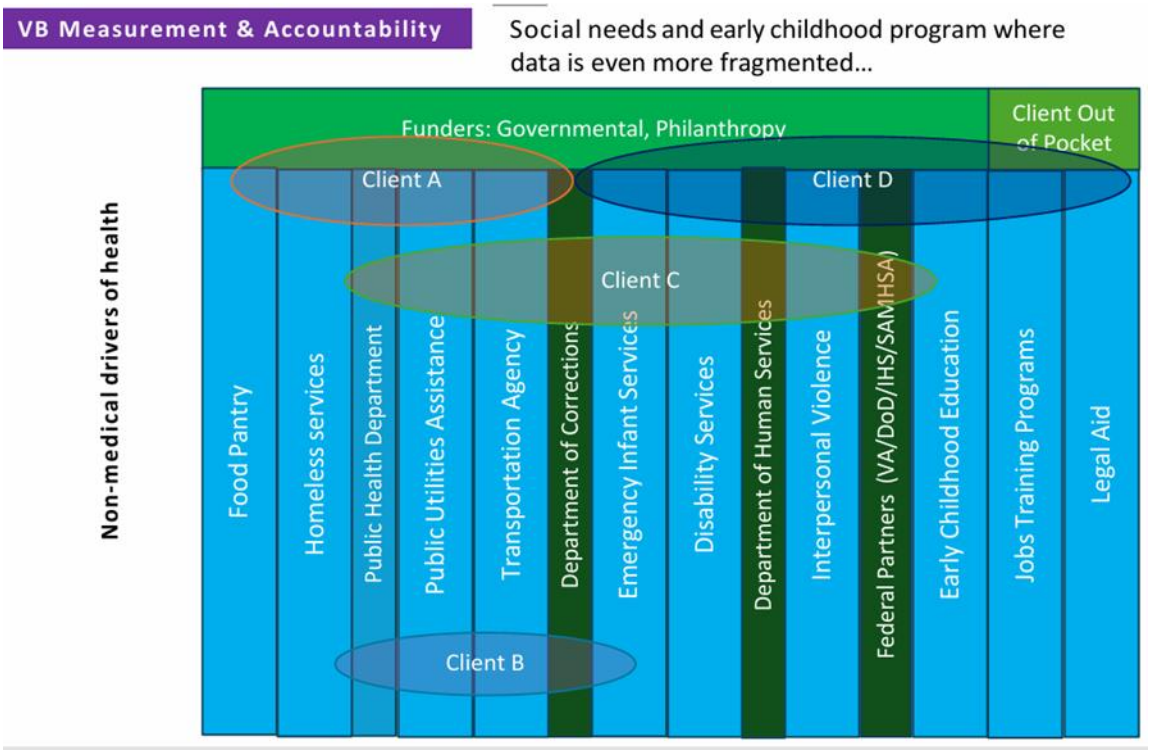
VB Measurement & Accountability

CPC+ Expenditures by Product Line

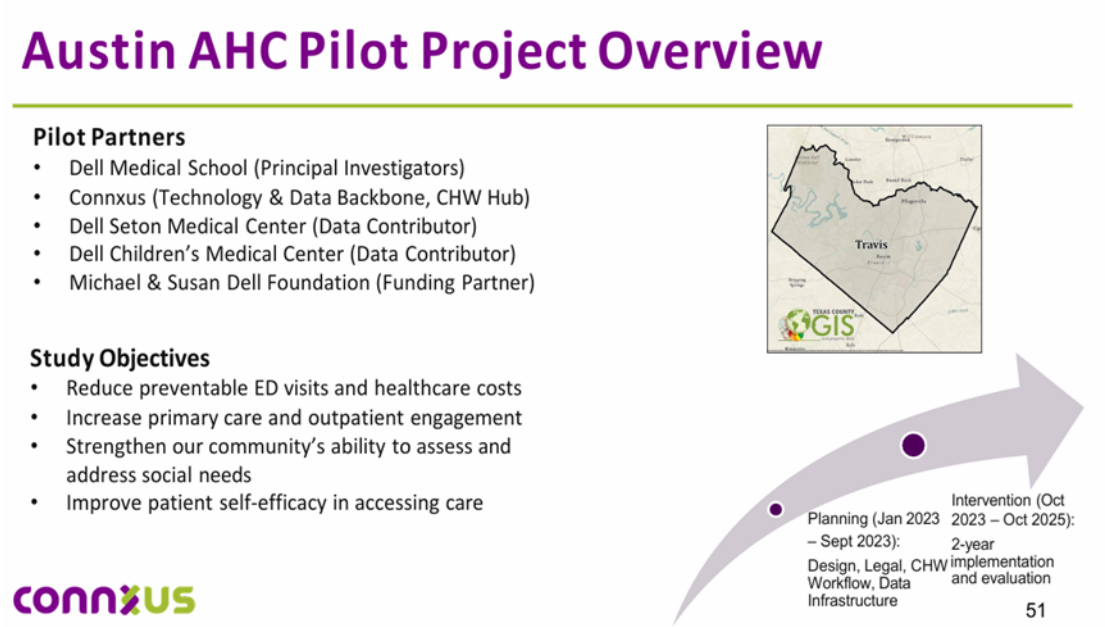
VB Measurement & Accountability

Identify Utilization and Cost for All Attributed Patients by Product Lines





NMDOH Sample Use Cases



AHC Patient Outreach & Eligibility

Patient Outreach

- Screen patients for health-related social needs via telephonic workflow (modeled after Dallas AHC).
- If patient lacks or having trouble connecting to a PCP, CHWs will refer to local FQHCs.
- A critical goal is building strong connections between CHWs and primary care homes.

Patient Eligibility Criteria

2 or more ED visits in the previous 12 months

Medicaid (STAR and CHIP) for Dell Children's patients, and Medicaid or MAP insurance status for Dell Seton patients

Reside in Travis County, with a cell phone and an address

Exclusion Criteria

- Primary diagnosis of mental/behavioral health or substance abuse
- Individuals experiencing homelessness and those who reside in shelters

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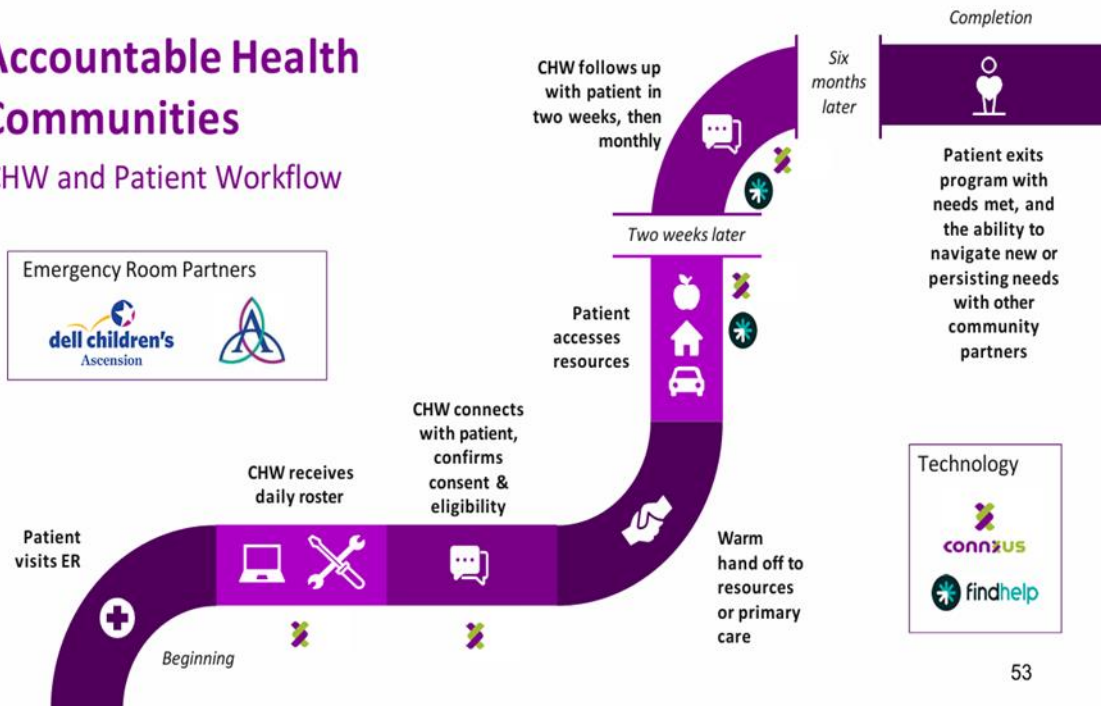
***MAP (Medical Access Program)**: Health coverage program for eligible patients in Travis County who are low-income and uninsured*

Accountable Health Communities

CHW and Patient Workflow



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CHW Navigation - High Success Rate

	Eligible	Called	Reached	Consented	Screened	Navigated
All patients	9797	3391 (35%)	2409 (71%)	1966 (82%)	1856 (94%)	1835 (99%)
MAP (BASIC)	1201	637 (53%)	417 (65%)	316 (76%)	301 (95%)	295 (98%)
Pediatrics (ALL PAYER)	6571	1667 (25%)	1373 (82%)	1199 (87%)	1137 (95%)	1136 (@100%)

*Data is for 7/ 1/24 – 6/30/25 *

	Patient Intake	Closed Loop Rate
Targets	30 new patients per CHW per month, 90 total	80% of referrals have a successful closed loop [2]
Current	50 – 60 new and 150 total patients per CHW per month	56% of referrals have a successful closed loop

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AHC Evaluation Results

Preventable ED Visits Decreased Significantly

Before Enrollment

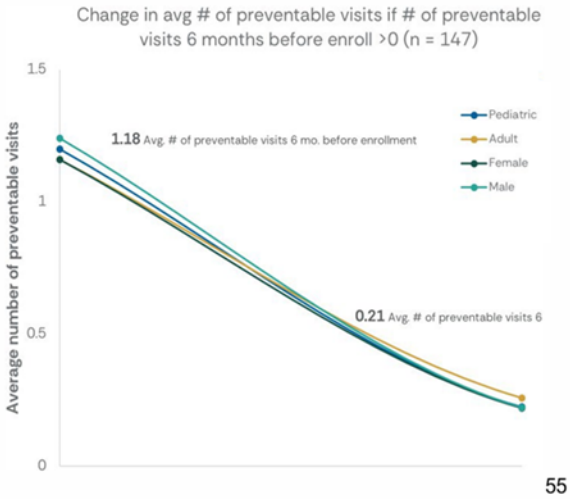
- 534 of 681 patients (78%) had no preventable ED visits in the 6 months before joining the program.

Among Higher-Risk Patients

- Of those with at least one preventable ED visit before enrollment, 85% reduced their visits within 6 months after completing the program.

Overall Impact

- 40% drop in total preventable ED visits (pre- vs. post-enrollment, 6-month comparison).



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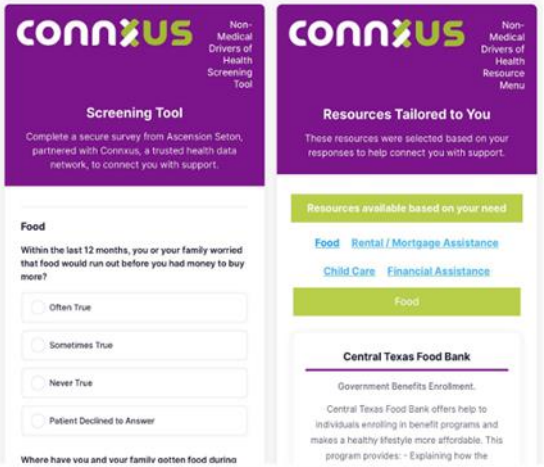
CHIRP Use Case with Ascension

- Comprehensive Hospital Increase Reimbursement Program (CHIRP) through Texas Medicaid
- Collect assessment of social needs and provide referral to socials services remotely through text messages for post discharged patients



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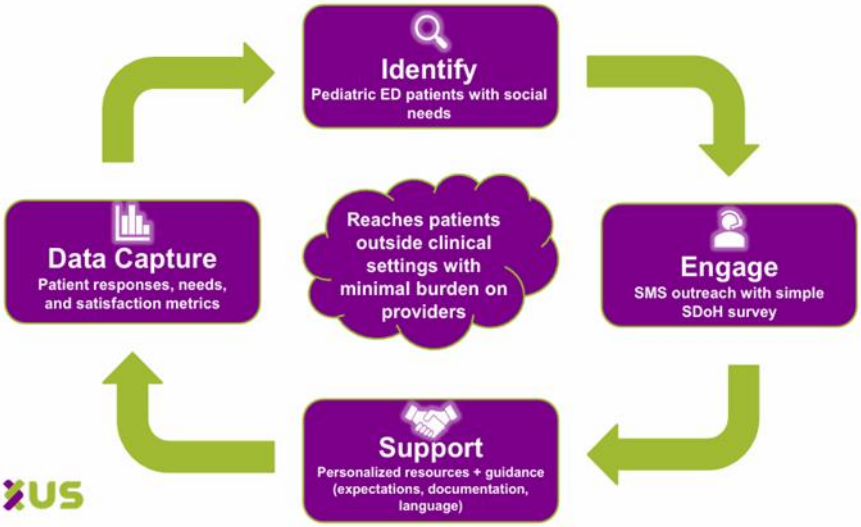
Expanding Patient Reach Beyond Clinical Settings



connxus

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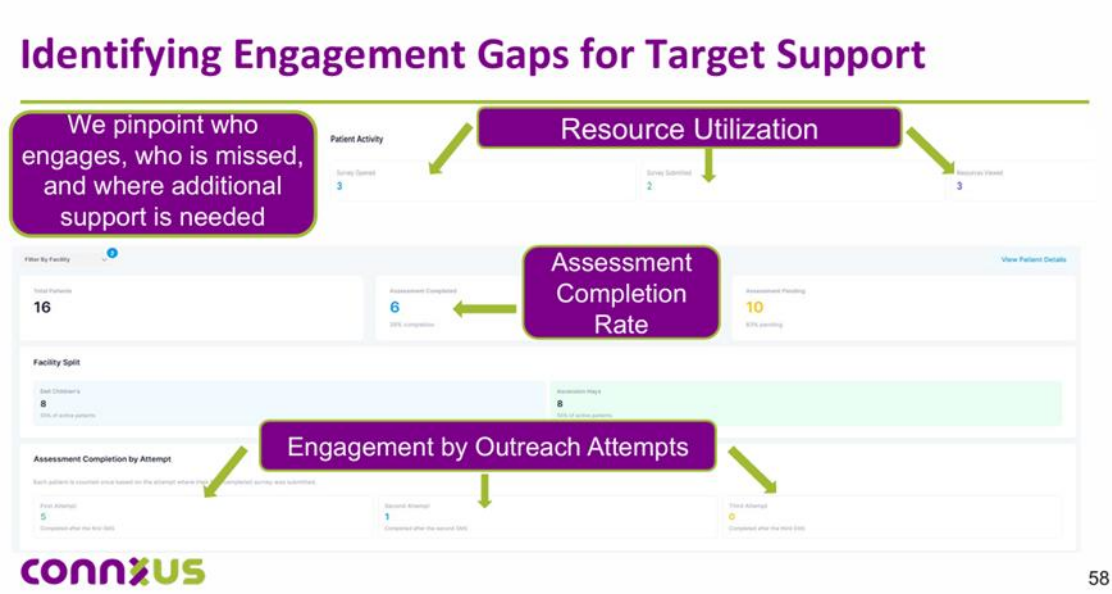
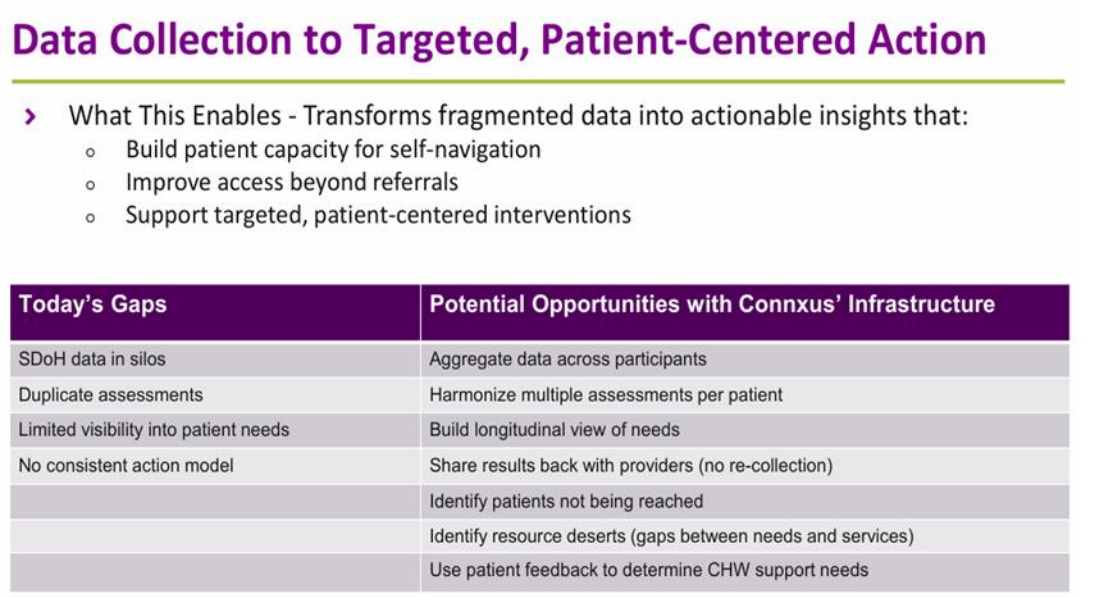




Discussion

In looking at Texas, there was a lot of white space, and then you noted that there were five providers of HIE in Texas and multiple providers in other states. In Oklahoma, is there one provider or are there multiples? Connxus stated we started out with two that grew to three. The state sat on the sidelines until that worked itself out through market

forces. The effect that had was the same effect it's had in Texas, which was providers sat on the sidelines, waited for there to be one ring to rule them all. Things really got going quickly when the state designated a health data utility. Because of the patient-centered data home model, there are just places that are so big, New York, California, Texas, that it may be difficult to get community-level trust.

The patient-centered data home model is pretty effective at leveling the playing field, meaning the data moves to whichever community you're in independent of state lines. And as you saw from the maps, state boundaries are no guarantee either because patients move.

When you have multiple providers of HIE do they all have to support the same level of data input, output? HIEs should at least have the same requirements. If I designed the system, I would've made one node, and everybody in the nation connect to it. But it's not politically or practically feasible to do that.

The fallback position is you make a system that accommodates change along the way, and that means implementing standards. The floor is established and generally adhered to by the networks. Everybody receives the same data, The data coming in, and then the data goes out, usually through a portal to providers, which is not super convenient, but if you have single sign-on ability, that can help in your EHR. Most importantly, every one of the networks should have a FHIR API. (Fast Healthcare Interoperability Resources). But if your networks all have a FHIR API then the data is accessible in the same way from every network as well. And in fact, if they're on patient-centered data home they will be collecting those FHIR APIs in one place. So, if it knows that patient David Kendrick has records in D-DFW and Houston, but also Oklahoma and Colorado, then those four FHIR APIs can be queried, and the data come back immediately, rather than needing to keep a full copy of all the data in every place all the time. ,

What are the one or two key things that really drive success in people being able to actually use the system? And what can states do?

With the incentive part of it thirty-six billion dollars were spent in high tech to get EHRs deployed. Five hundred million was spent to build out the health information exchange infrastructure. It's understandable to me why we have such a patchwork world of networks nationwide and even statewide, because they've all had to live in a realm of, shortage. And they've had to take whatever projects that came at them. They work with

foundations. Having a steady stream of sustainable funding in exchange for product delivery is important. And so, we had a real breakthrough in Oklahoma, where we went to our largest health plan and said, "Hey, we want to support your value-based payment models, but we don't want you to have to pay us anything. Why don't you just use us to measure your quality?" So, they put in their contracts for value-based payment models that they would only measure the quality of performance based on data coming from the health data utility. And what that did is it created a pull for all the providers to get connected and to be invested in the quality of the data they provided. That's a low cost, no cost, kind of thing that can help drive participation. There are a number of others, that, that can be put in place. On the provider side, to help it be utilized the FHIR API is really important for that to be available because it's also privacy preserving. Because most of the time, when somebody asks for outside data right now they get a CCD file, which has everything in your medical record, but everything is not needed. What is needed is the blood pressure or the A1C or whatever. And if I'm a health plan, I don't want that other stuff because that's just liability. If I'm another provider, I don't want that other stuff because that too is liability. So having the FHIR API is critical. Single sign-on is critical.

The EHR vendors have been more difficult to work with to get the single sign-ons deployed, although some of them are pretty good at it now. There are always the edge cases. But I think the provider workflow is critical. FHIR API is critical. And it's in the spirit of a health data utility, it's not just providers using it...It should be patients, should be services, should be lots of other groups.

4. Stakeholder Presentation: University of Florida Institute for Child Health Policy (ICHIP), The Digital Quality Measure Landscape

Summary Texas EQRO (University of Florida/Institute of Child Health Policy) described monthly data repository updates with enrollment, encounter, pharmacy, and provider extracts from HHSC. EQRO supplements administrative data with Texas Immunization Registry and supplemental clinical data from MCOs to capture care not present in claims and encounters. (e.g., screenings, labs, vital signs). The measure sets reported include NCQA HEDIS, CMS Core Set, potentially preventable admissions and /readmissions, ED visits, dental DQA measures, and state measures. The reporting goes to CMS, HHSC, and MCOs annually.

Timeline concern: by measurement year 2029, measures shown will be eCDS-only; without clinical data flowing into supplemental feeds. Performance rates will rely on administrative data that under-captures key clinical elements.

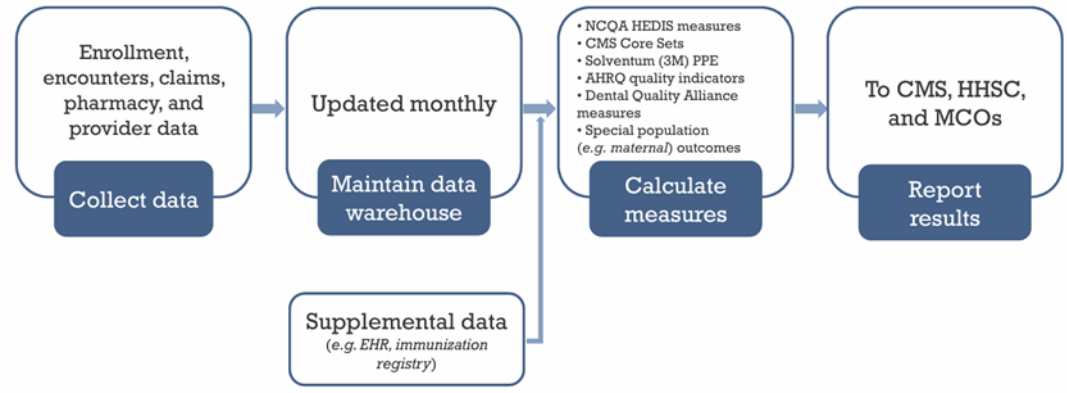
Measurement year 2024 comparisons show substantial drops when relying on administrative and eCDS pathways versus hybrid rates, with particularly stark gaps for depression screening measures. (Depression screening: Medicaid capture rates were characterized as not reflecting true quality; nationally, capture is also limited, and several MCOs had 0% on certain depression screening measures).

Q&A on "next steps" for Texas: indicate a need for a data aggregator and a way to review and certify patchy clinical data and ensure uniform elements for linkage back to claims/encounters.

Presentation

Texas Electronic Clinical Data System (ECDS) Measure Transition: Findings and Next Steps Deepa Ranka, MS Institute for Child Health Policy | Texas EQRO.

How Does Texas EQRO Receive Data?

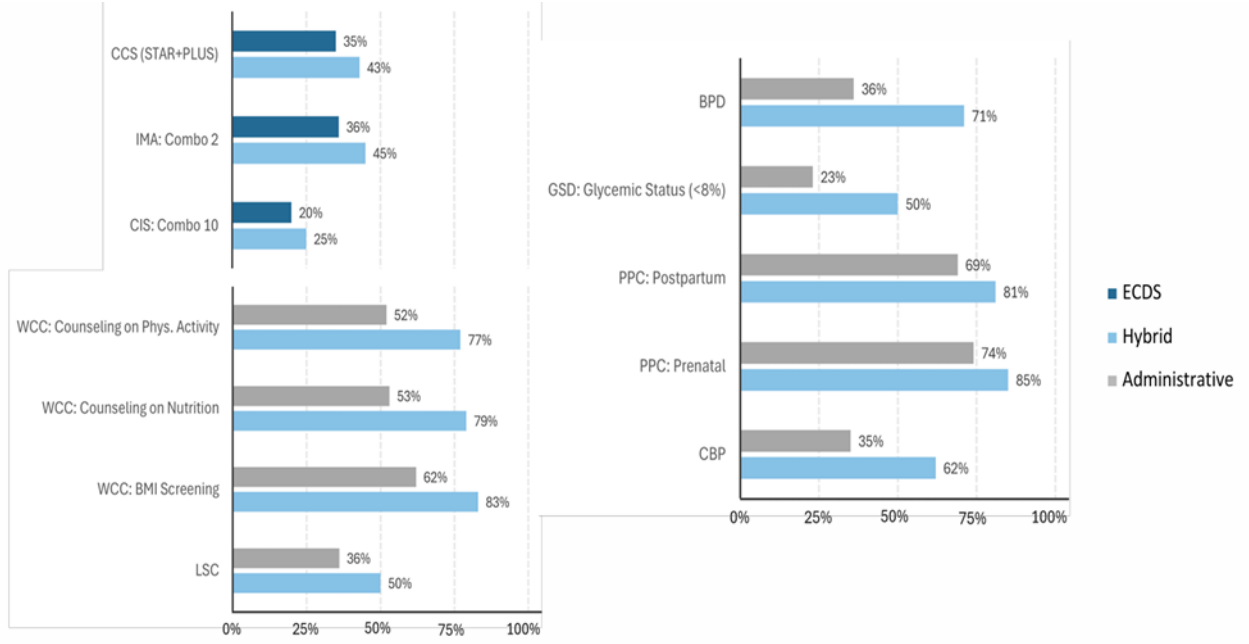


Hybrid and ECDS Measure Transition Timeline

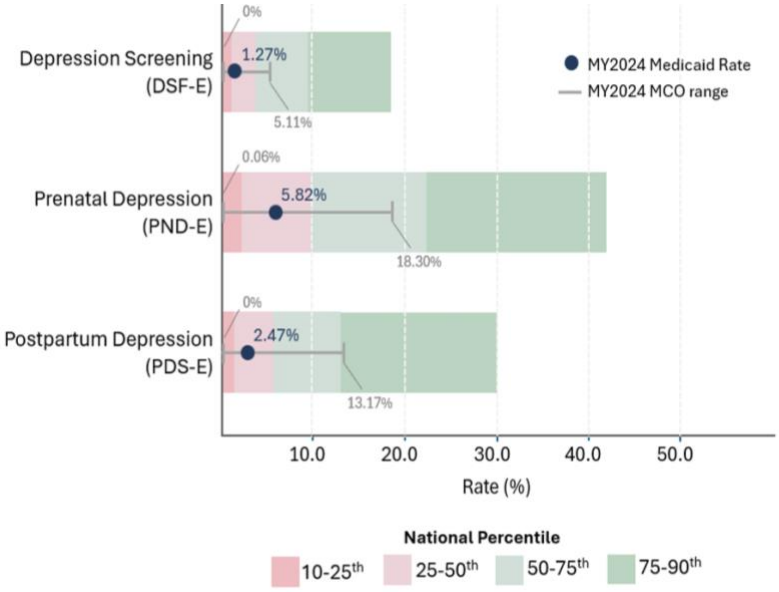
Measure	Measure Name	MY2024	MY2025	MY2026	MY2027	MY2028	MY2029
CIS	Childhood Immunization Status	H|E	E	E	E	E	E
IMA	Immunizations for Adolescents	H|E	E	E	E	E	E
CCS	Cervical Cancer Screening	H|E	E	E	E	E	E
LSC	Lead Screening in Children	H	H	E	E	E	E
CBP/BPC-E	Controlling High Blood Pressure	H	H|E	H|E	H|E	E	E
BPD	Blood Pressure Control for Patients With Diabetes	H	H	H|E	H|E	H|E	E
GSD	Glycemic Status Assessment for Patients With Diabetes	H	H	H	H|E	H|E	E

- H = Hybrid
- E = ECDS
- H|E = Both available

MY2024 Hybrid vs. Admin/ECDS Rates — STAR Program



ECDS Depression Screening: Texas Medicaid MY2024



Key Findings

- **Wide variation among MCOs in MY2024**
  The grey horizontal bar represents the range of measure results at MCO level. As shown in the graph, performance varied greatly across the MCOs, especially for prenatal depression screening (PND-E).
- **Opportunity: broader ECDS adoption**
  MCOs should be encouraged to expand adoption of electronic clinical data, given the transition towards ECDS measures.

The Texas HIE Landscape Today Texas has state-level HIE shared services (HIETexas) for ADT alerts and CCDA exchange but does not yet have a unified pipeline for FHIR-based clinical measure data. For ECDS reporting, clinical data exchange today is delivered through multiple regional HIEs operating independently:

REGIONAL HIEs OPERATING IN TEXAS*

- **Greater Houston Healthconnect**
  Houston / Southeast Texas
- **Healthcare Access San Antonio (HASA - now part of C3HIE)**
  South Central Texas
- **Integrated Care Collaboration (ICC/Connxus)**
  Central Texas / Austin
- **Rio Grande Valley HIE**
  South Texas
- **Paso del Norte HIE**
  El Paso region

IMPLICATIONS FOR ECDS REPORTING

No unified data flow
Regional HIEs do not fully interoperate. A patient seen across regions may have records in multiple systems with no consolidated view.

Uneven MCO coverage
MCOs operating statewide must connect to multiple HIEs separately. Coverage and data depth vary by region.

No statewide aggregation point
There is no single endpoint from which Texas Medicaid can pull FHIR-formatted clinical data for quality measurement.

Each MCO is on its own
Plans build their own clinical data pipelines. The MY2024 submission variation reflects this.

Where We Go From Here Closing the gap requires coordinated action at two levels:

Discussion

Texas has regional HIEs and we have Atlas and THSA... one of the recommendations that our data committee is going make is around assessing what resources we have and what the federal requirements are and thinking about the best way for the state to get there. It sounds like this single pipeline is designed so that health plans and others aren't having to connect to multiple entities. I don't fully understand data aggregator validation but understand a little bit better after today. But I just wanted to get thoughts on, given where Texas is currently, what the next steps could be.

The speakers stated that we definitely need, a data aggregator, whether it be HIE or Texas or HHSC; whether it be a vendor hired by HHSC or an external vendor of some kind. Currently, based on what we can see there is a platform that would work. We reviewed the data and noticed we do need a certification or an entity that can certify the data, like we do the encounter and claims data, because it is patchy at best. There are some critical elements that would be needed to link it back to the administrative claims data. It needs to be uniform, it needs to be reviewed, and it needs to be certified, either through a certification or otherwise.

NCQA stated that the Data Aggregator Validation is a program that focuses on maintaining the integrity of the HEDIS Performance Management system. So HEDIS is a set of measures, but it's also an audit and benchmarking set of activities that states rely

on so that they can compare health plans in Texas to health plans in Michigan to health plans in Washington. And no one can have a fuss about any of those comparisons because there is validity and reliability built into the, the process. The way HEDIS works now is on something called primary source verification. When an MCO submits data to NCQA, the auditors have to work with that MCO to make sure the information they're reporting can be tracked back to the primary source and remain true. Uh, so there's no sort of breakdowns in the whole process. What Data Aggregator Validation does is it takes that same perspective but looks at a pot of data. Looking at the Texas HIE and saying, "All right. Regardless of what MCO chooses to or chooses not to use any of this data, we're going to look at it and make sure it all tracks back to the primary source so that health plans don't have to actually go through that level of audit burden when they choose to use those data. "For quality reporting" is the focus. The validation of the data in general is so the overall system can say, "This is some good data and not just for reporting. We can start using it to make clinical decisions." That's the role data aggregator validation plays.

How does the data aggregator validator do that? How does it validate the data?

The speakers stated it is a qualitative process that the aggregator has to go through, like an audit. It's basically an audit on the aggregator itself, looking at their data processing, systems, looking at any, if any data are transitioned from one system to another, then we have the policies and procedures, and verification checks that the organization does to make sure there was nothing lost in that translation from one data standard to another. At the end of the day, we say, "All right. All the data right here in these tables that were drawn from... all of these other sources or tables themselves, the mapping was done correctly." There are verification checks in place to make sure that's happening. The audit is passed at an organizational level not a health plan level. But the health plan then knows, "All right, I can trust those data for reporting to HEDIS," and the HEDIS auditor will know, "Okay, you've got it from an aggregator that's passed data aggregator validation. We're not going to double check you on the primary source of those, of those data when you submit."

5. Stakeholder Presentation: **Modernizing Measurement: Digital Measures and State Use Cases.** Wendy Talbot VP, Measure and Data Operations; Kristine Toppe VP, State Affairs; Tom Curtis Director, State Affairs.

Summary NCQA overviewed traditional HEDIS (90+ measures) as historically paper-specified and heavily reliant on claims and administrative data and manual medical record review for plan comparison. The limitations of traditional HEDIS:

- claims-only insights,
- difficult to compare at delivery system/clinician level, and
- event-driven measurement that misses the full care journey and patient context.

They described the evolution path through 2030 from paper/manual to Digital Quality Measures (DQMs). DQMs are a change in how specs are written, not the intent of measurement using FHIR-based data exchange, machine-interpretable logic using CQL, and standardized data concepts. The benefits highlighted include:

- reduced interpretation/programming burden and errors,
- lower maintenance cost/variability,
- configurable "allowable adjustments" (e.g., age/population) without changing clinical intent, and
- better support for real-time/prospective quality improvement.

Digital HEDIS aims to reduce "chart chasing," increase interoperability, and better support value-based care with more actionable, outcome-oriented measures across care settings.

NCQA presented common challenges driving digital measurement: variability in EHR formats, lack of standardization/mapping, data exchange difficulties, data integrity and trust issues, and the high cost of "patchwork" fixes.

North Carolina example: channel data from providers and the state to the HIE, calculate FHIR-based DQMs and return results to the state, providers, and / or plans; The initial measure set includes controlling high blood pressure, glycemic assessment, and depression screening/follow-up. North Carolina's early step was to implement NCQA's Data Aggregator Validation (DAV) to systematically validate aggregated data back to the source.

Rhode Island example: broader interoperability approach spanning Medicaid + commercial. DAV was implemented in 2020 prioritizing digital use cases (e.g., CMS Core Set reporting, CCBHC, ACO, state-directed payments, provider, HCBS, fee-for-service) with initial focus on ACO and CCBHC. Rhode Island focused on transitioning HIE reporting from opt-in to opt-out; using CRISP Shared Services; publicly released scope of work and RFP requiring vendor FHIR/CQL capabilities.

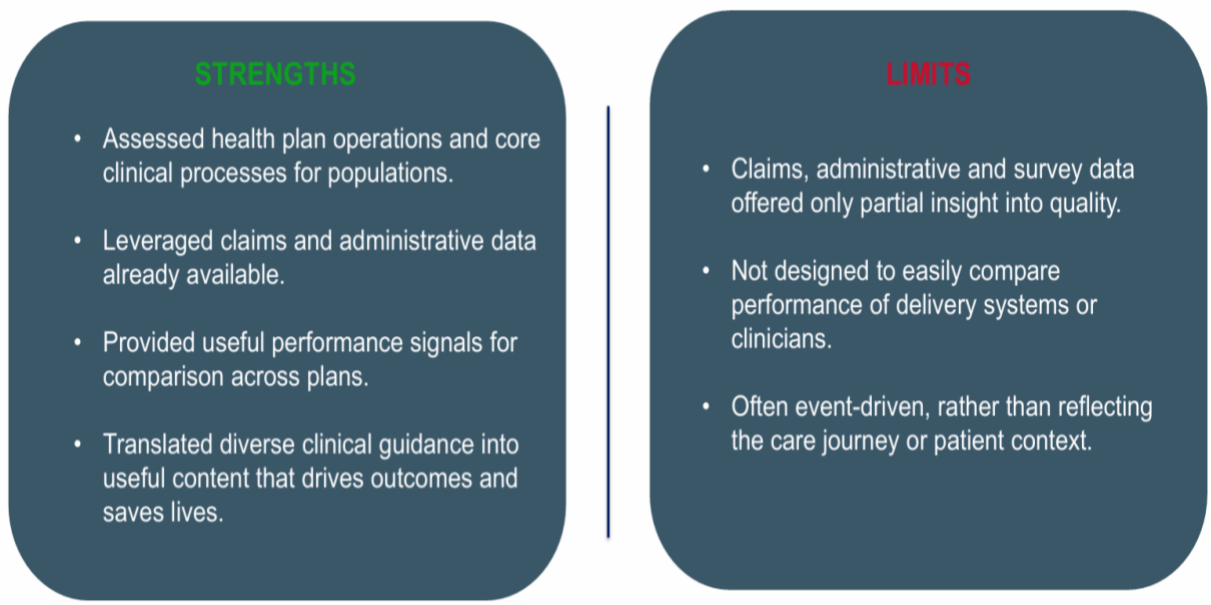
Discussion noted DAV's roots in maintaining HEDIS validity and reliability through "primary source verification," shifting audit burden from individual MCOs to the aggregator (e.g., HIE) so plans can trust data for reporting.

DAV is an audit-like organizational review of the aggregator's processes, mappings, policies and procedures, and verification checks to ensure no data loss or incorrect translation across systems.

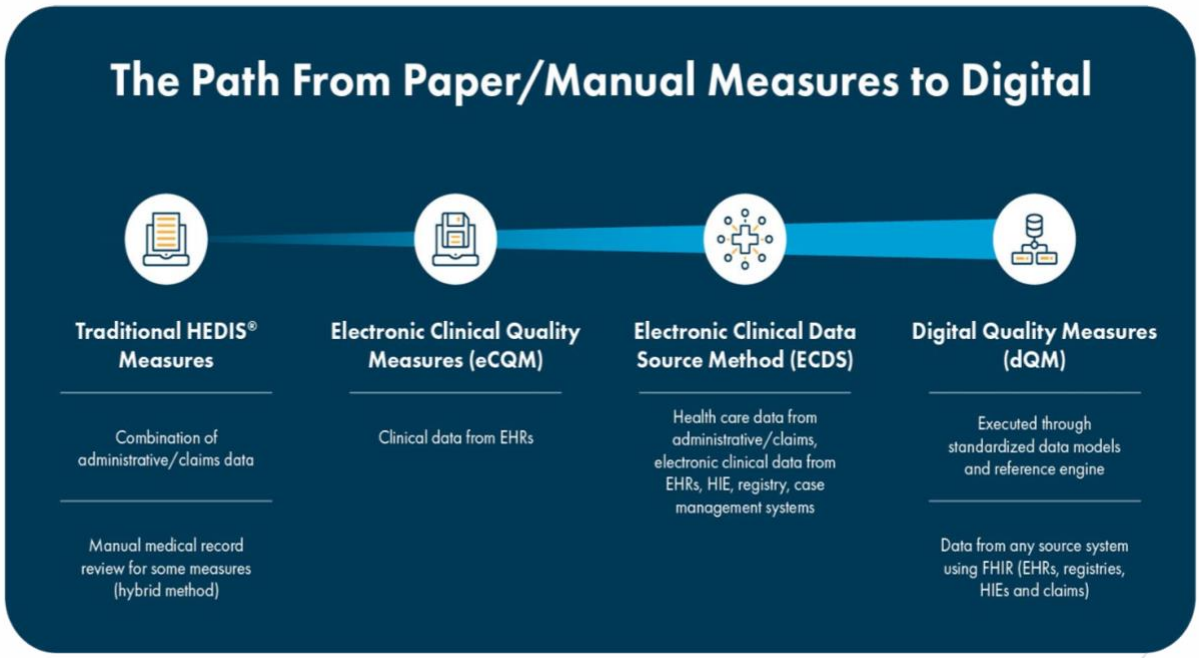
Committee discussion emphasized leveraging Texas's existing efforts (e.g., Texas Atlas project) to understand current "where data flows" before connecting networks and standardizing.

Presentation

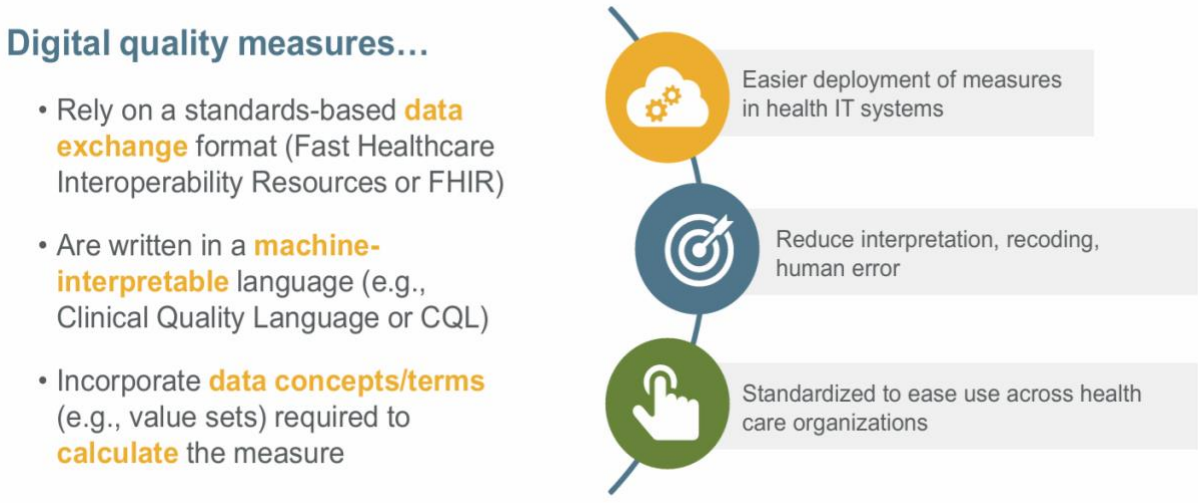
Traditional HEDIS Measures: Strengths & Limits



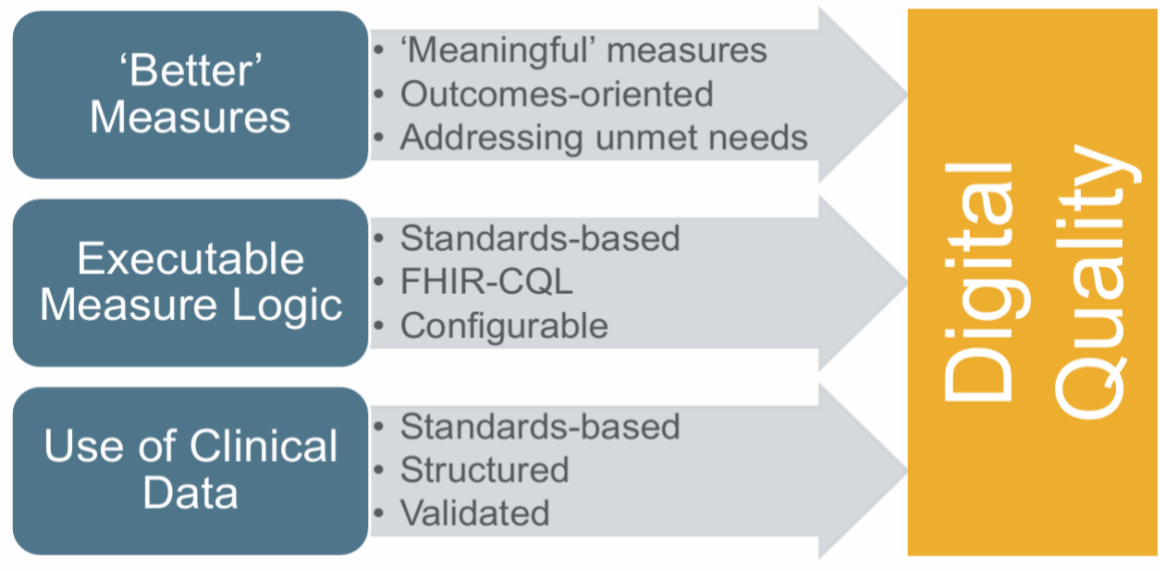
NCQA Digital Transition



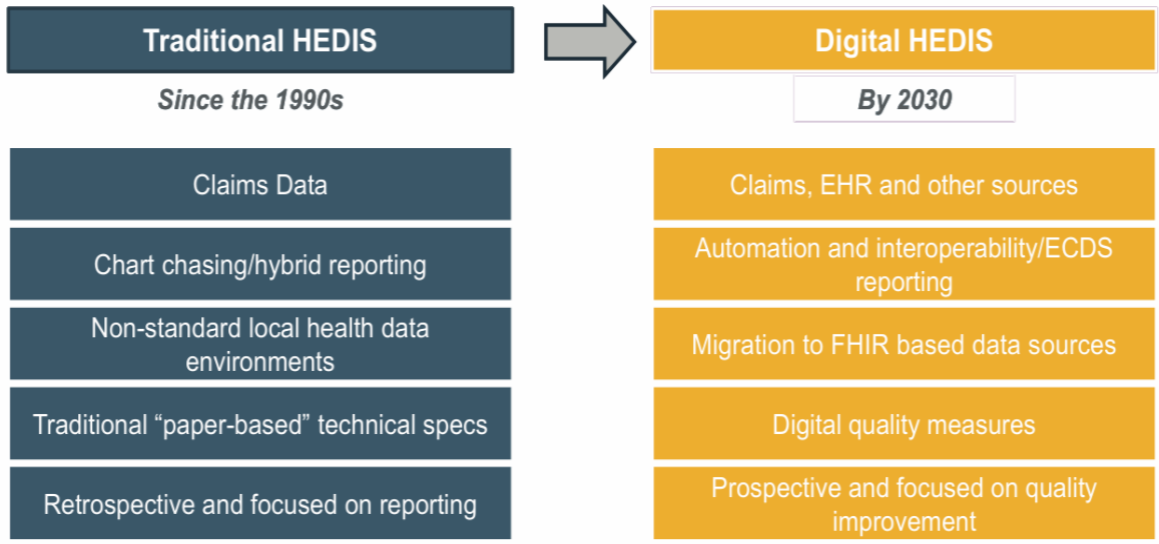
What are Digital Quality Measures (dQMs)?



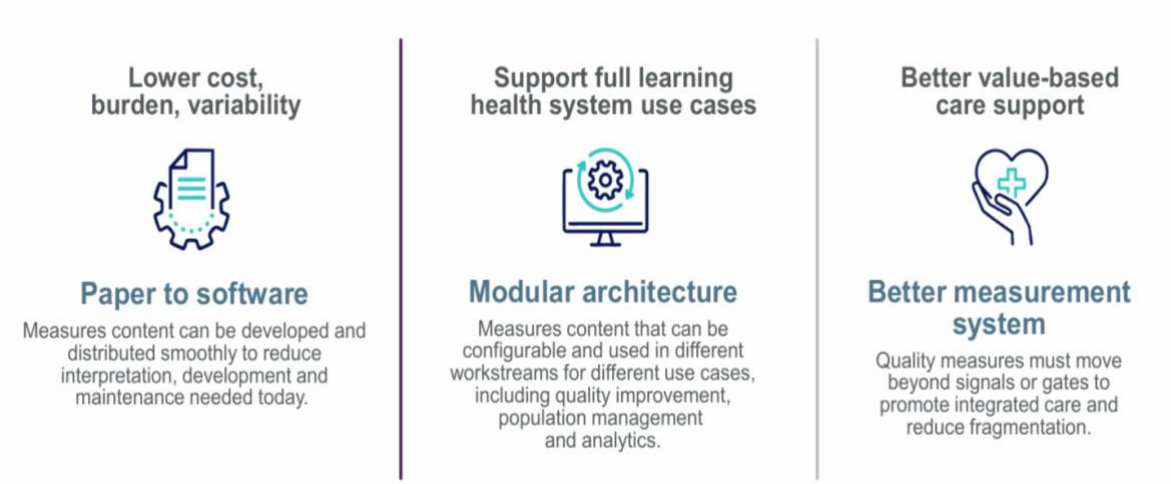
Core Premise of Digital Quality



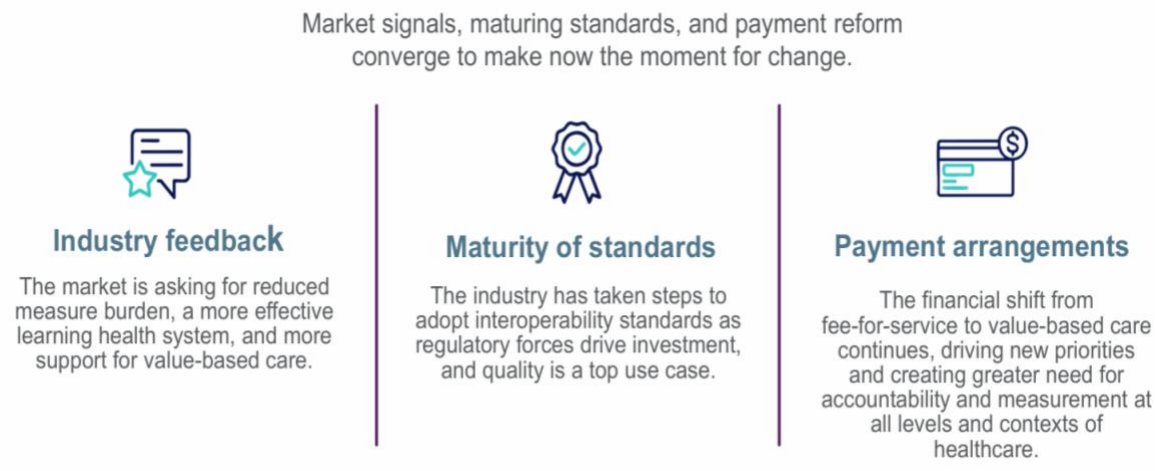
Transformation from Traditional to Digital HEDIS



Digital Quality Benefits



Why Evolve Now?



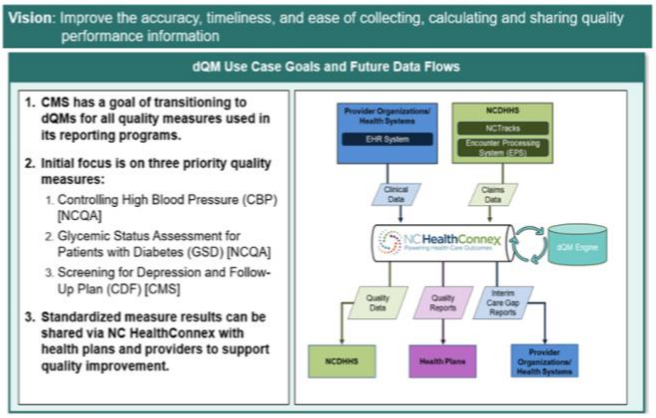
Role of States and Their Progress Shifting to Digital Forward

- Technology & Infrastructure – variability in EHR formats
- Data Standardization – data not collected in discrete fields or mapped to industry standard codes
- Data Integration – issues integrating data across different EHRs
- Data Integrity – inaccurate, incomplete, or missing data
- Reporting Burden – quality reporting remains labor intensive and costly

State Examples

North Carolina

- Starting with Care Management as the focus of improved clinical data.
- State HIE tested and validated over multiple years to ensure clinical data flow on selected medical episodes. Launched DAV in 2024.
- Beginning to explore the creation of a concept and RFP for vendor support on FHIR and CQL capacity.
- Goal of leveraging their HIE and a measure calculator for dQMs.

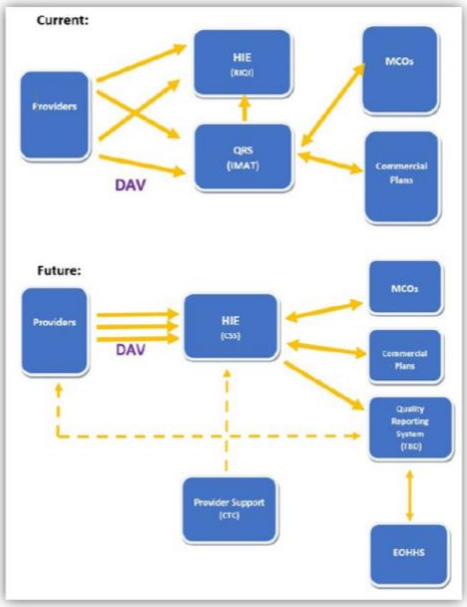


State Use Cases

Rhode Island

Rhode Island

- Launched DAV in 2020 and measure rate comparisons using clinical data in 2024.
- Desire to leverage clinical data for reporting CMS Core Set.
- Created a concept for a Quality Reporting System using HIE (CRISP) and a measure calculator.
- Procurement released for vendor to support FHIR and CQL capacity.
- Aim to utilize dQMs to report Core Set, and consideration for future uses once validated.



Discussion

It looks like one of the initial steps from the two examples is the establishment of, of some sort of state DAV capability. Could you elaborate a little bit more on what goes into launching a state, DAV?

The speakers stated that the DAV program is the Data Aggregator Validation program. And I those that have gone through the program have found benefits in the part that uses clinical data, particularly those that are aggregated, let's say, at an HIE or other site or sort of a data aggregator, there is the need to be able to validate or use those data, to pass an audit, particularly the HEDIS audit if you're using the data for HEDIS health plan reporting. The Data Aggregator Validation program acts as the data intermediary, the validation of those data as kind of a one and done, validating that data back to the source. In Rhode Island the HIE has gone through the DAV program to be able to get back to the providers, that they received the data from, to then prevent the MCO, who is the recipient of those data, from having to support that. So really, it just leverages the ease of that data exchange and that flow because there's trust in the data as it's passing through subsequent end users.

6. Subcommittee updates:

In Summary

Non-Medical Drivers of Health (NMDOH) work group recommendations focused on HB 1575 (standardized screening questions for pregnant moms in STAR Medicaid; additional provider types such as CHWs/doulas) with emphasis on improved screening data quality, data sharing, and actions to address identified needs (e.g., transportation, food security). NMDOH also recommended improving enrollment processes for doulas and CHWs using best practices and potential process refinements. Additional NMDOH recommendations were to strengthen MCO–nonprofit/CBO partnership capacity and guidance (including policy levers like value-added services, PIPs, APMs, and philanthropic funding); support SNAP eligibility/process improvements to reduce error rates and minimize health impacts; work with the Legislature on evidence-based strategies including diabetes prevention program support.
Value-Based Care in Rural Texas recommendations included planning for sustainability of Rural Texas Strong-funded services through payer/state collaboration

(billable services, Medicaid covered benefits, or APMs); share best practices via the Office of Rural Hospital Finance and its academy and provide annual progress feedback to the committee.

Rural behavioral health recommendation addressed expanding covered mental health benefits for mild-to-moderate youth needs and increase rates for existing programs (e.g., Youth Empowerment Services) to improve provider participation.

Rural workforce/training recommendation addressed funding innovative training/mentoring (mobile simulation, Project ECHO-type models) for clinical and community-based workforce; add APM participation incentives for models addressing high-need shortages in rural areas.

Alternative Payment Models (APM) recommendations addressed promoting APMs targeting primary care and chronic disease prevention (maternal health, pediatrics, behavioral health) and leverage HHSC's collected framework data to spread best practices. APM recommendations also included: build on CHIC Kids Pilot and STAR Kids lessons to support APMs for children with medical complexity via streamlined oversight for comprehensive health homes, reduced administrative burden, and outcome benchmarks.

APM financing recommendation addressed reviewing financing mechanisms to sustain high-value models not well incentivized by encounter-based capitation-setting (e.g., workforce supports, non-billable services, NMDOH-focused APMs).

Timely and actionable data recommendations: conduct a statewide interoperability/HIE/NMDOH data-sharing landscape assessment (HHSC or neutral contractor); pursue federal matching funds via APDs; align with CMS frameworks; leverage Texas Atlis to expand connectivity; engage stakeholders across health and social sectors.

Data recommendations also included HHSC forming a work group to define roles and target dates for DQM transition, assess plan readiness, prioritize data quality, and support providers' EHR functionality use. Data recommendations further included enabling UT's all-payer claims database (APCD) to create more actionable public dashboards using APCD and other state resources (without moving or changing APCD governance).

Recommendations

Non-Medical Drivers of Health (NMDOH)

1. HHSC should review implementation of HB 1575 (88th Legislature), which required HHSC to develop standardized screening questions related to nonmedical needs for pregnant women in STAR Medicaid and allows CHWs and doulas to become billable provider types under HHSC's Case Management for CPW program, for lessons learned and next steps to include:

- Improving the quality and collection of data for the screening and identify next steps based on screening data, including to evaluate pathways to reimburse providers for screening.
- Improving data sharing across providers, MCOs, and other stakeholders to enable shared action to address needs.
- Evaluating what actions MCOs and partners are taking to help get identified needs met.
- Improving provider enrollment of doulas and CHWs by reviewing best practices for doula and CHW services for pregnant women. Assess the CPW program for compatibility with best practices and provide recommendations on Medicaid program areas that are an appropriate fit based on best practices.

2. HHSC should outline pathways to increase the capacity of nonprofit organizations to engage with MCOs to more effectively implement NMDOH services that align with Texas Medicaid and CHIP initiatives, such as HB 1575 (88th Legislature) and HB 26 (89th Legislature) to include:

- Providing guidance on best practices between MCOs and nonprofit organizations for policy levers MCOs have available such as Value Added Services, Performance Improvement Projects, Alternative Payment Models, and MCO philanthropic funding.
- Evaluating infrastructure needs to enable such partnerships and for MCO and community-based organizations efforts to be recognized.

3. HHSC should make efficiency changes to reduce SNAP error rates and streamline the eligibility process to minimize the potential negative health impact of federal SNAP changes on Texas Medicaid recipients.

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4. HHSC should work with the Texas Legislature to identify evidence-based strategies that include NMDOH elements for a Diabetes Prevention Program benefit in Texas Medicaid.

No Discussion

Value-Based Care in Rural Texas

Held monthly meetings (March – May) with guest presentations and discussion / development of legislative recommendations.

March: Pilot program utilizing digital platform to help address behavioral health needs of rural students (grades 4-12) (Lynn Price, M.Ed, LPC, District Lead Counselor, Pecos-Barstow-Toyah ISD (Permian Basin area, Reeves and Ward counties))

April: OnMed Presentation highlighting their service in rural areas and partner collaborations (Mindy Walker, National Vice President, Business Development; Lisa McFarlane, Vice President, Business Development)

May: Final recommendations for 2026 legislative report

1. HHSC should help ensure the sustainability of Rural Texas Strong initiatives after the end of the five-year funding period provided by the federal Rural Health Transformation Program (RHTP). HHSC Financial Services should:

- Collaborate closely with the Texas Medicaid program and other key payers on how these services may be paid for in the future, including through billable services and alternative payment models.
- Coordinate with the HHSC Office of Rural Hospital Finance (RHF) to incorporate identified billing mechanisms and payment models into the training provided through the Rural Hospital Officers Academy related to revenue maximization and organization management.
- Provide annual feedback to this Committee on progress made in the sustainability efforts.

2.HHSC should work with the Texas Legislature to expand the mental health services covered as benefits under Texas Medicaid and increase rates for existing mental health programs to help address challenges in caring for children with complex needs and increase the availability of mental health services for rural youth. HHSC should:

- Coordinate with payers to identify the services that are increasingly utilized to address the mild to moderate mental health needs of children but are not covered benefits under Texas Medicaid.
- Evaluate and increase rates for existing mental health programs, such as the Youth Empowerment Services program, to increase access to and sustain services for children with serious mental health needs.

3. HHSC should promote innovative training programs and care delivery models that expand access to rural health services and increase workforce training and preparedness in rural communities. HHSC should:

- Fund innovative training and mentoring models to aid in both clinical and community-based workforce development and emergency preparedness, such as mobile simulation training centers, obstetric-emergency department simulation training, Project ECHO, community health support applications, digital health certification modules, and grow-your-own training/apprenticeship programs.
- Incentivize participation in models that address high-need care shortages in rural areas by adding to the APM Priorities for MCOs in the State Health Plan, allowing them to earn points participation in rural/non-metro areas, as well as additional points for models specific to a high-need care shortage such as maternal health services**.**

No discussion

Alternative Payment Models in Texas Medicaid

1. HHSC should promote APM opportunities that address primary care and chronic disease prevention, focusing on maternal health, pediatrics, and behavioral health:

- Assess strong primary care models based on data HHSC has collected from new APM framework
- Opportunities for chronic disease prevention for maternal health including in the postpartum year; opportunity to educate new moms (and increase utilization of high value services)
- Children – e.g., well child visits, asthma
- Behavioral health – e.g., integrated care, next step to sustain Texas Child Health Access Through Telemedicine (TCHATT), Child and Perinatal Psychiatry Access Networks (CPAN/PeriPAN), new CMS model ASPIRE (complex pediatrics)

2. HHSC should identify next steps to incentivize MCOs to continue APMs focused on children with medical complexity (CMC) based on positive results from the Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot Program.

- For the small group of Texas children (.5-1%) who are CMC, take lessons learned from STAR Kids and CHIC to allow a different oversight structure for comprehensive health homes within managed care.
- This should include ways to streamline care coordination, incentivize care integration, establish outcome benchmarks specific to CMC, and reduce provider administrative burden.
- Partner with health homes, families, managed care organizations (MCOs) and HHSC to develop a CHIC 2.0 program based on pilot findings.

3. HHSC should review financing mechanisms that would sustain high value, effective Medicaid APMs that are not incentivized in the current financial structure of encounters and capitation rate setting. HHSC can review MCO reports from the revised HHSC APM Framework for effective examples, such as:

- APMs that effectively address provider workforce shortages (e.g., home nurses and behavioral health providers)
- APMs that include some non-billable services, such as for nurse home visiting programs and technological innovations that improve health
- APMs that address non-medical drivers of health

No discussion

Timely and Actionable Data

1. HHSC or a neutral, third-party contractor should perform a landscape assessment of where Texas is in terms of data interoperability, including health information exchange (HIE) and sharing of data on NMDOH. Based on that assessment: HHSC should continue to explore strategies to enhance data connectivity and interoperability to enhance care coordination across the full continuum of care and incentivize quality improvement, including:

- pursuing federal matching funds through Advanced Planning Documents (APDs) for infrastructure financing
- aligning with CMS' Tech Framework and ONC strategies and standards

- leveraging Texas' MCO-driven ATLIS incentives to expand connectivity, including to a broader range of provider types and community-based organizations • engaging key stakeholders including local HIEs, hospitals, MCOs, and participating provider types (including BH and community partners, building on strong local efforts to share actionable data across health and social sectors)
- reviewing other Medicaid managed care states and existing Texas initiatives (e.g., EDEN) to identify successful approaches for incentivizing connectivity across the full continuum of care

2. HHSC should assess statewide readiness and establish a comprehensive roadmap to successfully meet the 2030 digital quality measures (dQM) requirements. To inform this transition, HHSC should:

- establish a workgroup to clearly define the respective roles of HHSC, MCOs, HIEs, and providers in achieving this transition and create a plan with target dates for progress to ensure requirements are achieved;
- survey MCOs on their preparation strategies;
- prioritize initiatives that ensure adequate data quality, and
- support providers to leverage functionality already in electronic medical records (EMRs).

3. The State should optimize the use of the All-Payer Claims Database (APCD) and existing Texas data resources, such as the Medicaid Quality Performance Portal and EDEN, to produce actionable, interactive, public-facing dashboards that benchmark healthcare utilization, cost, and quality outcomes across different regions and provider types. Texas should study successful APCD implementations in other states to identify proven models for making this data highly actionable for policymakers, providers, and the public.

No discussion

7. Public comment. No public comment was offered

8. Consideration of draft recommendations for the legislative report as required by Title 1, Texas Administrative Code, Section 351.821(d)(2)

MOTION: Adopt all thirteen recommendations across all subcommittees prevailed.

9. Discussion: 2026 priorities and timeline

Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC) Report Timeline	
Milestones	**Due Date**
VBPQIAC reviews draft recommendations, conducts vote	5/18/2026
Draft Report shared by liaison with committee members	8/10/2026
VBPQIAC reviews final recommendations and votes on draft report (concurrent item)	8/17/2026
Draft report sent to HHSC SMEs for review (concurrent item)	8/17/2026
HHSC SMEs complete content review and feedback and return to liaison (9 business days)	8/28/2026
Chair makes nonsubstantial edits as needed and sends report to liaison	9/1/2026
Draft report sent to QDAR Director/VBI Manager for review	9/3/2026
Draft report reviewed by QDAR Director/ VBI Manager and returned to liaison	9/10/2026
Liaison gets packet ready for submission to DAC	9/10/2026
Draft sent to DAC for review (5-10 business days)	9/14/2026
Draft sent to DEC for review (5 business days)	9/30/2026
Draft sent to SMD for review (20 business days)	10/12/2026
Final report sent to EC (10 business days)	11/11/2026
Report published and posted to website	12/1/2026

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

No action items proposed

Future Meetings

- Aug. 17, 2026
- Nov. 16, 2026

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

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