Clinics Pathway Approach

Impacts & Reflections

EPISCOPAL HEALTH FOUNDATION

Executive Summary: Overview of CPA, its goals, and key achievements

The Clinics Pathway Approach (CPA) is the largest funding initiative in the history of the Episcopal Health Foundation (EHF) and was designed to prepare select Texas safety-net clinics for a healthcare marketplace that incentivizes influencing health outcomes and total cost of care. Building on earlier programs and a Medicaid payment reform feasibility study, CPA was designed to help Community Health Centers (CHCs)- also known as Federally Qualified Health Centers (FQHCs) strengthen their capacity to deliver population health strategies, address non-medical drivers of health (NMDOH), and improve long-term health outcomes.

Program Design & Implementation

Launched in April 2021 and concluding in July 2026, CPA is a five-year initiative supporting 11 CHCs through annual grants ($200K–$500K), individualized technical assistance, peer learning, and evaluation. Clinics progressed through a tiered logic model:

Planning Level	Prepares clinics lacking foundational infrastructure
Level 1	Builds capacity for population health management
Level 2	Supports execution of NMDOH interventions and data integration
Level 3	Focuses on engaging payers and sustaining community-based prevention

Training & Technical Assistance evolved annually, starting with the foundational skills of basic project management and organizational change management, and progressing to payer engagement, analytics, and care team redesign. Starling Advisors led project management, while JSI conducted evaluation. The program adapted responsively to clinic needs and the evolving post-pandemic landscape.

Grantee Progress & Impact

Grantee progress varied:

High performers have educated their Boards of Directors about the importance of population health-oriented payment models, executed and demonstrated success in more advanced contracts with healthcare payers, and made sustainable changes to their data infrastructure and primary care team structure.

Mid-level clinics made structural advances (e.g., EHR upgrades, Community Health Worker (CHW) deployment) to support long-term goals.

Early-stage clinics focused on foundational stability in IT, staffing, and financial systems.

Notable system-level changes that support the long-term success of the CPA cohort include the creation of My Texas My Health, a statewide, health center-led Clinically Integrated Network (CIN) established by the Texas Association of Community Health Centers (TACHC). My Texas My health now holds value-based contracts and supports sustainability beyond CPA's term.

Evaluation & Lessons Learned

JSI's mixed-method evaluation revealed several key themes:

- Clinics implemented multi-disciplinary care teams better able to address population health outcomes.
- Enhanced data infrastructure and care team specialization improved care delivery.
- Clinics shifted focus from infrastructure to optimization and sustainability.
- Stronger NMDOH screening and community partnerships emerged, though readiness for value-based contracting varied among clinics.
- An emphasis on data management and QI processes, more so than NMDOH, propelled clinics toward successful participation in value-based care efforts.

Important lessons include the need to track external factors such as staff turnover, regulatory changes, and evolving community needs to contextualize program success.

Background

In 2017, the Episcopal Health Foundation sought to build upon the foundation's previous work facilitating innovation amongst the primary care safety net in Texas. EHF had a long history of working with Community Health Centers (CHCs, or clinics) via initiatives like the Community Centered Health Homes (CCHH) and Texas Accountable Communities of Health Initiative (TACHI) programs and wanted to build upon this work. EHF was aware that the healthcare marketplace was shifting to value-based, rather than volume based, reimbursement models, and wanted to ensure that the primary care safety net in Texas was prepared for this shift.

Definition of Value-Based Payment

Value-based payment models, also known as advanced payment models (APMs) are healthcare reimbursement models that incentivize demonstrated changes to health outcomes and/or reductions in healthcare spending. Healthcare payers across all regions and all types of insurance coverage are universally shifting to these types of payment arrangements. Most healthcare payers, including public payers like Medicaid and Medicare, are shifting to a value-based payment system, where payments are more closely tied to health outcomes and the quality of care provided rather than simply the number of patients seen. Basic value-based payment models can involve additional payments to reward certain healthcare provider actions, such as providing preventive services like immunizations. More advanced models can offer healthcare providers the opportunity to receive additional payment if they demonstrate a reduction in total healthcare spending due to keeping patients healthier and less in need of expensive hospitalizations.

EHF commissioned a Medicaid payment reform feasibility study in 2017-2018, and this study concluded that while other states had used momentum and funding made available through the Affordable Care Act to move their Medicaid programs towards value-based payment models, this shift was happening slowly in Texas. The foundation decided to develop a multi-year program designed to help Community Health Centers prepare for value-based payment, with the long-term goal of community health centers being better equipped to invest in and deliver preventative community health interventions. This program became the Clinics Pathway Approach (CPA).

EHF developed a CPA logic model, invited eleven health center grantees to apply and conducted baseline assessments throughout 2019. The CPA program was intended to launch in 2020, but this launch was delayed due to the COVID-19 pandemic and the immense strain on delivery systems as providers responded to pandemic needs. CPA officially launched as a five-year funding initiative in 2021, providing large annual grants as well as targeted training and technical assistance to a cohort of these eleven community health center grantees.

Project Goals and Objectives

In the CPA, EHF's "big bet" was that if clinics provide comprehensive services using population health approaches, they would be able to deliver care that better address the non-medical drivers of health and engage in community prevention. The interim goal of the CPA program was to embed strong population health management practices so that clinics could enter and succeed in emerging value-based reimbursement models. The long-term CPA goal was that the funding earned from these payment arrangement could be redeployed to prevention, community based care and better health outcomes at the patient and community levels.

When the program launched, CPA program design followed a three-tiered Logic Model. The program intent was for grantees to move up the levels of the logic model through the five-year program term.

Level 1 Focused on strengthening clinics' capacity and infrastructure (such as community health workers, care managers, or population health analytic platforms) to begin engaging in population health management activities.

Level 2 Focused on supporting clinics to undertake population health management activities with their patients- such as proactive outreach to all diabetic patients with uncontrolled blood sugar or all children eligible for an immunization. Ideally these activities would also include addressing non-medical drivers of health, such as screening all patients for food insecurity and provide connection to food banks or other community-based organizations as needed.

Level 3 Focused on supporting clinics to work with payors, hospitals, and other stakeholders to develop strategies to sustainably finance community prevention work.

Founding CPA Program Logic Model - Summary

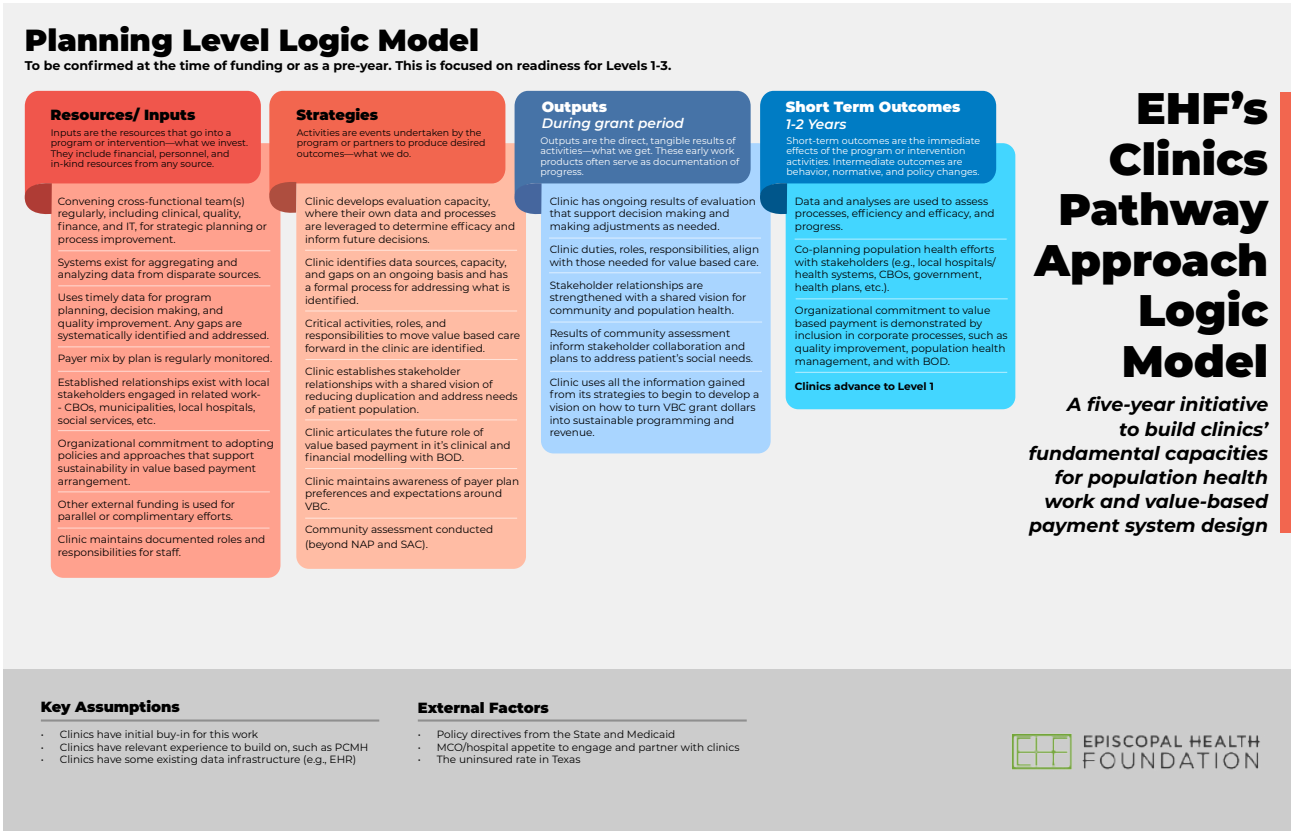
High Level Clinics Pathway Approach Logic Model

EHF Inputs	**Strategies**	**Outputs** During Grant Period	**Short-Term Outcomes** 1-3 Years	**Long Term Outcomes** 4 years & beyond
Resources: • Technical Assistance • Training/Learning Collaboratives • Research and Evaluation	Address gaps in capacity that impact the planning and implementation of population heath strategies and value-based approaches.	Clinics have clinical and operational workflows in place that support population health efforts.	Clinics and their partners are using shared data to inform population health efforts (including risk, cost, and utilization data).	Clinics and their community partners can demonstrate improvement in patients' social and health needs.
Funding Mechanisms: • Multi-year project funding • One-time TA support • One-time collaboration and planning efforts	Address clinic strategic, financial and operational infrastructure and capacity to progress all three Levels of development.	Clinics have demonstrated organizational effectiveness and commitment to the priority payment reform domains.	Clinics create financially sustainable models that move them from Level 1 to Levels 2 & 3.	Clinics and their community partners can successfully demonstrate improved community health outcomes as well as positive ROI.
Collaborations: • Clinic collaborations/ partnerships to create scale and efficiencies • Funders and philanthropy • Managed care/payers • Community based/service organizations • Gov't (local and statewide) • Health systems/hospitals	Clinics build and expand data collection and analytics to support SDOH, population health and value-based models.	Clinics capacity to capture new data sets (i.e. SDOH, cost, etc.).	Clinics expand their infrastructure and clinical capacity over time to address SDOH, population heath and upstream models.	Community health prevention activities are sustainably funded
	Clinics invest in performance measurement and outcomes tracking across clinical, operational, and financial domains	Clinics implement innovative pilots for upstream models of intervention and population health.	Clinic leadership has developed an organizational culture that is committed to community prevention.	Culture of prevention and partnership is fully integrated in all strategies.
	Clinics build partnerships with stakeholders who support population health strategies.	Clinics invest time and resources into organizational change.	Clinics have formal agreements with payers and others to engage in value-based models	Clinics demonstrate success under value-based payment arrangements, including taking on risk-bearing contracts.
		Clinics and their community partners have closed loop referral and care management programs that integrate across systems.		

Key Assumptions:
• Clinics have high adaptive capacity for changing their culture and organizational capabilities
• Clinics will commit to moving from Level 1 through Level 3 as part of this process
• Clinics across the cohort will not start at the same point of development

External Factors:
• Policy directives from the State and Medicaid
• MCO/hospital appetite to engage and partner with clinics
• The uninsured rate in Texas

As the CPA program progressed to the project mid-point, the evaluation team utilized updated program data to revise the Logic Model at the onset of CPA program year three. In this logic model revision, EHF established a foundational "Planning Level" leading into Level 1. evaluation data that despite a baseline assessment, many grantees had entered the CPA program having not yet developed the Level 1 competencies and were still working to master these capacities. Additionally, the COVID-19 pandemic had permanent impacts on the healthcare delivery system and the environmental inputs in the Logic Model had to be updated to reflect those changes. EHF's evaluation partner revised the Logic Model to the following:



Level 1 Logic Model

Resources/ Inputs

EHF Resources and Inputs:

Providing grants to fill specific gaps in clinics' capacity to do population health management work; providing grants for one-time collaboration and planning efforts.

Facilitating effective technical assistance by identifying consultants and resources.

Facilitating learning collaboratives and peer learning opportunities (including coordinated work with other funders).

Convene collaborators and stakeholders (i.e. payers, CBOs, government, etc.) to support population health efforts and other opportunities.

Conducting in-depth research and evaluations focused on what works for whom and why.

Clinic Resources and Inputs:

Clinic has or maintains evaluation and data capacity that support decision making.

Clinic duties, roles, responsibilities, align with those needed for value based care.

Stakeholder relationships with a shared vision for community and population health exist and are maintained.

Clinic has organizational commitment and buy-in for value based payment.

Strategies

Clinic uses grant funding to address specific organizational gaps in their ability to do population health management work, with a lens to sustainability.

Clinic actively participates in or leads the development of peer learning opportunities around how to do population health management (led by third party, have a local/ state-specific context).

Clinic develops/ implements an infrastructure to systematically and effectively capture patient data, specifically quality outcomes and NMDoH data.

Clinic develops internal capacity (across clinical and financial) to assess alternative payment models and value based contracts.

Clinic regularly reviews roles and responsibilities and updates with additional or changed responsibilities needed for VBC.

A value proposition of value based care for providers and patients is articulated.

Outputs
During grant period

Clinics have captured broad patient data set, including screening for patient NMDoH needs and data used for clinical planning and identifying population health priorities.

Clinics have established appropriate staffing to do population health management (either through recruiting new staff or training existing staff).

Clinic has an inventory of data sources and is developing a strategy to access and leverage these sources to further population health management in value based arrangements.

Demonstrated organizational commitment to key payment reform readiness domains through demonstrated leadership-led planning for population health, NMDoH, and other core competency areas.

Financial and clinical teams regularly assess APMs and VBCs and communicate potential impacts.

Clinics are implementing a standardized NMDoH screening process, and documenting patient screening results.

Value proposition informs decision making and assessment of provider and patient satisfaction.

Short Term Outcomes
1-2 Years

Clinics have strengthened their capacity to engage in population health management through increased capacity in a number of core competency areas (organizational commitment, clinical management and care management program; NMDoH, health IT and data analytics, financial health and planning).

Clinic has strengthened its population management skills and awareness of its data assets to such a place that it can evaluate its ability to engage in networks or exchanges, and what resources are needed to do so.

Clinic roles and responsibilities that fit within their own clinical workflows and systems and reflect increased understanding and readiness for value based care.

Clinic and stakeholders have regular, fruitful communication about community capacity to address social needs.

Clinics advance to Level 2

Long Term Outcome
2-3 Years

Long-term outcomes refer to the desired results of the program, as well as policy changes and can take years to accomplish.

Level 2 Outputs:

Clinics use hotspotting/risk stratification to target interventions to population subgroups.

Clinics are implementing a closed-loop referral process for patients with unmet social needs.

Clinics are engaging in social-risk targeted care activities in support of chronic disease management (i.e. home remediation for asthma).

Clinics formalize partnerships with MCOs, payors, and hospitals to engage in APMs or other population health activities (i.e. ED diversion).

Clinics have a formal agreement in place to support bi-directional data sharing with partners, including payer data to support clinical and population health planning.

Key Assumptions

- Clinics have high adaptive capacity for changing their culture and organizational capabilities
- Clinics will commit to moving from Level 1 through Level 3 as part of this process
- Clinics across the cohort will not start at the same point of development

External Factors

- Policy directives from the State and Medicaid
- MCO/hospital appetite to engage and partner with clinics
- The uninsured rate in Texas
- Ongoing staff turnover, staffing challenges across health care
- TACHC support activities
- Progress on and availability of CIN
- Scale and availability of partners and stakeholders
- Data capacity (including availability of data and data sharing capability) of partners.
- TX legislation and trends

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Level 2 Logic Model

Resources/ Inputs

EHF Resources and Inputs:

Providing grants to fund clinics to enhance their population health management work as well as collaboration and planning efforts.

Providing or identifying technical assistance resources.

Conducting environmental scans or research on various payment and delivery models (ACOs, APMs, etc.).

Conducting environmental scans or research on clinic partnership opportunities.

Conducting in-depth research and evaluations focused on what works for whom and why.

Convene collaborators and stakeholders (i.e. payers, CBOs, government, etc.) to support population health efforts.

Plus Clinic Resources and Inputs from Level 1

Strategies

Clinics are using grant dollars to improve their population health management work.

Clinics maximize existing alternative payment programs.

Clinics are beginning to develop partnerships with key stakeholders (MCOs, hospitals, CBOs, IPAS).

Clinics quantify and articulate their ROI to partners (their value proposition).

Clinics identify key clinical outcomes to be improved upon.

Clinics expand care coordination and empanelment efforts.

Clinic leverages internal capacity (across administrative, clinical, and financial) to monitor alternative payment models and value based contracts on an ongoing basis.

Outputs
During grant period

Clinic uses hotspotting/risk stratification to target interventions to population subgroups.

Clinic is implementing a comprehensive, documented, closed-loop referral process for patients with unmet social needs (NMDoH).

Clinic is engaging in social-risk targeted care activities in support of chronic disease management (i.e. home remediation for asthma).

Clinic formalizes partnerships with MCOs, payors, and hospitals to engage in APMs or other population health activities (i.e. ED diversion).

Clinic has a formal agreement in place to support bi-directional data sharing with partners, including payer data to support clinical and population health planning.

Clinic is monitoring and improving documentation and coding of medical, behavioral, and social factors.

Short Term Outcomes
1-2 Years

Clinic care protocols are influenced by patient risk scores and social needs assessment findings (Clinical and Care Management program).

Patients can access additional services to address their unmet social needs (NMDoH).

Clinic and their respective partners are collaboratively using shared data to inform population health improvement efforts and improve services and outcomes (health IT and data).

Clinic draws down available P4P & APM funding and re-invests in infrastructure for population health, NMDoH, and value-based activities (financial health and planning).

Clinic organizational commitment is expanded through additional partnerships and strategies (i.e. hiring of additional staff, etc.) (organizational commitment to implementing population health strategy).

Clinics advance to Level 3

Long Term Outcome
2-3 Years

Clinic identifies and obtains non-philanthropic funding sources, to the extent available, to support population health management activities to participate in APMs, coordinate care, and/or address pop health/NMDoH.

Clinic patients' social needs are improved.

Clinic demonstrates improved health outcomes, as measured by clinic-selected measures.

In collaboration with partners, clinic can quantify both the impact of addressing and not addressing unmet patient NMDoH needs, at the population level.

Plus Outputs from Level 3

Key Assumptions

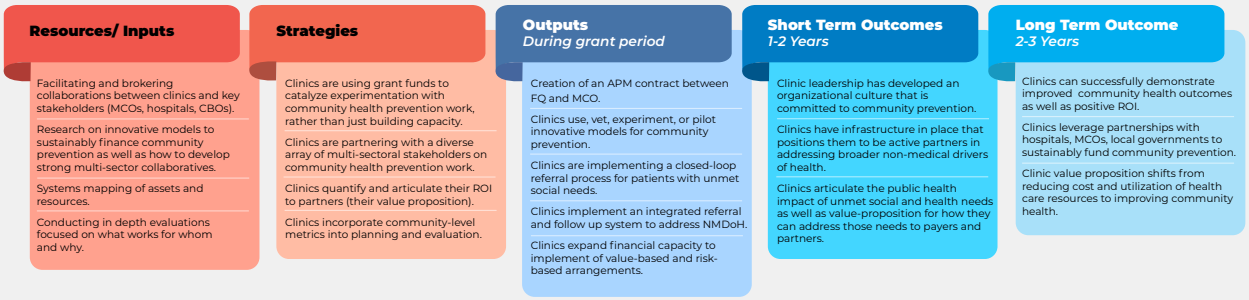
- Clinics have robust infrastructure in place for population health management
- Clinic business models reflect an attention to issues such as payer mix, patient population size, etc.

External Factors

- Policy directives from the State and Medicaid
- MCO/hospital appetite to engage and partner with clinics
- The uninsured rate in Texas
- Ongoing staff turnover, staffing challenges across health care
- TACHC support activities
- Progress on and availability of CIN
- Scale and availability of partners and stakeholders
- Data capacity (including availability of data and data sharing capability) of partners.
- TX legislation and trends

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Level 3 Logic Model



Key Assumptions

- Clinics have robust infrastructure in place for population health management
- Clinic business models reflect an attention to issues such as payer mix, patient population size, etc.

External Factors

- Policy directives from state Medicaid
- The uninsured rate in Texas
- MCO/Hospital appetite to engage/partner with clinics to do this work

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CPA Program Supports

The guiding supports of the CPA were:

1. Long-term, significant grantee funding over a period of five years
2. Training and Education for the grantee cohort
3. Targeted, Individualized Technical Assistance for individual grantees
4. Peer Learning opportunities to share best practices
5. Evaluation as a tool for progress as needed

Funding

EHF provided annual grants between $200,000 - $500,000 to each grantee. These funds were largely unrestricted, and grantees could choose where to allocate these dollars. EHF Program Officers worked closely with grantees to craft a project budget and workplan that accompanied each year's application and were flexible and responsive when changes needed to be made throughout the initiative.

Training and Technical Assistance

EHF supported the full grantee cohort with virtual and in person trainings throughout the CPA program. The training and TA curriculum, described in more detail in later toolkit sections, was developed each year in response to grantee requests, policy, economic and systemic changes, and evaluation findings as well as the desired competencies outlined in the CPA Logic Model. In addition to cohort wide virtual and in person trainings, EHF also provided individualized technical assistance to all grantees. Technical assistance (TA) included support developing CPA workplans, budgets and grant applications each year. As the evaluation base grew, more targeted TA was provided to grantees who experienced barriers and expressed need to EHF. In the final CPA program year, all grantees received transition planning support.

Evaluation

Program evaluation was a critical component of the CPA program. EHF's evaluation partner, JSI, designed and delivered a program evaluation that tracked CPA grantee progress, influenced foundation strategy, and provided a valuable learning tool for grantees themselves. The program evaluation component is a key tool in CPA implementation.

Foundation Funding and Support

The CPA program is the largest investment of EHF funding in the foundation's history. This program's design was influenced by previous initiatives, including Community Centered Health Homes and Texas Accountable Communities for Health, and sought to apply lessons learned to the CPA program.

EHF initiated the program based on need established in a payment reform feasibility study, used an interdisciplinary team to draft a program logic model, and involved grantees in the planning effort. EHF asked grantees to conduct a self-assessment to set a performance baseline as part of the evaluation. The foundation was clear with grantees that the CPA program would be a collaborative effort, and grantees would receive continuous support over a five-year period to succeed.

EHF originally planned to launch CPA as a five-year program starting in June 2020. It was immediately clear from February 2020 that this timeline would need to be adjusted in order to reflect the crisis of the COVID-19 pandemic. EHF pushed the CPA initiation by a year but continued to engage grantees in a planning cohort of virtual training and technical assistance in calendar year 2020.

With each CPA program year, EHF has remained flexible and consistent with grantees, adjusting workplans and budgets as needed. The CPA program has benefited from EHF Program Officers' familiarity and strong relationships with their grantees.

Training and Technical Assistance By Year

EHF's CPA program partner Starling Advisors served as the project management lead for training and technical assistance. In collaboration with evaluation partner JSI, Starling Advisors developed each CPA program year's training and TA plan and, in many cases, developed and delivered portions of the content as well. Below is a year-by-year outline of CPA Training and Technical Assistance. In every program year, Starling worked closely with grantees to develop their project work plans and budgets, and to periodically monitor progress and address barriers to progress throughout the year.

Starling Advisors is a consulting firm specializing in community health centers, value-based payment models. For the past 15 years, Starling has worked with health centers across the country to develop new models of sustainable, innovative and community focused care.

JSI is a health care research and consulting organization committed to improving the health of individuals and communities. JSI maintains a vast portfolio of projects focused on health policy, program evaluation, operations, performance measurement, quality management, and capacity building. JSI is nationally recognized for community and public health expertise. Much of JSI's work focuses on populations insured by Medicaid, Medicaid payers and providers, and stakeholders influencing or administrating Medicaid programs.

JSI has evaluated multiple programs funded by EHF and its partners, including the evaluation of My Texas My Health's early implementation. JSI and Starling Advisors have a longstanding history of collaboration on VBP initiatives.

PLANNING PHASE June 2020–May 2021

Training and TA in this planning phase were delivered entirely virtually due to the COVID-19 pandemic. Grantees participated in two learning cohorts, the first focused on project management and the second focused on change management. Project management and change management are foundational organizational competencies necessary to implement and sustain large scale projects like population health management and value-based payment transformation.

The cohorts received virtual training via webinar, guidance on converting their CPA applications into a concrete strategic plan, best practices around selecting project leaders, and support as they navigated the challenges of being a primary care provider responding to a public health emergency.

YEAR 1 June 2020–May 2021

In the first official year of the CPA Program, TA was initially delivered virtually. Grantees received six webinars, each addressing core competencies in the CPA Logic Model Level 1. The sessions addressed population health management, risk stratification, social determinants of health and health equity, engaging community providers, analyzing patient risk data, and experiences rapidly pivoting to telemedicine as a result of the COVID-19 pandemic.

Based on initial evaluation data, grantees expressed a need to educate their Board of Directors about the importance of value-based care and its relationship to their core mission. EHF provided asynchronous learning sessions targeted towards Community Health Center Board leaders. EHF provided asynchronous learning sessions targeted towards Community Health Center Board leaders.

The program year ended with its first in person learning collaborative convening. The one-day session provided foundation and evaluation updates, and featured health center leaders sharing their progress to date and their plans for CPA program year 2. The session also brought in a payer perspective, including a speaker from the Texas Association of Community Health Plans, whose member plans have a large presence in Texas Medicaid and also participate in other coverage programs.

YEAR 2 June 2022–May 2023

The second program year provided virtual peer learning, direct grantee technical assistance, and in person Learning Collaboratives. Starling placed the grantees into three virtual peer groups organized by project focus and grantee payer mix and infrastructure. The group's topics were Payer Strategy/Engagement, Risk Stratification, and Community-based Partnerships. The peer groups met every other month, and Starling facilitated informal discussions of successes and challenges as well as best practices. Starling also provided individual support to grantees to maintain the project management and change management practices they'd developed in the planning stage.

In this second program year, the TA shifted to focus more concretely on payer data and the principles of value-based payment Grantees were ready for this shift because of the foundational skills they had developed in the first program year. Starling conducted a payer mix assessment for every grantee which educated grantees about their own payer mix and contracting complexity and also helped inform the foundation of what level of value-based contracting each grantee had attained.

EHF held two in person CPA Learning Collaborative Convenings in Program Year 2. The first took place in September 2022, featuring policy and evaluation updates, and highlighting the importance of scale and collective leverage in contracting negotiations. The session featured health center peer speakers from neighboring Louisiana and Oklahoma sharing their experiences establishing a health center owned clinically integrated network, or CIN. Clinically Integrated Networks are formal, legal alliances of healthcare providers–that can include hospitals, employed physicians, and independent practitioners–who collaborate to improve care quality and reduce costs. By implementing shared clinical protocols, data systems, and performance benchmarks, they manage population health and legally negotiate contracts with payers. Individual health centers on their own don't serve a large enough number of patients to effectively negotiate with healthcare payers and often can also provide better clinical programming when working together in a CIN arrangement. The Louisiana and Oklahoma health center leaders shared their experience using collective power to succeed in value-based payment arrangements together.

The final Year 2 Learning Collaborative took place in May 2023, and featured grantee speakers sharing their work on payer engagement and community-based partner engagement. The session also introduced grantees to the Texas Association of Community Health Center (TACHC) leaders who were successfully developing their own Texas based health center owned clinically integrated network.

YEAR 3 June 2023–May 2024

In CPA Program Year 3, technical assistance was more targeted to individual grantees who were having difficulty making progress.

Notably, in year 3 the CPA program shifted to include health care payers into the conversation. This shift reflected the reality that health centers must engage with payers to sustain their CPA work long-term and that the newly formed TACHC clinically integrated network, My Texas My Health, offered a pathway to do so. EHF held a joint Managed Care Organization (MCO) and Community Health Center learning session in August 2023. The session featured speakers from health centers, from Medicaid health plans and from My Texas My Health.

YEAR 4 June 2024–May 2025

In CPA Program Year 4, training focused on more advanced competencies of value-based payment readiness, such as more accurate coding, intensive case management, and building financial reserves to hold contracts with downside financial risk. EHF hosted a virtual education series on medical coding and the role coding plays in value-based care. The foundation also held a single in person learning convening in September 2024 featuring speakers from My Texas My Health, evaluation and policy updates, and introduced the need for grantee transition planning as the foundation and grantees entered the final CPA Program Year.

YEAR 5 June 2025–May 2026 (IN PROGRESS)

The foundation convened grantees in Fall 2025 to discuss transition planning for the end of the official CPA program. My Texas My Health will be a key partner to health centers in continuing their work in this area.

Infrastructure & Systems Level Support

From the very beginning of CPA program planning, EHF understood larger environmental and policy trends would impact health center grantee progress. There is a ceiling on how far an individual health center can advance in value-based payment models, as these models require thousands of covered patient lives to be meaningful for health care payers. Additionally, health care payers are regulated by and most responsive to the state Medicaid agency which sets the terms of the MCO contracts.

EHF made key decisions throughout the CPA program to respond to these systemic realities. First, EHF worked hard to establish a strong working relationship with the Texas Association of Community Health Centers. This relationship has flourished, to the point where EHF was able to fund TACHC to assist in the formation of its own health-centered governed clinically integrated network (CIN). This is a key achievement, reflecting skillful leadership and member engagement by TACHC, and strategic commitment to the safety net by EHF. TACHC's CIN now operates as My Texas My Health (MTMH) and holds value-based payment contracts with Medicare through the Medicare Shared Savings Program and with multiple Medicaid Managed Care Plans. MTMH offers a pathway to sustain the work and support of the CPA program on the statewide level for the long term.

The other key decision EHF made was the incorporation of payers. EHF has facilitated a Managed Care Learning Collaborative for several years, and the foundation connected these health plan attendees with the CPA grantees in 2023. EHF also made available the policy experts who lead content development for the MCO Collaborative to both individual CPA grantees and to My Texas My Health. Lastly, the foundation includes the policy experts in on-going CPA program planning so CPA programming can adapt to changes in state policy and payer focus.

Appendix C (Supplemental Information on Policy Landscape) includes more information about how MTMH advances its participating centers' value-base care efforts as well as about the policy and payer landscape in which they undertake this work.

Evaluation Themes

Maturing Population Health Integration

Clinics have moved from foundational planning to actively integrating population health strategies into daily operations and clinical workflows. This includes utilizing data (CQMs, care gaps), engaging community health workers (CHWs), and improving internal communication for better alignment with population health goals. This progress further supports care management, moving it from decisions made by individual providers to resource allocation based on risk scoring and other modeling.

Advancements in Health IT and Data Utilization

Many sites initially underestimated the need for investment in data and concurrent workflows. Over time, health centers have significantly improved their data and technological infrastructure, optimizing EHRs, using various tools to track data, identify care gaps and support population health. There are an increased accessibility and utilization of data for quality improvement and patient care, including the use of dashboards and EHR data integration-- all of which has proved essential to their ability to make progress. The variability in data requirements for health plans remains a challenge.

Expansion and Specialization of Team

Clinics have expanded their care teams by broadening the scope of existing roles and implementing new positions (e.g., behavioral health, social workers, population health directors) to support comprehensive population health efforts. This reflects a commitment to scaling initiatives and providing more holistic care. There has also been increasing demand for other roles-- data analysts, report writers, and others who can maintain the access and utility of information from health IT systems and payers. One major facilitator was the presence of champions within clinics to advocate for and implement necessary investments.

Shifting Focus from Foundational Establishment to Optimization and Sustainability

Over the initial four years, clinics transitioned from initial efforts in establishing basic infrastructure and understanding VBC fundamentals to optimizing existing systems, enhancing internal communication, and prioritizing program and staff sustainability within population health and value-based care. Optimization includes focus on revenue capture, risk stratification, and measuring the impact of integrated initiatives.

Enhanced NMDOH Screening and Community Engagement

There's a clear progression in operationalizing NMDOH, with more widespread screening, improved tracking of referral data, and stronger efforts to develop relationships with Community-Based Organizations (CBOs) for patient resource connection. It is less clear from the evaluation whether these changes have increased individual clinics' readiness for value-based contracts.

Developing Relationships with MCOs

Clinics have shifted in their relationships with MCOs. Initially, clinics had a low understanding of VBP models and were more likely to accept MCO assessments of data. CPA participation has empowered population health staff at the health centers to feel more comfortable engaging in conversations with MCOs and setting expectations that may be more achievable on behalf of the site. Participation in the CIN has been key for bargaining power, Azara access, and peer support. Nevertheless, as CPA concludes, clinics continue to face challenges in obtaining reliable and timely data from payers and difficulty getting promised reimbursement.

Appendix C (Supplemental Information on Policy Landscape) contains more information about how to build and maintain effective relationships with health plans and engage with them to explore VBP opportunities.

Tiered Approach to Grantee Progress:

Grantees with Solid Progress

CLINIC A

Clinic A has demonstrated solid progress, particularly in its clinical and care management efforts. The organization successfully implemented a VBC Boot Camp for physicians to improve their knowledge and buy-in for value-based care. They have a robust care management team that has grown to 12 members and has been integrated into care teams across most of their sites. They have also successfully begun billing for Chronic Care Management (CCM) and Care Plan Oversight (CPW) and have shown improved provider engagement in VBC. The health center has also hired a Health Policy Analyst to manage relationships with managed care organizations (MCOs) and perform pro formas. A key accomplishment is their move to a new, state-of-the-art facility that includes a “Community Marketplace” for Community-Based Organizations (CBOs), fostering stronger partnerships.

CLINIC B

Clinic B has also made significant, quantifiable progress, even considering that they started out relatively advanced. They have added four new VBC contracts and are actively working to increase the percentage of their budget from VBCs from 3.5%. They’ve focused on refining their data and creating provider scorecards at both the panel and individual levels. The organization is in the process of transitioning to the new EHR, and despite the challenges, they’ve seen improved provider satisfaction with the new system. They have also integrated Community Health Workers (CHWs) into their care teams and are emphasizing patient engagement. The EHF funding has allowed the organization to try and narrow in on the most successful support staffing and resources for their ongoing population health work.

Grantees with Reasonable Progress

CLINIC C

Clinic C has made important, yet often hard-to-quantify, progress in laying the groundwork for future success. The organization has reconfigured its CHW team to support MyChart, which has led to increased patient enrollment and usage of the portal. This growth in the role and visibility of CHWs is hard to quantify in the CPA domains but is supportive of overall progress. They have also re-evaluated and deployed a new tool for social risk scoring and have a high percentage of closed-loop referrals for social risks. Clinic C has moved from a state of ambivalence to an organizational commitment to VBC participation, which is a critical internal shift. The organization is reconfiguring its Epic EHR to include population health and HEDIS modules to track quality and outcomes and is building the infrastructure to manage payer data.

CLINIC D

Clinic D is focused on laying the groundwork for its future population health work, which is heavily tied to its new EHR implementation. Many of their workflows and processes are waiting for the new EHR to be fully operationalized. They have a dedicated team member working on a project to formalize empanelment, which is currently a manual process. The organization is also in the process of improving its call center and communication between its billing and clinical outcomes managers. They have community partners, but providers are hesitant to ask patients about social needs due to an inability to address or refer them out. This illustrates the critical need to build foundational NMDOH processes before expanding efforts.

CLINIC E

Clinic E is notable for its response to non-medical determinants of health, and the way it leveraged the flexibility of CPA funding to try out different approaches. The clinic adopted an early focus on social needs, developing its own in-house platform for closing social needs referrals. Although interoperability was sometimes a challenge, they cultivated robust community partnerships, with onsite kiosks and virtual links to reach a high volume of individuals. Over time, they saw a need to supplement the technology with personal navigation and made plans for AmeriCorps volunteers to provide personal navigation. Although federal funding cuts disrupted this approach, Clinic D gained valuable expertise that it will carry into the future. Critically, CPA participation provided Clinic D with the space to rethink its strategy, shifting from a non-profit mindset to greater fiscal mindedness. For example, its strategy now includes engagement with the local governing agency to make a case for funding at the county level.

Grantees Still Building Foundational Skills

CLINIC F

Clinic F is still in the early stages of formalizing many processes, which is an essential first step before scaling. The organization recently rebranded and is pursuing PCMH accreditation (receiving it in the fourth year of this initiative). They are actively working to create a streamlined process for NMDOH screening, which will populate in their Phreesia system and be referred to a care team member. They have also established a coalition of staff called "The Delta Force" to discuss goals and initiatives. However, the organization is facing significant challenges, including the turnover of its entire billing and finance department, lack of authority and autonomy to move work forward, reliance on vendors and external parties for support and education, and a perception from leadership that they will eventually be pushed to switch from their current EHR (Athena) to Epic. This highlights the need for foundational financial and IT stability to support future population health work and VBC readiness.

CLINIC G

Clinic G has focused on internal foundational improvements that are crucial but not always visible externally. They have, really beginning in the fourth year of the initiative, made significant strides in improving communication workflows between departments and clarifying roles, which has led to better organizational alignment. They hired a Chief Integration Officer to help with the workload of the Chief Clinical Officer and have brought their IT services back in-house, allowing for closer collaboration. Clinic G has also successfully implemented a strong process for NMDOH screenings that has gained buy-in from providers and staff. They have added new positions, including nurses, a medical social worker, and an analyst, which has helped improve staffing stability and clinical measures.

Case Studies and Testimonials:

At the final CPA Grantee Learning Session in fall 2025, each grantee organization reflected on their accomplishments and key lessons learned throughout the course of the five year program. These grantee reflections and case studies were captured in a roadmap, shared below.

AccessHealth CPA Journey

Health Navigation Platform



Where We started

My Health Sphere (HNP) launched as a digital platform to close a persistent gap in healthcare: the unmet social needs that drive health outcomes. Our goal was clear; transition from fragmented, paper-based referrals to a real-time, coordinated system that connects patients to trusted community resources when needs fall outside clinical care. This shift enables us to deliver on the promise of whole-person, value-based care.

Our CPA Team

- Palak Jalan-CEO
- Jordan Neal- Director of Population Health
- Ismelda Serrano-Health Navigation Coordinator
- Julie Davidson– AmeriCorps Health Navigation Manager



YEAR 1

Lessons Learned

- Successful adoption hinges on clinical integration; screening must be seamless for providers and relevant to care.
- Data systems don't naturally talk; bridging electronic health records and referral platforms require investment in interoperability.



Biggest Wins



- Self-engagement from patients has replaced passive referrals; we now verify impact, not assume it.
- Assessments, flyers, and follow-ups reminders are automated.
- Smart triage: The system prioritizes by need, escalating complex cases to care coordination.
- Low lift for partners: Partners set referral limits to avoid overload.
- We've built a scalable, digital referral model that strengthens partnerships, supports compliance, and improves patient outcomes- all without increasing administrative burden.

MY HEALTH SPHERE

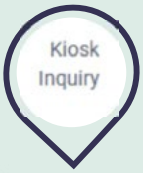
Looking Ahead

- Scale standardized screenings tied to managed care organization incentive models.
- Advocate for reimbursement frameworks that reflect the true value of non-clinical interventions.
- Extend care coordination beyond physical infrastructure, enabling virtual and bilateral partnerships.
- Leverage the platform for measurable gains in prevention, coordination, and long-term outcomes, shifting from reactive care to proactive health.
- Continue advancing value-based care models that address patients' non-medical factors of health.

Best Investment

- Digitize manual processes and build closed-loop referral infrastructure
- Apply risk stratification to focus staff effort where it matters most
- Advance a high-ROI, team-based model of care that is measurable, efficient, and aligned with payer expectations





YEAR 5

Our Highlights

Year 1	Year 2	Year 3	Year 4	Year 5
Digital Infrastructure	Pilot launch/ Kiosk Rollout	Remote Partner Integration	Smart Link Activation	Bilateral Referrals

Our CPA Journey



Where we started

- No organizational awareness of VBC
- No IT infrastructure for VBC (e.g., SlicerDicer in Epic)
- Baseline 5% AWV completion rate
- Minimal engagement with contracts/payors

Our CPA Team

- Y1 – informatics only
- Y2 – CCO + CCM lead
- Y3 – CCO + Population Health Director + Director of Care Management

YEAR 1

Lessons learned

- Be more aggressive in data management/submission
- Invest more resources into the IT lift needed; keep IT "at the table"
- Understand our negotiating power with payors





Biggest Wins



- Expanded team-based care through Care Management (13 CMs)
- Made significant organizational changes
- Built financially sustainable model for VBC in an FQHC
- 800% increase in AWVs
- Avg $1M/year in VBC payments

WACO FAMILY MEDICINE

Best Investments

- SlicerDicer for data analysis
- VBC Boot Camp training for all clinicians
- Directors of Pop Health and Care Management
- Care Management department





Looking Ahead

- Continue all current initiatives
- Operationalize Epic's Compass Rose for Care Management and Specialty Pharmacy
- Expand CM as able
- Begin CPW work with CM
- Consider contracts through the CIN

YEAR 5

Our Highlights

Year 1	Year 2	Year 3	Year 4	Year 5
Epic	Care Managers	WFM BOOT CAMP VBC	*More* Care Managers	Epic Compass Rose

HOPE CLINIC
a community health center

HOPE Clinic's CPA Journey



Where We Started

HOPE Clinic's initial goals were to keep patients out of ER & to receive incentives from payers (then, added Altus ACE) via value-based care (VBC) contracts.

Our CPA Team

- CPA Leaders: Dr. Andrea Caracostis-CEO, Shane Chen-COO, Penny Yang-CFO, Justin King-CIO, Dr. Fatimah Lalani-CMO: Oversees transition to VBC model on high levels.
- Leon Jerrels (Director of Clinical Services & QI): Oversees & improves clinical policies & procedures
- Penny Vongsaphay (HEDIS Coordinator): Works closely with payers to improve HEDIS measures in care services serving our patient population.
- Chau Le (Project Manager): Ensures timely completion of projects & deliverables related to VBC model.

YEAR 1

Lessons Learned

- "Power in numbers" – Collaboration & partnership is the key to success.
- Focus on standardizing workflows, procedures, and policies while implementing innovative initiatives, instead of doing it after the implementation.
- Involve providers in VBC initiatives more.





Biggest Wins



- Interface with HCCN to be more data-driven & tech-savvy.
- CIN (Clinically Integrated Network) is created by TACHC & Dr. Andrea Caracostis's initiatives that acts as an aggregator benefiting non-profit organizations.
- Joined CIN & TACHC ACO (Accountable Care Organization).



Best Investment

Funding for electronic platforms: Azara & Phreesia.

- Azara: Azara has expanded our capacity to conduct ER & Hospital Admission follow-ups daily, in conjucnction with CareMessage. In 2025, we pioneered Payer Integration Module (Centene & UHC) and are testing with Wellpoint.
- Phreesia: All 5 sites went digital for registration & checkin in 2023. In Aug 2025, 76.6% visits completed electronic registration, in which 61.1% completed it before arriving to their appointment.





Looking Ahead

- Focus on sustainability in generating revenues via VBC contracts and increasing provider productivity (automatic productivity reports generated by Azara, detailed reports sent out regularly by HIT Analyst, Provider Scorecards).
- eCW Optimization to improve EMR efficiency.
- Develop formal quality and processes to improve procedures and policies that are standardized across all clinics.

YEAR 5

Year 1

- 3-year strategic planning developed (2021-2023).
- Implemented Babyscript.

Year 2

- eCW Admin promoted.
- Data Analyst hired.
- Learning, training, & implementing the Pathways.

Year 3

- CPA Project Manager & HEDIS Coordinator hired.
- Implemented multiple projects aiding VBC initiatives- Phreesia, CareMessage, Azara, CoveredMeds, Unite Us.

Year 4

- Multiple HRSA Awardee Badges obtained.

Year 5

- Implemented Delfina, Azara Payer Integration Module.
- Utilize Clinical Rules Engine within eCW to auto-populate codes using structured data.

Our CPA Journey

Our CPA goals are to improve population health management and participation in alternative payment models by expanding our capacity for care coordination, strengthening APM contracting relationships, and leveraging health information technology to improve patient outcomes.



Where we started

Build population health team, begin participating in APM/VBC contracts, evaluate HIT systems

YEAR 1

Our CPA Team

Population Health, Analytics, Quality, Clinical Services, Revenue Cycle, Community Health and Advocacy, and Leadership



Lessons learned

Establish analytics team and switch to Epic OCHIN sooner, establish program evaluation methods earlier





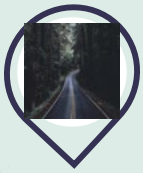
Biggest Wins

Established population health team and care coordination programs, implemented new Epic OCHIN EMR and analytic infrastructure to support operations and performance analysis, increased participation in APM models

PEOPLE'S COMMUNITY CLINIC

Looking Ahead

Expand participation and performance in APM/VBC contracts by enhancing performance reporting, broadening population health strategies, and strengthening whole-person care approaches such as integrating NMDOH workflows



Best Investment

Building our teams, including roles, responsibilities, and scope; implementing our new Epic OCHIN EMR



YEAR 5

Our Highlights

Year 1	Year 2	Year 3	Year 4	Year 5
Built pop health team and set strategy	Initial participation in APMs	Expanded Care Coordination program	Migration from NextGen to Epic OCHIN EMR	Pop health mgmt., NMDOH strategies, and APM participation

El Centro de Corazón
Quality Health Care

Our CPA Journey



Year 1

- El Centro makes population health scalable to its needs and budget





Year 5

- Increase funding and staffing to recruit skilled, dedicated Population Health and Quality professionals
- Guiding Coalition for VBC Excellence
- Expanding CHW and LCSW roles both inside and outside clinical settings

Where We Started

- SDOH food insecurity screening and SUDs
- Board of Directors not fully aware of VBC contracting and Population Health
- Extremely limited staff

Best Investment



- Upskill staffing
- IT Investments, such as Compass Rose, Imprivata, and Azara

Highlights



- TACHC Quality Axis Program
- HRSA Badges
- American Heart Association
- CHW Research Work

Looking Ahead



- Opportunities for additional incentives
- More confident and willing to pursue VBC contracts
- NCQA PCMH with distinction in Behavioral Health

Vibrance Health CPA Journey

Where we started

We recognized the importance of value-based and patient-centered care for our community and aligned with fellow FQHCs through the CIN. Even before formal contracts were in place, we focused on preparing for this transition by building a strong foundation and setting clear priorities. From the start, our goal was to expand population health efforts and lead meaningful change for our patients and community.



Our CPA Team

Our work began 2020 with support from Starling Advisors, who helped us design a roadmap to guide our transition to value-based care. To lead this effort, we created the Organizational Impact (OIM) Team, which later evolved into two groups: The Project Support Team and the Population Health Team. The Population Health Team is growing with new staff and leadership, focused on expanding population health efforts and advancing value-based care.

YEAR 1

Lessons learned

If we were staring now, we would pace ourselves and recognize that moving towards value-based care is a long-term journey. Early on, we expected the process to move faster, but one of the biggest challenges was helping staff shift their mindset and buy into this new approach. With more intentional communication and engagement from the start, we could have built readiness more smoothly.





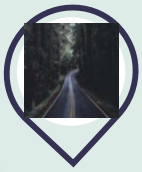
Biggest Wins



Our biggest wins include building a dedicated Population Health Team, acquiring provider incentive contracts with multiple MCOs, and improving quality measures that support incentive payments. We also transitioned to a new project management platform, developing strategy, workflows, and staff training to ensure success. In addition, four of our clinics achieved PCMH transformation, further strengthening patients-centered care and quality improvement. Together, these accomplishments have strengthened our foundation and framework for advancing value-based care.

VIBRANCE HEALTH

Looking Ahead



As the CPA program ends, we are carrying forward the systems and partnerships built through this investment. We will continue advancing value-based care through our VBC contracts with the CIN & ACO and sustaining our Provider Incentive Programs with payors. We remain committed to adapting, innovating, and leading as health care continues to evolve.

Best Investment

The best investment has been in our people and the tools that set us up for success. CPA support allowed us to dedicate staff time, provide training, and equip our teams with resources like Azara, which strengthen our ability to track data, improve quality, and advance value-based care and population health.



YEAR 5

Our Highlights

Year 1

- Started planning with Starling
- OIM Team formed
- Created internal phone tree

Year 2

- Roadmap completed
- OIM transitioned to Project support
- Population Health Team created

Year 3

- Launched Inventory Management System
- Hired dedicated staff to oversee operations

Year 4

- Implemented new project mgmt. platform
- Staff trained on workflows and tracking tools
- Began first CIN/ACO contract

Year 5

- Continued CIN/ACO contracts
- Four clinics achieved PCMH Transformation
- Improved quality measures and incentive payments

Lone ★ Star
Circle of Care

Clinics Pathways Approach (CPA) Journey

Where We Started

We began with a high-performing clinical system that had maximized most pay-for-performance opportunities. However, fragmented interventions, siloed efforts, and limited resources posed challenges to further advancing our value-based care performance.



Our CPA Team

Led by Lindsey Tippit, COO, our CPA Team brought together a cross-functional group with deep expertise in clinical operations, population health, and data analytics—driving strategic alignment and operational effectiveness.

YEAR 1

Lesson Learned

Success in value-based care requires harmonizing centralized population health strategies with real-time, point-of-care workflows. Integration—not isolation—is key.







Biggest Wins

We evolved into a mature, data-driven clinical system focused on delivering high-value care with limited resources. Through continuous refinement of operations, care pathways, and targeted interventions, we built a resilient and responsive infrastructure.

Best Investment

CPA funding strengthened our data and analytics capabilities, enhancing efficiency and insight. It also enabled us to staff and validate new roles within the extended care team—unlocking performance gains and laying the groundwork for more advanced APM models.





Looking Ahead

We're committed to sustaining the processes and interventions we've built, while strategically expanding our APM portfolio to deepen impact and drive long-term transformation.

YEAR 5

Year 1	Year 2	Year 3	Year 4	Year 5
Process ReDesign initiated; PMO established	Clinical Pathways and Empanelization implemented	Case Management implemented; SDoH/NMDoH efforts expanded	Preparation for, and transition to, athenaOne and athenaOne Dental	athenaOne workflow improvement; APM expansion

Our CPA Journey

SHR CPA has advanced its care delivery model by identifying high-risk patients and implementing care management strategies to improve outcomes. The organization has also embraced value-based care partnerships, which are beginning to show positive financial returns.



Where we started

Engage a consultant to initiate risk stratification and build partnerships with healthcare payers..

SPECIAL HEALTH RESOURCES
A FAMILY OF HEALTHCARE CENTERS

YEAR 1

Lessons learned

In hindsight, we could have more effectively leveraged the technical assistance available from JSI. Additionally, visiting other FQHCs would have offered valuable insights into best practices for fully optimizing our participation in the VBC program.





Our CPA Team

The CPA team began with a small care coordination group and has expanded to include nursing leadership and a broader clinical staff.
Tammi Smith, RN, DON
Alice Luna, RN, Asst. DON
Shawna Murphy, LPN, Pop. Health Manager
Dina Jenkins, LPN
Shikita Bailey RN
Aiesha Murphy, CMA



Biggest Wins

One of our most significant achievements has been receiving reimbursement for the work conducted through VBC efforts. This has empowered our care coordinators to develop and implement more effective care plans, resulting in enhanced support for our patients.

Best Investment

CPA funding made this work possible by providing the financial resources needed to build a dedicated team. The ability to support additional staffing was the key factor in successfully launching and sustaining the project.





Looking Ahead

SHR will continue its participation in the value-based care program and aims to secure additional MCO contracts through the TACHC CIN initiative.

YEAR 5

Our Highlights

Year 1	Year 2	Year 3	Year 4	Year 5
				

Lone Star Family Health Center's CPA Journey

Our journey began as an attempt to move our organization into a population health focused world of value-based healthcare. We started with a 20-year-old EMR, an unconnected EDR, and a skeleton crew of determined leaders.

Where we started

We sketched out our initial proposal by creating a matrix that aligned our strategic plan to EHF's framework and strategic priorities. Knowing the project would go on for several years, we mapped out a 3-year proposal for how we envisioned our Center's evolution. We knew we had a lot of work to do to understand how we were contracted with payors, what our patients' experience was with our health center, how we could leverage technology more efficiently, and making sure we had the right expertise on our team.



Team Evolution

Ensuring we had the right expertise at-hand was of utmost importance. We had turnover in key positions such as CFO during this period, but we also lacked critical talent in health informatics and reporting. We built those positions into our project plan.

YEAR 1

Lessons learned

Given what we know now, we would have…

- Stopped investing so much time and money in our former EHR and immediately begin the process of procuring a new EHR.
- Worked more intensively on building provider relationships at the outset.
- Created a payor contracting liaison position in year 1 or 2.
- Signed onto the TACHC ACO immediately instead of waiting a year.





Biggest Wins

- Enhanced clinical workflows and reporting capabilities through an EHR transition, while putting in place a knowledgeable and dedicated team
- Nurtured relationships with our providers and now work more collaboratively and effectively as a cohesive team
- Formalized care teams by pod and satellite locations through empanelment procedures to move our continuity of care measure from 30% to over 60%
- Joined TACHC CIN and ACO
- Conroe building expansion, which enhanced patient wayfinding



Our CPA Team

Team Lead

Heidi W. Bunyan, MPH, MHA is our team leader. With over 20 years experience in healthcare, and almost10 years as a COO, she has worked in clinical and non-clinical areas in both inpatient and outpatient settings.

Core Team

Karen Harwell, MS, CPA, CEO
Lata Joshi, MD, CMO
Matthew Gullick, MS, CFO
Daniel Porter, MD, Medical Director
Anne Miles, MS, MBA, OTR, Director of Health Informatics
Logan Giutta, MBA, RN, Director of Clinical Operations
Kerri Ward, MSN, RN, Clinical Outcomes Manager

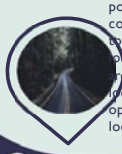
Best Investment

Our work would have not been possible in this timeframe without the CPA funding. The ability to have funders that understand the constraints the organization must work within is invaluable. Additionally, having the support of our colleagues throughout the state was a huge bonus. During the time of the CPA we expanded our Willis and Conroe locations. The CPA funding allowed us to free up other sources of capital to fund those projects. We think the best investments we made with the funding were the Director of Health Informatics position and the transition to new EHR.



Looking Ahead

Given our residency program, empanelment still remains a focus. We continue to analyze and renegotiate payor contracts, work with the TACHC CIN, and refine our population health approach. We also continue to look for additional ways to grow our revenue through [illegible] ration and service expansion. We are slated to open a new Magnolia location in 2026 and intend to add optometry services to our main location within the next 6 months.



YEAR 5

LONE STAR FAMILY HEALTH CENTER

Year 1 Year 2 Year 3 Year 4 Year 5



MyCHN JOURNEY

We dedicated substantial effort to designing and implementing advanced technology solutions integrated directly into our clinical workflows and Electronic Medical Record (EMR) systems. This strategic investment has established a robust infrastructure for capturing, standardizing, and utilizing clinical and operational data—enabling us to drive key Value-Based Care initiatives, enhance population health management, and support data-driven decision-making across the organization.



Where we started

Patient Empanelment
Care Gap Dashboard
SDOH Manager
Patient Facing Digital Forms

YEAR 1

Our CPA Team

Team Leader: Melialoha Bartlett, VBC Manager (Health Systems VP)
Team: CEO, CMO, CAO, Quality, SDOH

Collaborative Effort for Organization Change



Lessons learned

Invest additional time vetting Developers
Dedicated Project Management
Dedicated Stakeholders





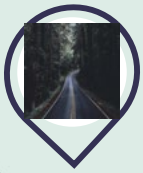


Biggest Wins

SDOH Standalone Community Facing Platform
Integration of SDOH Platform into EMR
Quality Accountability: Patient Panels
Referral Tracking System

Looking Ahead

MyCHN will invest in strategic initiatives that support our transition to Value-Based Care, allowing us to pilot new care delivery models, optimize patient outcomes, and align incentives around quality and value rather than volume.



Best Investment

CPA funding enabled us to explore, develop, and evaluate innovative solutions beyond the constraints of traditional fee-for-service models.



YEAR 5

Our Highlights

Year 1	Year 2	Year 3	Year 4	Year 5
Care Gap Dashboard	*Integrate Dashboard into EMR*	*Standalone SDOH Platform*	*Medicaid CPW*	*Improve Quality NLP Close Gaps*

Our CPA Journey

COMMUNITYCARE™ HEALTH CENTERS

CommUnityCare launched a patient portal in 2021 designed not only to enhance access to care but also to serve as a dynamic tool for healthcare navigation and SDOH support.

Where We Started

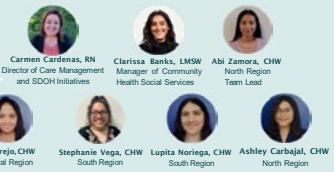
Our Population Health Management journey began in 2017 with screening for social drivers of health. In 2018, we welcomed our first CHWs to support patients beyond clinical care. By 2021, we launched a new electronic health record and patient portal, followed by the MyChart CHW Program. Implementation focused on five key areas—Team, Training, Marketing, Enrollment Interventions, and Workflows—with a goal of 40% portal enrollment organization-wide.

YEAR 1

Lessons Learned

- Do not underestimate your patients' ability to use technology
- Marketing and awareness of portal features are critical
- Portal features are designed to eliminate system barriers and enhance patient engagement
- Proxy access is a complex process, especially at pediatric sites
- Prepare scalable support mechanisms to promptly manage high volumes of patient portal requests or risk eroding patient confidence in the platform

Our CPA Team



Biggest Wins



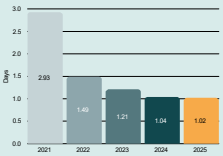
58%

MyChart Active Patients

CHW Account Activations

2021 Aug - Dec	2,448
2022	9,466
2023	8,827
2024	15,321
2025 Jan - Sept	15,852

- CHWs are responsible for **58%** of portal activations
- **89,272** MyChart Active Patients
- CHWs Enrolled **51,914** Accounts (including proxy accounts)



Average Message Handling Time:
Our clinical team has steadily reduced average message handling time year over year by streamlining workflows and enhancing operational efficiency

Best Investment

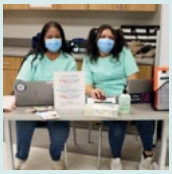
The CPA investment empowered us to dedicate team members as subject matter experts, allowing frontline staff to focus on adopting the new electronic health record while portal best practices were developed, documented, and shared organization-wide to sustain engagement.

Looking Ahead

- We aim to increase appointment scheduling through MyChart beyond the current baseline
- Supporting organization-wide implementation of eCheck-in by educating patients on the check-in process
- Support the MyChart Optimization Workgroup by applying expertise gained through the CPA grant initiative
- We will document and scale best practices for enrollments, proxies, and portal support across the organization to sustain engagement and advance meaningful use of the patient portal

YEAR 5

Our Highlights



On-Site Support:
Our MyChart CHWs table across our sites to assist patients with account activation, troubleshooting, and personalized guidance—making the patient portal more accessible and easier to navigate



Empowering Our Partners:
Helping CBOs navigate our portal to better support their clients with account activation and issue resolution



Enhancing Proxy Access:
CHWs have played a key role in shaping and refining proxy workflows, while also educating families and caregivers on how to access and manage their loved ones' health information



Advancing Pharmacy Engagement:
In collaboration with pharmacy and clinical teams, our CHWs promoted Willow Pharmacy features—guiding patients through prescription reviews, refill requests, and medication management



Cultivating Future CHWs:
Our CHWs are mentoring and inspiring the next generation—laying the foundation for a strong, community-driven health workforce



Expanding Access in Our Communities:
Our team actively participates in community events to connect individuals with financial eligibility support, primary care appointments, and MyChart access—ensuring everyone has the tools they need to manage their health

Monitoring and Assessment

The evaluation and assessment of the EHF Clinical Pathways Approach (CPA) initiative is a multi-year process that utilizes a mixed-methods approach. The evaluation was conducted by the JSI team and was designed to understand the participating clinics' capacities, strengths, needs, and progress across five domains: population health strategy, clinical care management, financial position for alternative payment models (APM)/value-based care (VBC), operationalizing non-medical drivers of health (NMDOH), and health IT and data infrastructure. Each year of the initiative, the evaluation included regular surveys and data review for quantitative evaluation purposes, and once a year key informant interviews, held in the fall, and site visits, held in the spring, for qualitative assessment.

Quantitative Evaluation

The quantitative portion of the evaluation relies on brief surveys administered twice per year (May-July and November-January). These surveys act as a "pulse check" to monitor the clinics' progress in the initiative. The survey responses are used to assign a self-reported score (on a 0-9 scale) for each of the five domains. These scores help the evaluators understand the clinics' performance and cohort them into early stage (0-2), medium (3-5), or high (6-9) performing groups.

Qualitative Assessment

Qualitative data is gathered through key informant interviews and annual site visits. The site visits, which take place in May and June, are a crucial part of this assessment. During these visits, JSI staff use a semi-structured interview guide with questions tailored to each clinic's most recent survey responses.

The main goals of these visits are to:

- Assess progress and movement within the CPA program.
- Understand the implementation and maintenance of systems that support population health and APMs.
- Gather feedback from health center teams on the feasibility and value of participating in the CPA.
- Collect retrospective lessons learned from the initiative.

The site visits typically last about 3.5 hours and include a discussion with representatives from the health center. After each visit, the two JSI facilitators summarize the data and assign an inferred score for each of the five domains.

Internal Evaluation Process Reflections & Lessons Learned

The five-year evaluation has been crucial for understanding the long-term impact and sustainability of the CPA initiative. The length of the evaluation allows for a more comprehensive assessment that goes beyond immediate outputs and captures the evolution of an organization in the key domains.

A sustained evaluation of a five-year initiative includes many lessons learned beyond just the themes discussed above, particularly related to what impacts the initiative and evaluation and therefore must be tracked alongside the qualitative and quantitative gathered data as part of the formal evaluation activities.

Important considerations for evaluation:

Staff Turnover

High staff turnover can disrupt program continuity and institutional knowledge.

- Future evaluators will benefit from formally tracking the turnover of key initiative staff at each participating organization.
- The evaluation should assess how organizations mitigate this risk through strong onboarding processes, documentation, and a positive work culture.

Regulatory Uncertainty

Changes in healthcare policy and funding can significantly impact a health center's ability to operate.

- Future evaluators will benefit from formally tracking the timing of announcements and implementation of regulatory changes (whether changes in statute, reimbursement, or rules).
- The evaluation should examine how organizations adapt to these changes and diversify their funding sources.

Engagement of Financial Staff

Even in health centers with strong cross-functional teams or communication and finance staff tend to be at a remove from clinical and workflow processes that drive savings in value-based care models.

- Future evaluators will benefit from tracking the participation of finance staff and perhaps monitoring the knowledge of finance, revenue cycle, and related staff.
- The evaluation should consider the progression of readiness for value-based care and alternative payment models.

Evolving Community Needs

The needs of a community can change over a five-year period due to demographic shifts, economic changes, or public health crises.

- Future evaluators will benefit from tracking demographic (health center-specific and community-specific) or other standardized community specific data annually to track those changes.
- The evaluation should engage with how health centers monitor, are impacted by, and respond to these evolving needs.

Technology Adoption

The integration of new and advancing technologies, such as telehealth/ virtual care, EHRs, population health analytics platforms, and perhaps even AI is influential on ongoing progress.

- Future evaluators will benefit from assessing the resources and capabilities that current technologies require for sustainability.
- The evaluation should assess the effectiveness and challenges of technology adoption.
- In a five-year evaluation like this, it's important to use a mixed-methods approach, combining quantitative data (e.g., regular survey results, financial information, standardized data such as UDS) with qualitative data (e.g., key informant interviews, site visits). This approach provides a holistic view of the organization's progress and the impact of external factors.

Introduction to the Toolkit

EHF hopes the impact of the CPA program will extend far beyond the achievements of the initial eleven health center grantees. To support the spread of lessons learning in this expansive five-year initiative, the foundation commissioned a catalog of the training, learning content, and other resources that were provided to grantees over the past five years. The CPA Community Health Center Toolkit is available to both health centers undertaking this work in Texas as well as organizations supporting health centers to implement improved population health management.

This toolkit consolidates the training and technical assistance curriculum and resources that were utilized throughout the CPA program to drive change, build capacity, and promote peer to peer learning. The toolkit resources are organized in alignment with the CPA Logic Model:

Planning Level	• Education Models for Health Center Boards of Directors, providing an overview of value-based payment and it's relevance to health center mission and strategy • Change Management Education modules and tools to implement change management processes at an organization • Project Management guidelines and resources
CPA Level 1	• Education materials providing overview of value-based care, value-based payment, and link between these concepts and health center values and long term strategy • Guidelines for developing a population health roadmap and roadmap templates • Basic payer mix assessment tool
CPA Level 2	• Education modules providing overview of how clinical data is used in value-based payment models and population health • Care team and project leader position descriptions • Value-based contracting and data agreement review checklists
CPA Level 3	• Advanced payer mix assessment tools • Complex data tools and guidelines, focused on patient risk stratification • Education material on the importance of scale and joint contracting in value-based payment models

Conclusion

Summary of Key Findings and Impact

The Clinics Pathway Approach program was the largest investment ever made by the Episcopal Health Foundation into the Texas primary care safety net. Through this program, eleven community health centers built their capacity to provide high quality population health management programming. This capacity is important both to improving community health outcomes, and to ensuring the long-term financial health of these community health centers. Strong population health management capacity is critical to CHC financial health because it enables CHC providers to enter and succeed in the value-based payment arrangements. Value-based payment models are the future of healthcare payment, and safety net providers like community health centers are often at a disadvantage when attempting to enter these types of contracts.

The CPA program improved grantee ability to enter and succeed in these payment models. At the onset of the program, the majority of grantees had limited exposure to and familiarity with complex payment arrangements, and those who had experience had limited success. At the conclusion of the program, all eleven grantees participated in some level of complex payment model.

The CPA funding enabled grantees to hire additional staff, train providers and care teams on key population health concepts, and invest in analytic health information technology. The CPA training and technical assistance programming educated grantees on value-based payment models, change and project management, key competencies in population health, and the importance of peer collaboration and collective action. These investments will continue to support the long-term success of Texas safety net providers.

Future Directions and Sustainability: Potential next steps and how the impact of the CPA project can be sustained

Two of the key lessons learned during the course of the CPA program provide insight on how this program can evolve in the future. The first lesson is the importance of collective action. Community health centers cannot succeed long term in value-based payment models without working together. The vehicle for continuing this work together now exists formally in My Texas My Health, the health center owned and governed clinically integrated network supported by Texas Association of Community Health Centers. My Texas My Health is a key strategy to continue advancing health center progress in the area of population health.

The second lesson learned is that the broader policy and financial environment have huge influence on health center ability to sustain this work. In the last year of the CPA program, Medicaid experienced significant financial cuts and health center financial health worsened across Texas and across the country. As Medicaid finances tighten, health centers will need to focus on payment models and programs that have sustainable revenue and can make up for some of these losses. Medicare did not sustain as significant cuts as Medicaid, and Medicare is a growing revenue source for health centers nationally. Applying the CPA principles developed in the course of this program to promote success in Medicare as well as continuing to focus on the key quality priorities of the Texas Medicaid program are potential next steps as the CPA program evolves.

A. Evaluation Reports

JSI conducted the full CPA Program Evaluation, a critical component of this program. Year over year evaluation summaries are available here.

B. Supplemental Information on Policy Landscape

Supplemental Information on Policy Landscape

Federal and Texas value-based payment policy and regulatory environments

Policy Landscape

- Patient/payer mix – what patients does the FQHC serve at a high enough volume to engage with key payers?
- What is the policy and regulatory environment to enable value-based care in large programs such as Medicaid and Medicare?
- How can My Texas My Health - the clinically integrated network (CIN) established by the Texas Association of Community Health Centers (TACHC) – assist its member FQHCs with negotiating and administering VBP arrangements?
- How can an FQHC (or the CIN) effectively engage payers to discuss and negotiate VBP arrangements, also known as alternative payment models (APMs) in the Texas Medicaid managed care program?
- Which performance metrics are a priority for each payer and does the FQHC have the tools to be successful in improving those key metrics?

Contractual Issues

- What are the requirements of each payer/model – pay for quality, shared savings, shared savings with downside risk? Is the FQHC ready for this type of model?
- Are the terms of the value-based payment (VBP) contract acceptable to the FQHC?
    - For example, what is the glidepath before the FQHC would be required to take downside risk? (Some payers may want to move to downside risk sooner than an FQHC prefers.)
    - How does the payer handle attribution? This has been an ongoing challenge in value-based payment arrangements – the payer and provider sometimes have very different pictures of which members should be attributed to a particular provider.

What patients do the FQHC/CIN serve at a high enough volume to engage with key payers?

Patient Mix FQHCs in Texas serve a large, diverse patient base. According to TACHC, in 2024 they provided primary care to 1.9 million patients, serving about 1 in 17 Texans, at 700 sites across 131 counties. That same year, Texas FQHCs' patient mix was 34% uninsured, 29% Medicaid, 28% privately insured, 7% Medicare and 2% Children's Health Insurance Program (CHIP)/Other.[1] Texas health centers served about 12% of all Medicaid and CHIP enrollees in the state.[2] In comparison, FQHCs' average patient mix nationwide in 2024 was 18% uninsured, 49% Medicaid/CHIP, 22% privately insured, and 11% Medicare.[3] It is important to routinely monitor federal and state policy changes, which can have a significant impact on FQHC payer mix, payment rates, and value-based care opportunities.

Two large programs where FQHCs have opportunities to engage in VBP arrangements are Medicaid and Medicare. Texas Medicaid primarily covers low-income children, pregnant women, individuals with disabilities, and older adults. Most other states' Medicaid programs also cover more low-income adults. Medicare is a federal program that covers adults 65 years and older and certain individuals with disabilities.

How can My Texas My Health - the clinically integrated network (CIN) established by TACHC - assist its member FQHCs with negotiating and administering value-based payment arrangements?

My Texas My Health

Because VBP arrangements take significant time and money to negotiate and administer, payers are most interested in entering into value-based care arrangements with providers who serve a substantial number of their covered members. TACHC's CIN - My Texas, My Health - has over 50 member FQHCs, which gives it considerable volume compared to individual health centers. It also offers much of the "back end" infrastructure needed to engage in value-based care arrangements and there are economies of scale by performing these functions for a group of health centers rather than individually.

In Texas Medicaid, contracted managed care organizations (MCOs) must meet state performance targets that a minimum percentage of their total payments are associated with VBP or APM arrangements, so it makes sense that MCOs would start with their largest providers to meet these targets. By bringing together many of TACHC's member FQHCs, the CIN has substantial Medicaid patient volume that makes it a more attractive VBP partner.

Also, Medicare and Texas Medicaid health plans (of which there are many) have the flexibility to implement different VBP models, which can increase administrative burden for providers as they work to negotiate different arrangements with multiple payers across the state. With its combined patient volume in over one half of Texas' counties, including the largest urban centers, My Texas My Health likely is in a better position to negotiate more standardized contracts with health plans. In recent years, some Medicaid MCOs have begun to use third party intermediaries to manage some of their VBP arrangements (e.g., Equality Health, Uvo, Main Street), which also is a common practice in Medicare. With My Texas My Health serving a similar role for its members, it can help ensure that more of the financial rewards for successful performance in VBP models stay with its member FQHCs to continue to improve care in their communities.

What is the policy and regulatory environment to enable value-based care in large programs such as Medicaid and Medicare?

CMS Innovation Center

The Centers for Medicare and Medicaid Services' Innovation Center (CMS Innovation Center) is a key player in advancing value-based care. Medicare and Medicaid are publicly funded programs that represent a large percentage of national health care expenditures (39% in 2023)[4] and care for some of the most complex patients (older adults, adults and children with disabilities, and lower-income pregnant women, among others). Since 2011, the Innovation Center has developed and tested many health care payment and service delivery models to improve patient care, lower costs, and align payment systems to promote patient-centered practices.[5]

As FQHCs work to engage payers in VBP arrangements, and particularly Medicare and Medicaid payers, it will be beneficial to understand and align with the current strategic direction of the CMS Innovation Center. In May 2025 the Innovation Center released a strategy update with four priority areas: promote evidence-based prevention; empower people to achieve their health goals; drive choice and competition; and protect federal taxpayers, including by requiring all models to have downside risk for providers and moving Medicare and Medicaid beneficiaries to accountable health arrangements with providers who assume global downside financial risk.[6]

Medicare Landscape

Medicare is a federal program that leads in value-based care. Its beneficiaries often have complex, costly health care needs. As of September 2024, there were over 4.7 million Medicare beneficiaries in Texas.[7] Within Texas FQHCs, Medicare beneficiaries represent 7% of Texas FQHCs' patients and 8% of revenues.

There are two types of Medicare: Traditional Medicare (fee-for-service) and Medicare Advantage (managed care administered through contracted health plans). Over time, more Medicare beneficiaries in Texas and nationwide are selecting Medicare Advantage health plan coverage instead of Traditional Medicare coverage. From 2014 to 2024, Medicare Advantage penetration in Texas went from 30% to 58% of beneficiaries.[8] Medicare Advantage has been more profitable for health insurers over the past ten years than Medicaid and the commercial insurance market. In 2023, the gross margin in Medicare Advantage per enrollee was $1,982, compared to $753 in Medicaid managed care, $910 in the group market, and $1,048 in the individual market.[9]

VBP Opportunities in Traditional Medicare

My Texas My Health (MTMH) participates in the Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) model in traditional Medicare and some individual Texas FQHCs also have participated in MSSP. MTMH joined MSSP in 2025 with 27 FQHCs serving 8,800 Medicare beneficiaries across Texas and six more FQHCs are joining the model in 2026 for a total of over 10,000 Medicare beneficiaries covered. The ACO is eligible for Advanced Investment Payment (AIP) to help build the infrastructure needed to be successful in the program. MSSP is an attractive option because of such advance payments and because it provides up to a five-year glide path before the ACO must take some downside risk. It also is a well-established program across the country with good data transparency and more stable enrollment than Medicaid and commercial insurance.

VBP Opportunities in Medicare Advantage

Texas Medicare beneficiaries have many different Medicare Advantage (MA) insurance companies (34)[10] and plans (373)[11] to choose from. Nationwide, UnitedHealthcare has 29% of MA enrollments, followed by Humana (18%) and BCBS affiliates (14%). Many of these same plans are large players in Texas Medicaid and the ACA Marketplace, so in negotiating VBP arrangements, there may be opportunities to leverage their presence across more than one of an FQHC's patient populations. My Texas My Health does not yet have a contract with an MA plan, but has discussed them, including with insurers who have a large presence in both Texas Medicaid and Medicare Advantage.

Medicaid and CHIP Landscape

Medicaid is a key payor for Texas FQHCs, so along with Medicare is a natural partner for VBP contracts. As of October 2025, My Texas My Health had two VBP contracts with Medicaid MCOs – a shared savings arrangement with UnitedHealth and a recently signed pay-for-quality contract with Aetna Better Health. The CIN has been in discussions with other health plans – both community health plans and commercial plans. Some individual FQHCs, and particularly larger health centers, also are engaging directly in VBP arrangements with Medicaid MCOs.

Medicaid and CHIP enrollees represented 32% of Texas FQHCs' patients and 28% of their revenue in 2024. As of March 2025, there were over 4.1 million Texans covered by Medicaid and CHIP, of which almost 3.2 million were children.[12] Other populations covered under Texas

Medicaid include low-income pregnant/postpartum women, older adults, and children and adults with disabilities. As previously noted, Texas health centers serve about 12% of Medicaid and CHIP members in the state.

Medicaid Managed Care

Texas is a Medicaid managed care state with 97% of enrollees served through contracted health plans.[13] As of January 2025, there were 18 contracted managed care organizations (MCOs) and three dental plans in 13 geographic service delivery areas (SDAs):[14]

A challenge for FQHCs, the CIN and all providers interested in participating in Texas Medicaid VBP arrangements is that there are so many different health plans serving clients in different parts of the state.

How can an FQHC (or the CIN) effectively engage payers to discuss and negotiate VBP arrangements, also known as APMs in the Texas Medicaid managed care program?

Building and maintaining effective relationships with MCOs

HHSC and state policymakers continue to push the need for providers and MCOs to partner to improve quality of care. This is the direction State leadership is taking too. Rather than appropriating additional funds for rate increases, the State is encouraging health plans to reward providers for quality care. This emphasis makes it essential for providers to partner with health plans to negotiate contracts and value-based arrangements to improve their financial stability. Additionally, building strong relationships can improve care coordination and patient outcomes, increase data sharing between providers and MCOs, enhance member engagement, and reduce costs for the state. Since Texas has a diverse range of health plans (community-based, hospital-based and national plans), there is not a one-size fits all approach but there are keys to building and sustaining relationships with MCOs, including understanding and strategically aligning with MCO priorities, and collaborating and engaging with key staff at health plans.

It is important for providers to demonstrate value by showing how programs, services, and goals are aligned with health plan priorities. To do so, it is key to study the Uniform Medicaid Managed Care Contract (the contract between HHSC and the MCOs) to understand health plan requirements and identify ways an FQHC can help an MCO meet the requirements.[15] This practice can also help providers speak the same language as the MCO they are engaging. Additionally, it is important to understand the MCO quality programs (see section below on APM framework and MCO pay-for-quality program) and health plan performance to identify the key metrics that a provider can assist a health plan achieve. HHSC maintains the Texas Healthcare Learning Collaborative portal that includes dashboards of MCO performance by region and program to assist with this activity.[16] For example, if a certain health plan in a service area is performing below the benchmark for prenatal visits, and an FQHC (or the CIN) can assist in improving that metric, then that is an activity to include in value based contracting design and negotiations.

Navigating and engaging health plans can be difficult. Attending health plan conferences, provider and stakeholder meetings in the community, and HHSC advisory committees is a way to meet health plan staff and leaders. Another strategy is working with health plan provider representatives to request a meeting directly with the Service Coordination Director, the Medical Director, and/or the Quality Director to introduce how you are aligned with the health plan and spur conversations around value-based contracting.

Health plans need assistance in engaging members and improving care coordination. Pinpointing ways to help MCOs identify and address member needs and designing programs that integrate with the MCO Service Coordination departments can help develop strong relationships. Regularly meeting with Service Coordinators to discuss and coordinate patient care provides value to the health plan while also providing the opportunity to constantly engage with the MCO. Health plans frequently struggle with staying in contact with their members, due to outdated addresses, lack of trust, and other factors. FQHCs often have a better pulse on their patients and sharing information with the MCO and identifying ways to help the health plan engage their members can go a long way to building stronger relationships.

Being data driven is another important way to show value and increase frequency of contact with a health plan. The willingness and ability to share data about MCO members, improvements in patient outcomes, identifying opportunities based on demographics or showcasing performance will also increase the likelihood of an MCO's willingness to engage.

A provider's willingness to eventually take downside risk and design value-based contracts around the MCO's pain points will help incentivize an MCO to engage. Providers need to also realize that some health plans may have standardized value-based contracts for certain providers, while other MCOs are looking for providers to bring to them a fully designed payment model that can be tweaked to fit within the MCO's priorities. Finally, it is important to recognize that building relationships and implementing value-based contracts can take a long time and some health plans experience frequent changes to their organizations, so patience, constant outreach, and being nimble are very important during the process.

Which performance metrics are a priority for Texas payers and does the FQHC have the tools to be successful in improving those key metrics?

Texas Medicaid Quality and VBP Initiatives

As FQHCs work to engage Texas Medicaid and CHIP MCOs in VBP arrangements, it is important to understand the incentives and programs in place to drive quality in Medicaid managed care. HHSC has several programs to incentivize its contracted MCOs to improve quality and engage in value-based care, which it describes in an annual report.[17] Two of those programs are particularly relevant to FQHCs who wish to engage in VBP arrangements with MCOs – the Pay for Quality Program and Alternative Payment Model Requirements for MCOs.

An FQHC or the CIN should consider the overlap between Uniform Data System (UDS) measures tracked for FQHCs and key measures for Medicaid and Medicare, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures. For some measures, an FQHC may have more confidence that it can move the needle, while for more challenging measures, such a seven-day follow up after a mental health hospitalization, it needs to determine what realistic improvement targets are.

Pay for Quality Program (P4Q)

HHSC's P4Q program encourages MCOs and their contracted providers to focus on health and care outcomes that are a priority for the state. Per HHSC, "For the medical P4Q program, up to 3% of each MCO's capitation is at risk of recoupment. MCOs that do not meet target performance thresholds for P4Q measures could lose capitation dollars. Performance is measured against benchmarks (performance within the year relative to state and national benchmarks) and against self (year-to-year improvement over an MCO's own performance). Recouped capitation dollars from low performing MCOs for at-risk measures are redistributed to high performing MCOs. If any funds remain after the collection and

redistribution process, they form a bonus pool to reward high-performing MCOs on bonus pool measures. Because MCOs can lose or gain substantial capitation dollars, this program incentivizes MCOs to collaborate with providers to develop VBP models that can help ensure success."[18]

The at-risk measures are particularly important in the P4Q Program. An MCO is at risk of losing up to 3% of its monthly capitation payments from the state if it performs poorly on these measures. So, MCOs are likely to include these measures in VBP arrangements with providers to help them perform well in the program. As the following table shows, for 2025 across all models potentially preventable emergency room visits are an at-risk measure. Likewise, for certain Medicaid populations, glycemic status assessment, prenatal and postpartum care, and childhood immunization status are at-risk measures. The Texas Healthcare Learning Collaborative Portal contains historical information on how each MCO has performed on these measures (and many other measures) in different areas of the state, which can help assess which measures each MCO may be most interested in improving and how an FQHC's members are performing relative to an MCO's other providers.[19]

More details about the P4Q Program, including the bonus pool measures (which can change year to year), are available on HHSC's website.[20]

Table 1. Texas Medicaid P4Q At-Risk Measures 2025*

MEASURE	STAR+PLUS	STAR	STAR KIDS
Potentially Preventable Emergency Room Visits (PPVs)	X	X	X
Potentially Preventable Admissions (PPAs)		X	
Potentially Preventable Readmissions (PPRs)	X		
Prenatal and Postpartum Care (PPC)		X	
Glycemic Status Assessment for Patients with Diabetes (GSD)	X		
Cervical Cancer Screening (CCS)	X		
Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days and 30 Days	X		
Follow-Up After Hospitalization for Mental Illness (FUH) 7 Days - ages 6 to 17 years			X
Childhood Immunization Status (CIS) Combination 10		X	
Follow-up Care for Children Prescribed ADHD Medication (ADD-E) Initiation submeasure		X	X
Getting Specialized Services Composite (CAHPS)			X
Assistance with Care Coordination (NSCH)			X

* During the PHE, CHIP enrollment declined significantly due to Medicaid continuous enrollment requirements, impacting HHSC's ability to reliably calculate quality measures for CHIP at the MCO level. P4Q for CHIP MCOs will be revisited for the 2026-2027 calendar year cycle and will be posted on HHSC's website.

Alternate Payment Model (APM) Requirements for MCOs
FQHCs also should work to align with HHSC's alternative payment model (APM) requirements for MCOs. Per HHSC, "since 2018, it has required MCOs to shift an increasing proportion of provider reimbursement into APMs that link a portion of provider payments to measures of value (quality and efficiency). These APMs may involve financial risk on providers and reward them for meeting performance standards based on measures of value. In the first phase of VBP implementation through APMs, HHSC required MCOs to meet certain volumes of APM contracts with their providers, which were measured against annually increased targets over the six-year period (2018 – 2023). Starting with calendar year 2024 reporting, HHSC transitioned to an APM Performance Framework (APM-PF) that recognizes MCO efforts to adopt APMs beyond just meeting the payment targets. The below figure shows the main principles that guided the design of the new APM-PF."

Figure 5. APM Performance Framework Principles

Promote options and flexibility that align with HHSC priorities	Increase adoption of Accountable APMs	Improve reporting of APM activities	Broaden areas included in APMs	Foster MCO and provider collaboration for successful APMs

The APM performance framework principles include:
1. Promote options and flexibility that align with HHSC priorities
2. Increase adoption of accountable APMs
3. Improve reporting of APM activities
4. Broaden areas included in APMs
5. Foster MCO and provider collaboration for successful APMs

The main purpose of the expanded APM-PF is to give MCOs the option to be more creative in the expansion of APMs; to allow them to get credit for all efforts directed to this process; and to strengthen their relationship with providers by involving them closely in the process. Under the updated approach, MCOs are encouraged to develop and field innovative models that address specific quality improvement priorities, including models that encourage improvements in maternal health outcomes, reductions to potentially preventable ED visits, address non-medical drivers of health (NMDOH), support home and community-based services workforce development, and incentivize the integration of primary and behavioral health care services. HHSC has additional information on its website about its APM requirements for MCOs, including files that show what models they've chosen to implement each year.[21]

Conclusion and Key Takeaways

As individual FQHCs and the CIN pursue VBP arrangements, they are evaluating their payer mix, the ever-changing national and state policy environment, and where there are opportunities to align with different payers to improve the care and health of their members. An initial focus on Medicare (including MSSP) and Medicaid VBP arrangements is a sound strategy. These public programs represent a large percentage of FQHCs' patients and have an established track record of encouraging value-based care.


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