

FQHC & MCO Convening

LOCATION

Texas Union Santa Rita Room
2308 Whitis Ave, Austin TX

DATE

February 20, 2026
10:00am – 2:00pm

Welcome and Introductions

10:00am – 10:15am

Jana Eubank
CEO, TACHC

Shao-Chee Sim
Executive Vice President for Health Policy,
Research and Strategic Partnerships, EHF

Janet Walker
President and CEO, TACHP

FQHC Updates

10:15am – 10:55am

Jana Eubank
CEO, TACHC

Terri Sabella
CEO, HealthPoint (Bryan)

Jon Calvin
CEO, Lone Star Circle of Care (Georgetown)

MCO Updates

10:55am – 11:35am

**Lindsey R. Vasquez MD, CPE,CPHQ, FACOG,
PMH-C**
Director of Maternal and Women's Health,
Molina Healthcare of Texas

Victoria Mora
CEO, Parkland

Morgan Galow
Director of Alternative Payment Models,
UnitedHealthcare

HHSC MCO APM Framework

11:35am – 11:55am

Jimmy Blanton
Director, Office of Value-Based Initiatives,
Medicaid and CHIP Services, HHSC

Networking Lunch (provided)

11:55am – 12:15pm

Update from My Texas My Health Clinically Integrated Network

12:15pm – 12:30pm

Steve Ramirez, MD
Chief Innovations Officer, TACHC

State and Federal Policy Priorities

12:30pm – 12:50pm

Shelby Tracy
Chief Policy Officer, TACHC

Jamie Dudensing
CEO, TAHP

Networking Activity

12:50pm – 1:30pm

Facilitated by EHF and Treaty Oak Strategies

Activity Discussion

1:30pm – 1:50pm

Closing Remarks

1:50pm – 2:00pm

Shao-Chee Sim
Executive Vice President for Health Policy, Research and
Strategic Partnerships, EHF

Laurie Vanhoose
Principal, Treaty Oak Strategies

This convening is possible thanks to the
support of the Episcopal Health Foundation.

FQHC and MCO Convening

February 20, 2026

Welcome and Intros

Jana Eubank

CEO, Texas Association of Community
Health Centers

Shao-Chee Sim

Executive Vice President for Health
Policy, Research and Strategic
Partnerships, Episcopal Health
Foundation

Janet Walker

President and CEO, Texas Association of
Community Health Plans

FQHC Updates

Jana Eubank

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(Georgetown)

Texas Health Centers in 2024

79 FQHCs with
over 700 clinic
sites
in 131 counties

1.9 million
patients served
7.2 million total
visits



In Poverty
68%



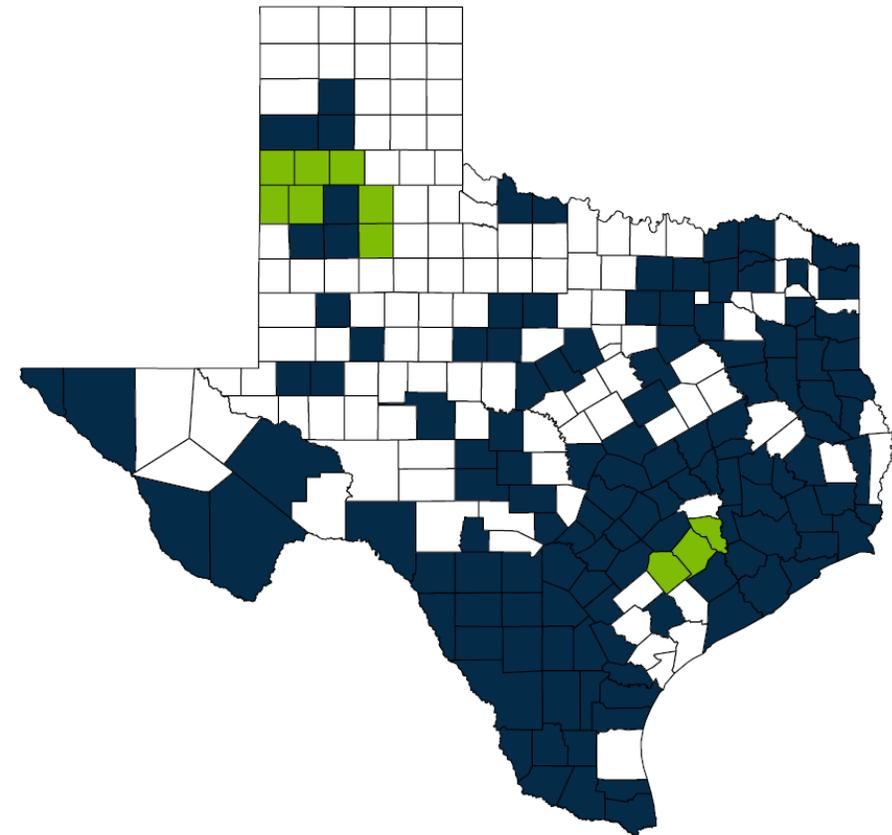
Women of
childbearing age
495,166



65 and older
172,250



Children
689,915



Primary care services 

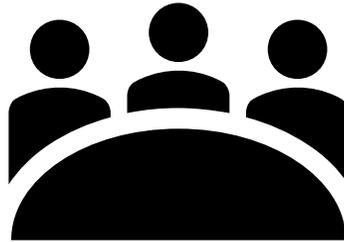
Support services only 

Health Center Characteristics



Located in areas of
high need

Provide care in medically underserved areas or to medically underserved populations



Consumer-driven
healthcare

At least 51% of every health center's governing board must be made up of patients



Open to Everyone

Regardless of insurance status or ability to pay, and offer sliding fee scale rates based on income



Comprehensive Set of
Services

Offer medical, dental, behavioral health, pharmacy, and other support services



HealthPoint at a Glance

- Federally Qualified Health Center serving high-need, high-cost populations
- Frontline role in **access, prevention, and total cost of care**
- Services beyond visits:
 - Expanded primary care
 - Behavioral health integration
 - Outreach, enrollment, and patient education
- HealthPoint is a **delivery system partner** in value-based care

Health
POINT

Payer Challenges Undermining Care Delivery

Timely Enrollment & Credentialing

Delays lead to:

- Care disruptions
- Administrative burden

Patients arrive before systems are ready

Cost vs. Reimbursement

CHCs absorb unreimbursed costs:

- Outreach & enrollment
- Patient education & navigation
- Expanded primary care models

Commercial and exchange plans:

- Reimbursement consistently a fraction of cost
- Misaligned with patient complexity

Data: From Chance to Performance

Current data challenges:

- Delayed
- Incomplete
- Inaccurate attribution and utilization data

Limits ability to:

- Intervene early
- Manage risk
- Deliver value-based outcomes

In total cost of care contracts:

Success today depends more on luck than execution

**Health
POINT**





Lone ★ Star
Circle of Care

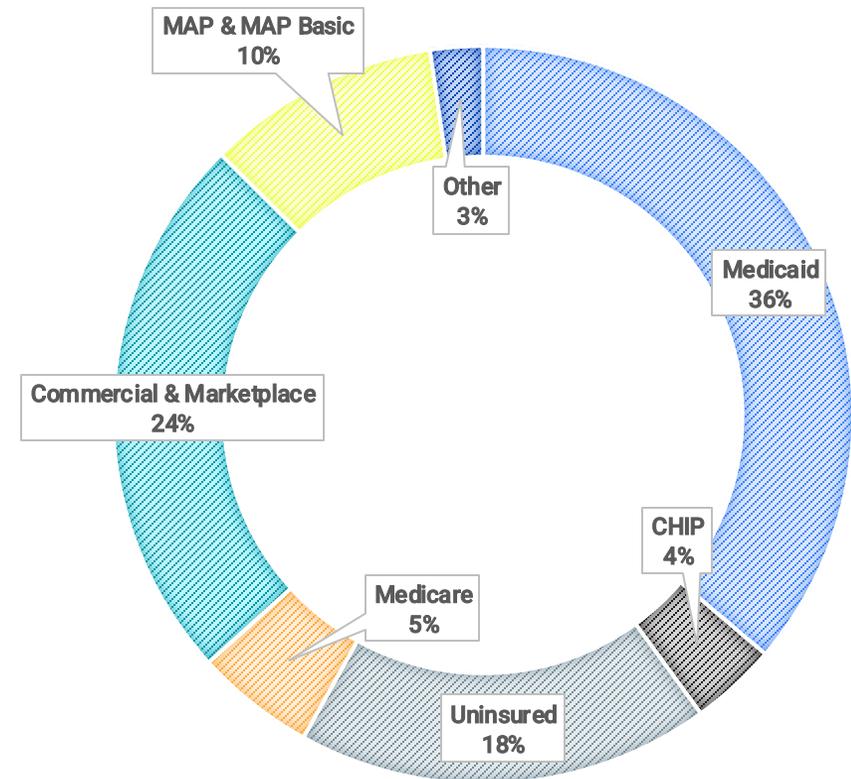
Lone Star Circle of Care (LSCC) Overview

Lone Star Circle of Care Overview

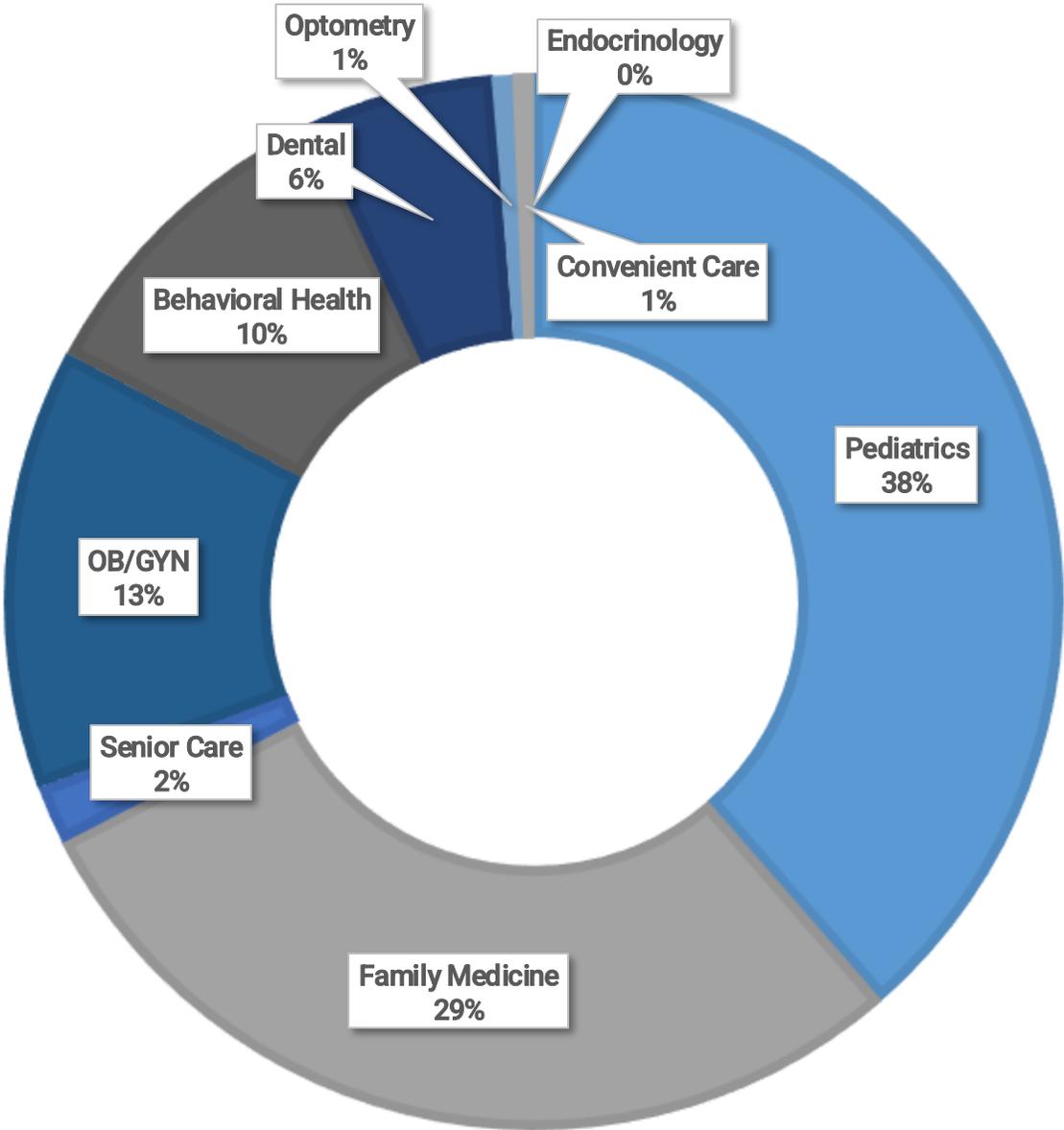


- ▶ Founded in 2001 in Georgetown, TX
- ▶ Private 501(c)(3) nonprofit Federally Qualified Health Center (FQHC)
- ▶ 23 clinic locations across 4 counties, plus mobile mammography
- ▶ 671 employees (FYE 2025)
- ▶ 130 full-time-equivalent physicians and advanced practice providers
- ▶ 330,992 patient encounters in FY2025
- ▶ Joint Commission accredited; Primary Care Medical Home (PCMH) designated

PATIENT ENCOUNTER MIX BY PAYER

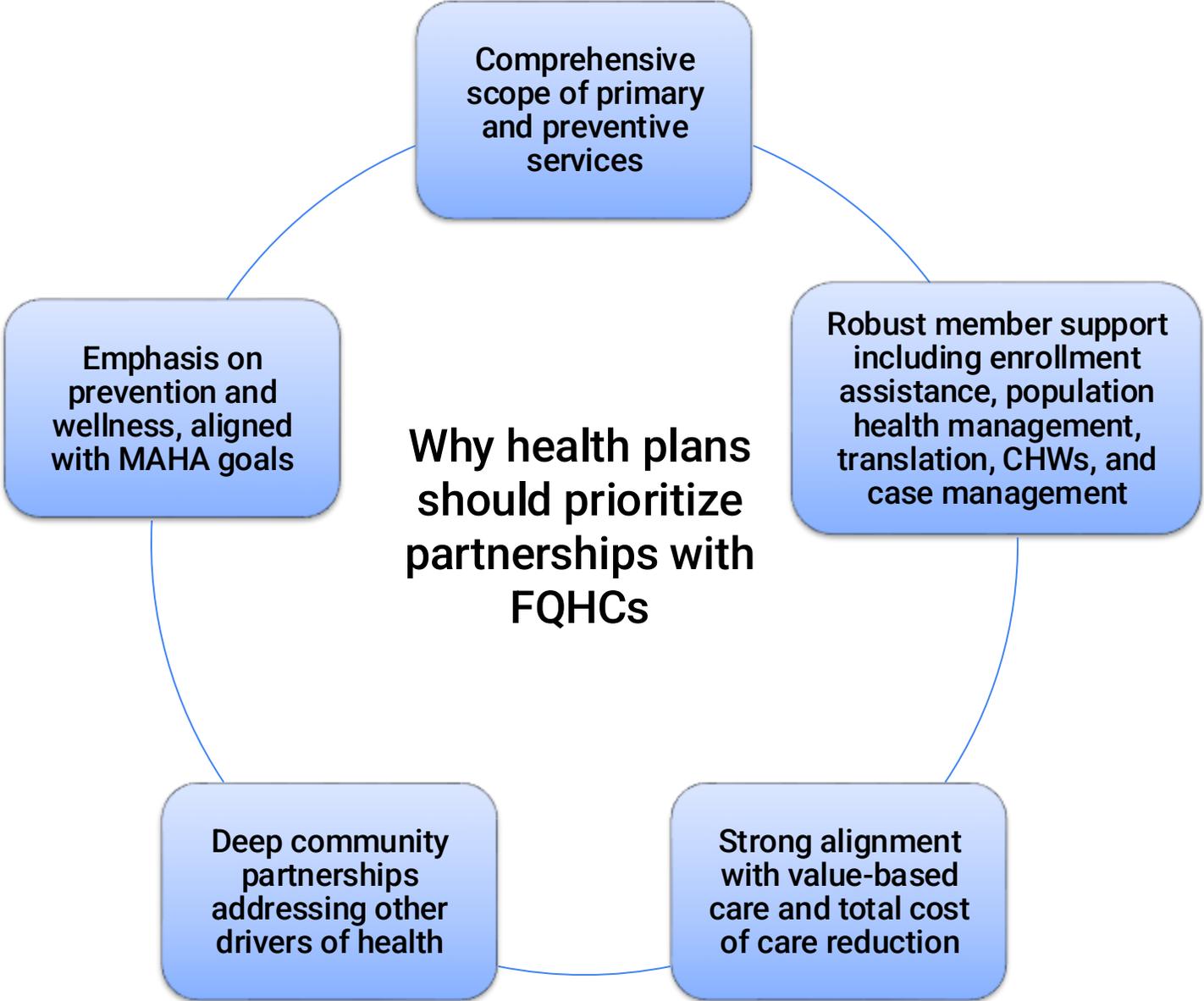


Patient Encounters by Service Line – FY2025



Other Service Lines:
- Pharmacy
- Mobile Mammography

FQHC Value Proposition



Opportunities to Strengthen MCO and FQHC Partnerships



- ▶ Resolve special projects timely to prevent cash-flow disruption
- ▶ Improve communication and care coordination between MCOs and FQHCs – clarify roles, eliminate gaps, and reduce duplication of efforts around outreach to members
- ▶ Increase primary care investment and flexible reimbursement models
- ▶ Provide timely access to full claims data for members to support value-based care efforts and care management
- ▶ Joint infrastructure planning to ensure service capacity meets member needs

FQHCs aim to be the provider of choice for MCO members

MCO Updates

Lindsey R. Vasquez MD,
CPE, CPHQ, FACOG, PMH-C
Director of Maternal and Women's
Health, Molina Healthcare of Texas

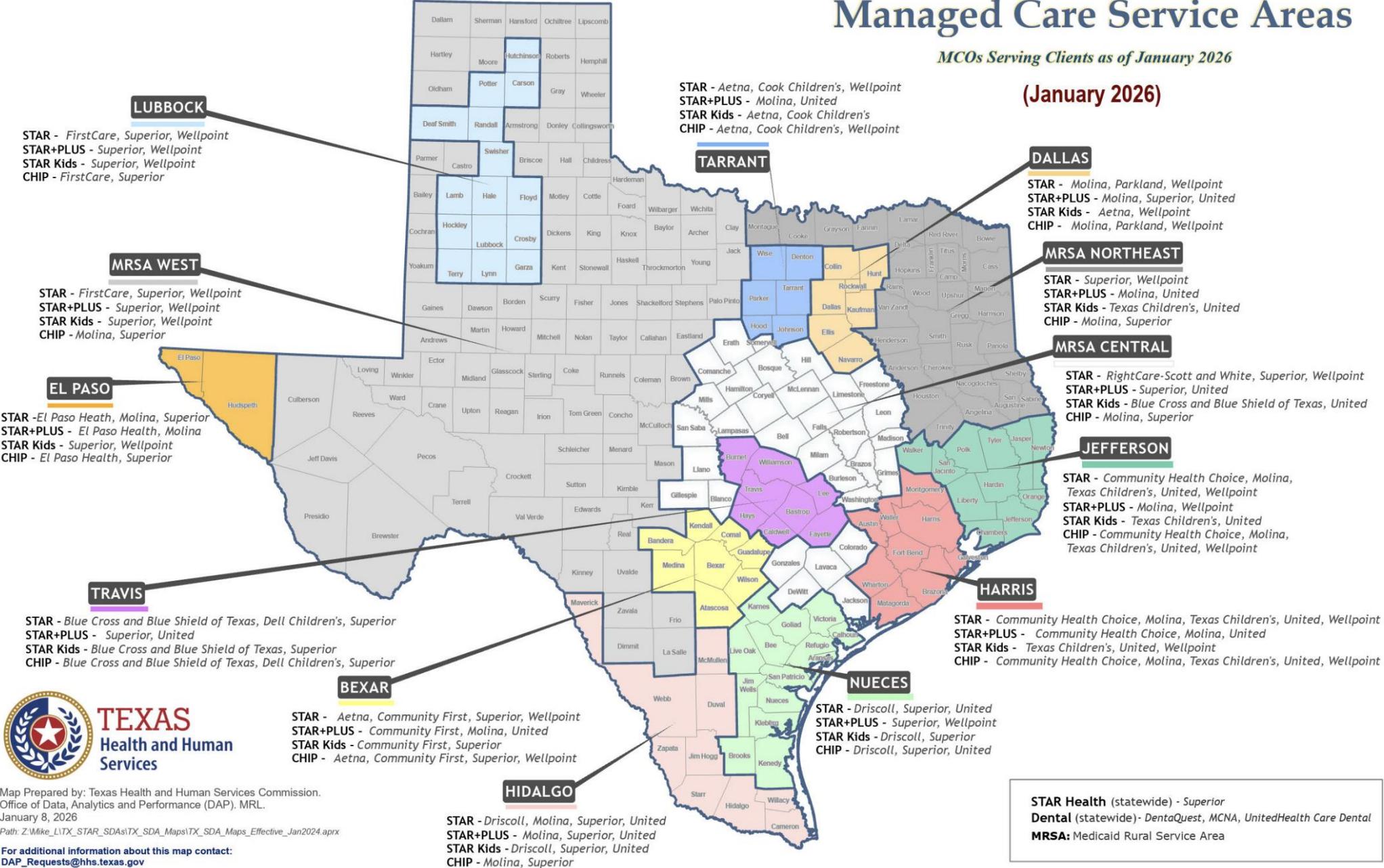
Victoria Mora
CEO, Parkland

Morgan Galow
Director of Alternative Payment
Models, UnitedHealthcare

Managed Care Service Areas

MCOs Serving Clients as of January 2026

(January 2026)



Map Prepared by: Texas Health and Human Services Commission.
 Office of Data, Analytics and Performance (DAP). MRL.
 January 8, 2026
 Path: Z:\Mike_L\TX_STAR_SDA\TX_SDA_Maps\TX_SDA_Maps_Effective_Jan2024.aprx
 For additional information about this map contact:
 DAP_Requests@hhs.texas.gov

STAR Health (statewide) - Superior
Dental (statewide) - DentaQuest, MCNA, UnitedHealth Care Dental
MRSA: Medicaid Rural Service Area

State Goals for Managed Care

The following Medicaid managed care goals are outlined in statute:

- ✓ Contain costs
- ✓ Incentivize innovation
- ✓ Prevent fraud, waste and abuse
- ✓ Ensure access
- ✓ Improve care and outcomes for patients

HHSC MCO APM Framework

Jimmy Blanton

Director, Office of Value-Based Initiatives,
Medicaid and CHIP Services, HHSC



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Alternative Payment Models (APMs) in Texas Medicaid

**Jimmy Blanton, Deputy Director, Quality and Program
Improvement, Medicaid and CHIP Services**

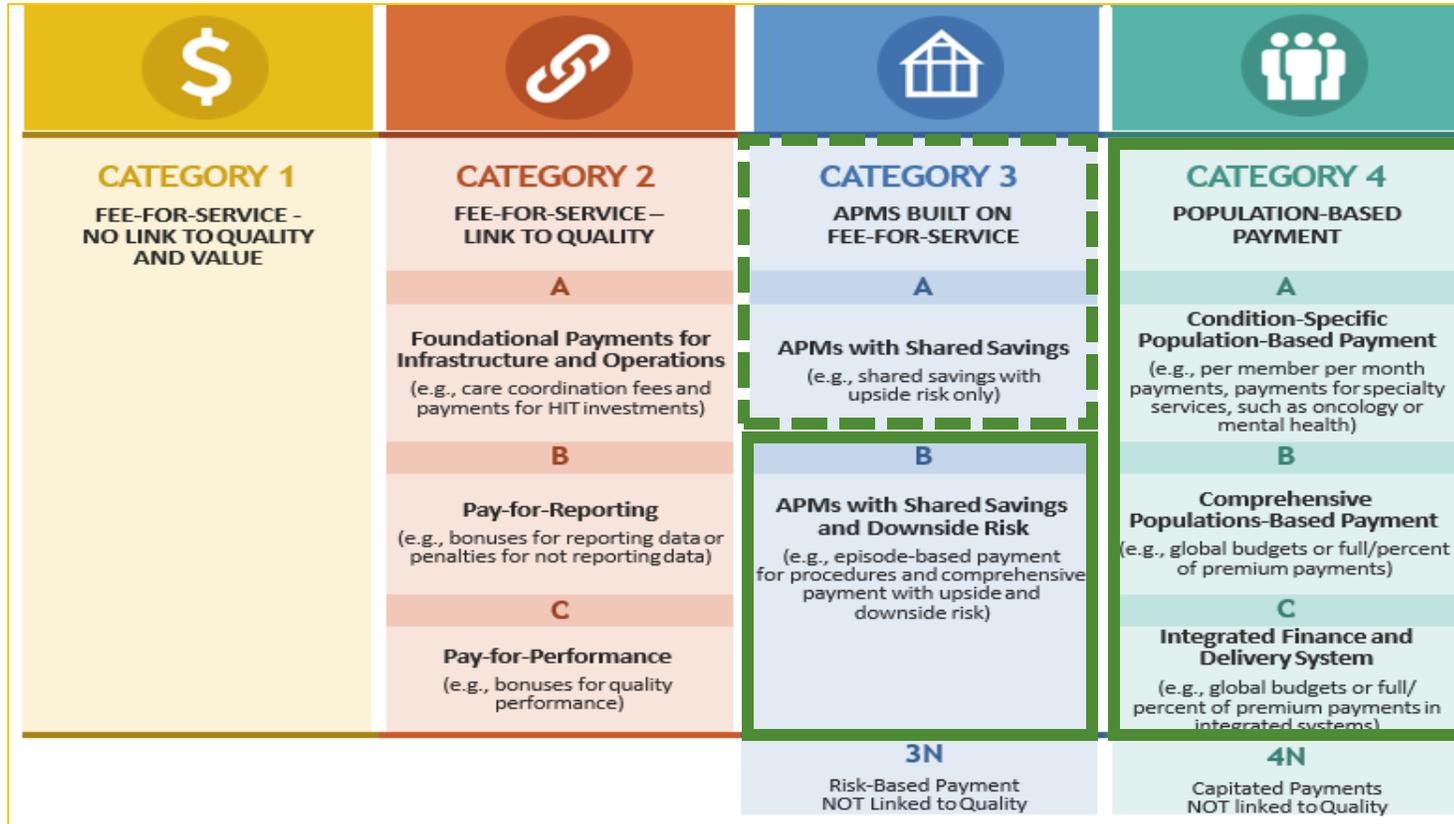
APM Requirements

Progression



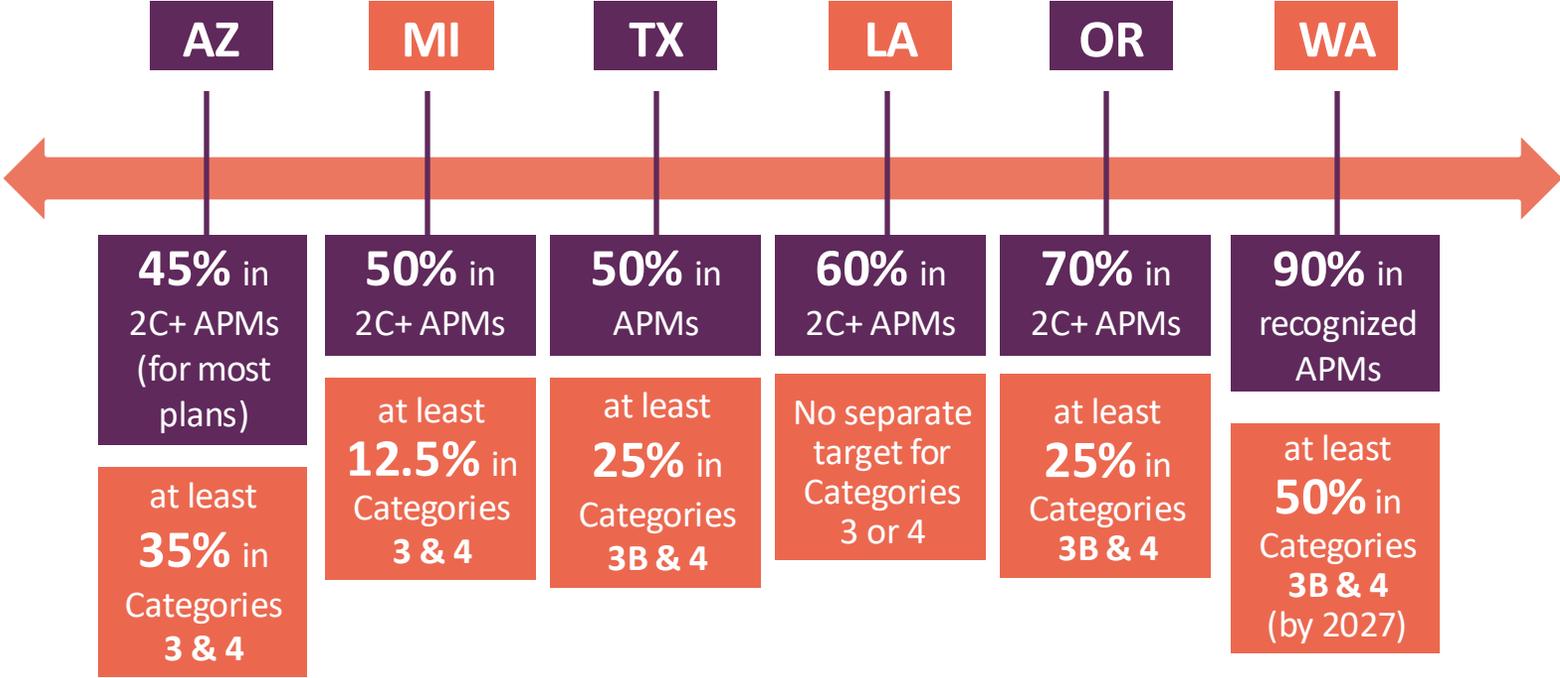
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*HCP-LAN APM Framework



*Health Care Payment Learning Action Network

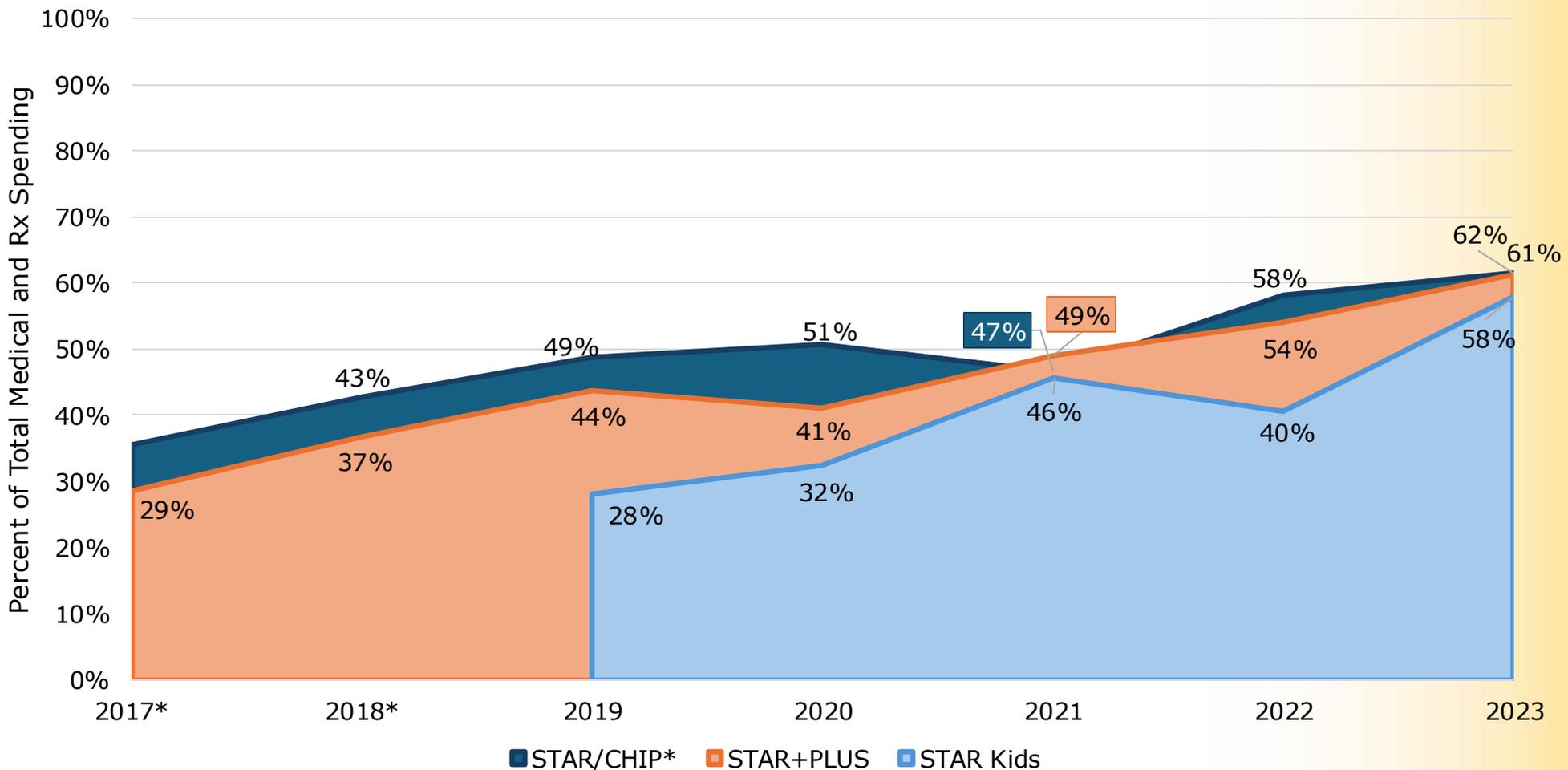
State MCO APM Targets in Medicaid*



Percent of Provider Payments in Contracts that Include APMs in Different LAN Categories

* State Health & Value Strategies: States Monitor Whether Managed Care Entities Meet VBP Targets. April 7, 2025.

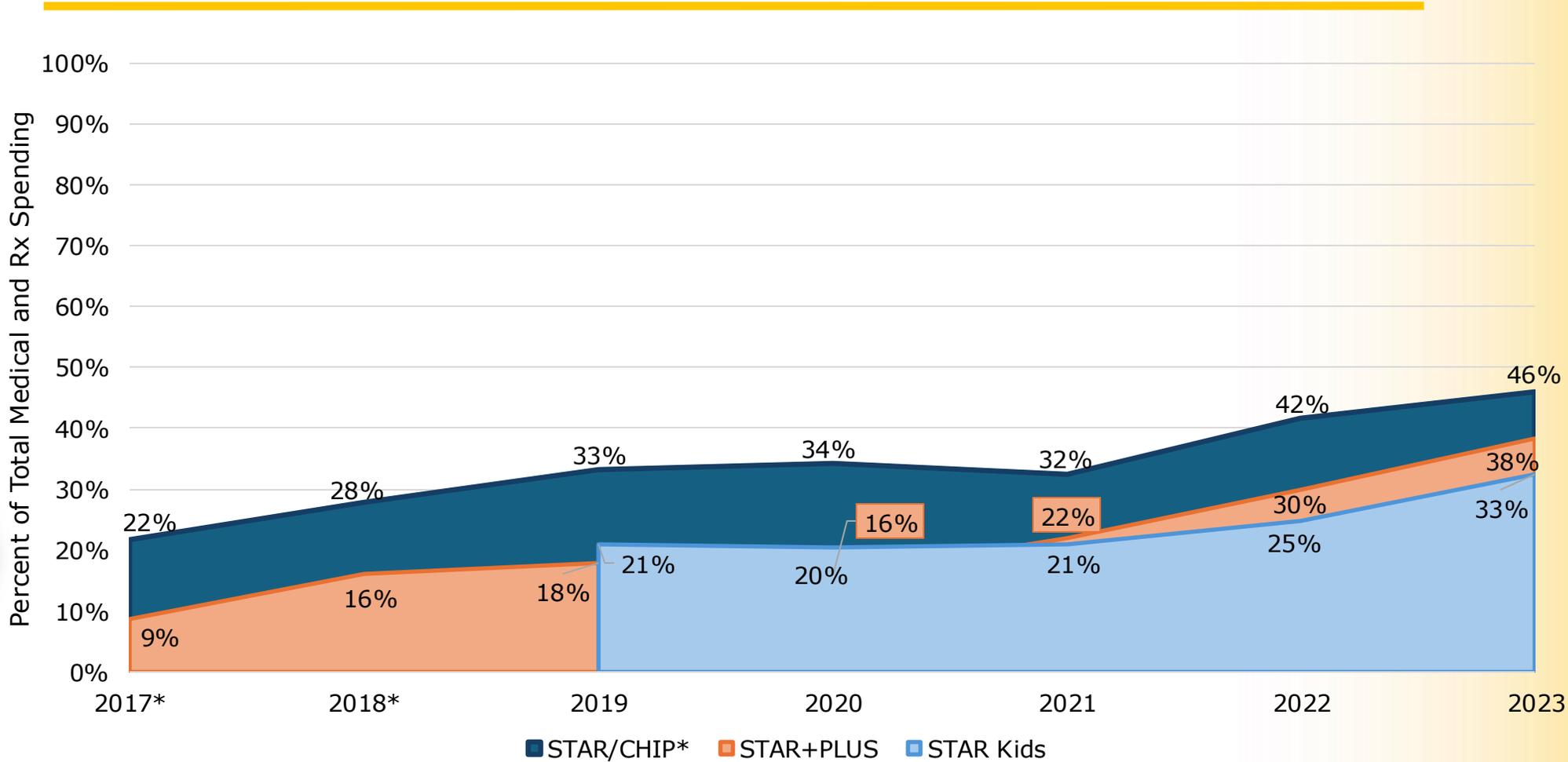
Overall State APM Payments by Managed Care Program



*Current analyses combines STAR & CHIP. CHIP data were not included for 2017 and 2018.



Risk-based State APM Payments by Managed Care Program



*Current analyses combines STAR & CHIP. CHIP data were not included for 2017 and 2018.

Phase II APM Results for Texas Medicaid

- MCOs moved 50% of payments into APMs that connect a portion of provider reimbursement to quality and efficiency metrics.
- MCOs fielded a variety of models with especially robust participation for primary care.
- MCOs paid an estimated \$130 million in APM incentives to providers in 2021.



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APM –PF Domains

The new APM-Performance Framework (PF) offers MCOs flexibility to advance value-based strategies and initiatives, while maintaining alignment with the HCP-LAN.

MCOs earn points across five APM domains:

- 1 Achievement levels
- 2 Quality Performance
- 3 APM Priorities
- 4 APM Pilots and/or Initiatives
- 5 APM Support/Provider Engagement



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Distribution of APM Payments/Incentives by Provider Type CY 2023

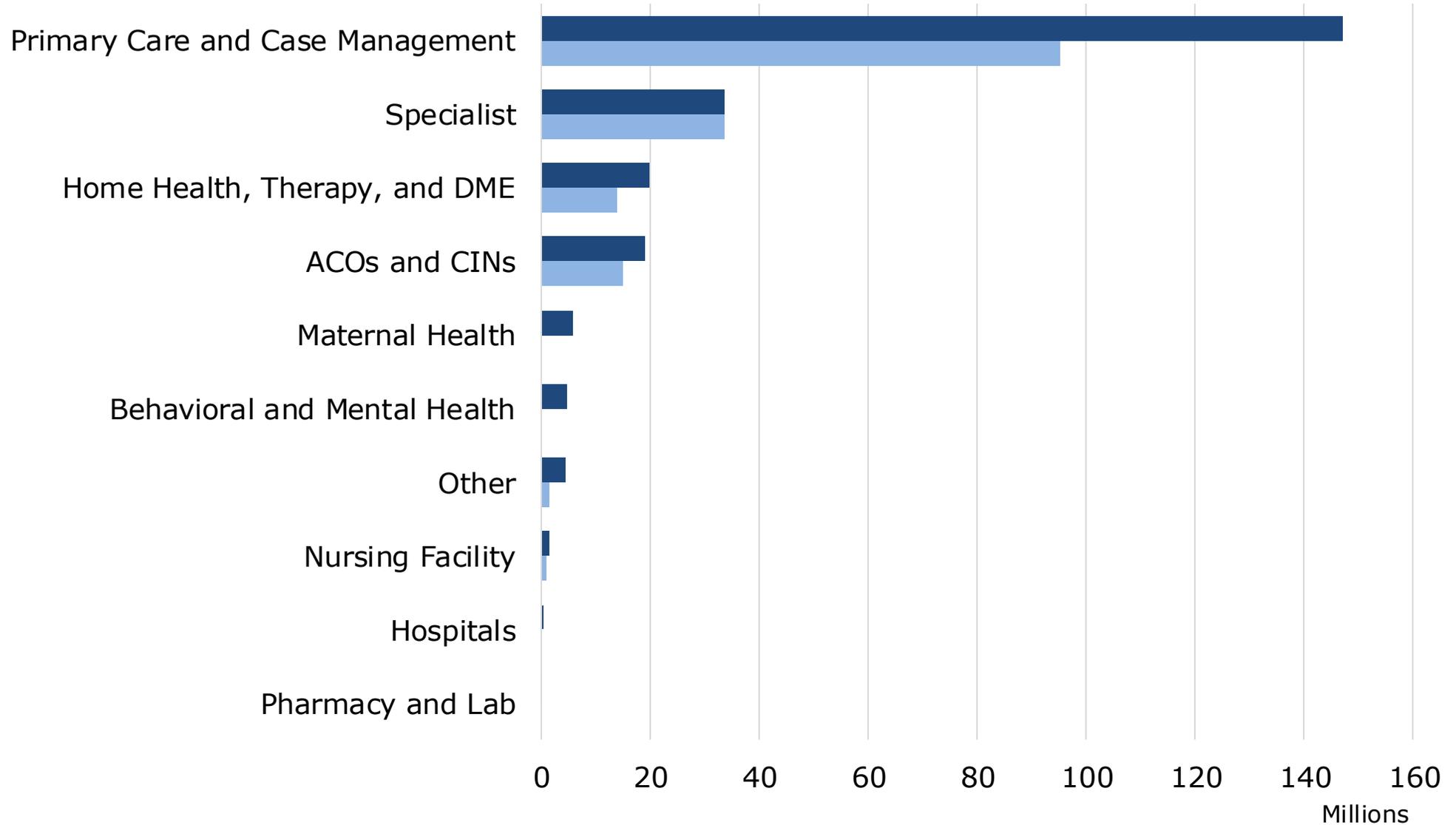
Provider Type	Total Payments	Percentage of Payments	Incentives	Percentage of Incentives
Hospitals including HQBPP	\$4,943,573,366	34%	\$462,930	0%
Primary Care and Case Management	\$3,894,333,813	27%	\$147,108,211	62%
Nursing Facility	\$1,844,963,150	13%	\$1,586,707	1%
ACOs and CINs	\$1,634,695,607	11%	\$19,036,932	8%
Pharmacy and Lab	\$756,779,319	5%	\$252,916	<1%
Home Health, Therapy, and DME	\$675,871,713	5%	\$19,767,223	8%
Behavioral and Mental Health	\$351,832,011	2%	\$4,653,723	2%
Maternal Health	\$92,880,337	1%	\$5,828,958	2%
Specialist	\$74,900,967	<1%	\$33,604,358	14%
Other	\$108,493,797	1%	\$4,506,595	2%
Total	\$14,378,324,079	100%	\$236,808,552	100%



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APM Incentive Payment Distribution: Overall vs. Risk-Based by Provider Type - CY 2023

■ Sum of Overall Incentives ■ Sum of Risk-based Incentives

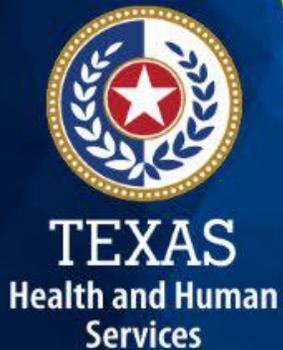


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Number of MCOs that Reported APM Priorities CY 2023

Priority Type	STAR & CHIP (16 MCOs)	STAR+PLUS (4 MCOs)	STAR Kids (9 MCOs)
Rural or Non-metro Community Based Providers*	12	3	7
APMs that Address Non-Medical Drivers of Health (NMDOH)	9	3	4
Primary and Behavioral Health Integration	11	4	7
Pharmacies and Pharmacists & Medication Therapy Management	10	3	6
Reduce Avoidable Emergency Department Visits	15	4	8

*While there are APMs that involve rural providers, there are additional APMs that serve rural members (services offered by Metro Providers).



Number APMs Reported as a Pilot by MCOs CY 2023

Priority Type	STAR & CHIP	STAR+ PLUS	STAR Kids
Maternal Care Model	2	0	*
Comprehensive Health Homes	10	6	18
Behavioral Health Evidenced Based Practice (EBP) or Workforce Development Pilot	8	4	6
Rural Health APM Pilot (Home Telemonitoring Services or Clinically Integrated Network)	8	6	7
Other Pilot(s) in Collaboration with HHSC to Test an Innovative Payment/Care Model	7	0	8
Home and Community Based Services (HCBS)	*	5	7
Transition from Pediatric to Adult Services for Individuals with Complex Medical Needs	*	2	3

*Not applicable



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APM Support/Provider Engagement

- The APM-PF includes five ways of involving and supporting providers with APMs:
 - APM Learning and Awareness with Providers
 - APM Performance Reports to Providers
 - APM Data Sharing with Providers
 - APM Strategic Plan/Roadmap and Annual Update
 - APM Evaluation



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MCO APMs with FQHCs

- A total of seven MCOs operating in 10 Service Delivery Areas reported FQHCs as an APM participant in 2023.
- FQHCs participated in both risk and non-risk models, earning at least \$7 million in incentive payments.
- MCOs report the following purposes for these APMs:
 - Support primary care and medical homes
 - Promote primary and behavioral health integration
 - Improve rural health
 - Strengthen clinical integration
 - Reduce ED visits



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Resources

[APM Data Collection Tool](#)

[NMDOH Action Plan](#)

[Texas Medicaid Quality Performance](#)

[HHSC Quality Initiatives website](#)

[Managed Care Quality Strategy](#)



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Thank you!

Jimmy.Blanton@HHS.Texas.gov

Lunch & Networking

Return at 12:15

Update from My Texas My Health Clinically Integrated Network

Steve Ramirez, MD

Chief Innovation Officer, Texas Association of
Community Health Centers



**MY TEXAS
MY HEALTH**

TACHC Clinically Integrated Network

Texas FQHCs in 2024



79 FQHCs in Texas with over 700 clinic sites in 131 counties

1.9 million patients served
7.2 million total visits



Physicians: 859
NP, PAs and CNMs: 915

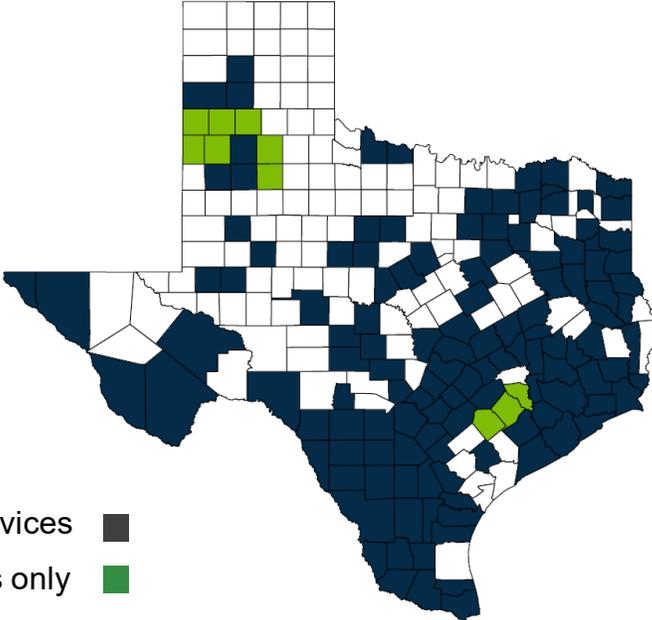


Community health workers: 150

Service Trends

Prenatal visits: **66,300**
Deliveries: **35,400**
Hypertension: **28%**
Diabetes: **20%**

Behavioral Health: **10%**
Enabling: **5%**
Virtual Visits: **11%**



Primary care services ■
Support services only ■

31% Medicaid/CHIP

584k

28% Private

513k

7% Medicare

138k

1.5% Duals

28k

34% Uninsured

129k <18yo

Our Journey and Beyond



March

VBC Readiness Assessment & Network Feasibility

October

EHF grant awarded; TACHC Board approves CIN

2022



May-October

TACHC Clinically Integrated Network (CIN) incorporated, governance established, participants join

2023



June-December

First VBC contracts finalized

2024



A Year of Building

Socializing the CIN with payers, exploring alternative payment opportunities, enhancing infrastructure.

Present

Largest health center led CIN in the country



Demonstrating Value

Focused on health center service support, education on contracts, & sharing best practices to deliver the best outcomes possible.

Network Strengths



62 Health Center CIN Participants

Tier 1

(more APM experience & readiness)

Tier 2

(emerging)

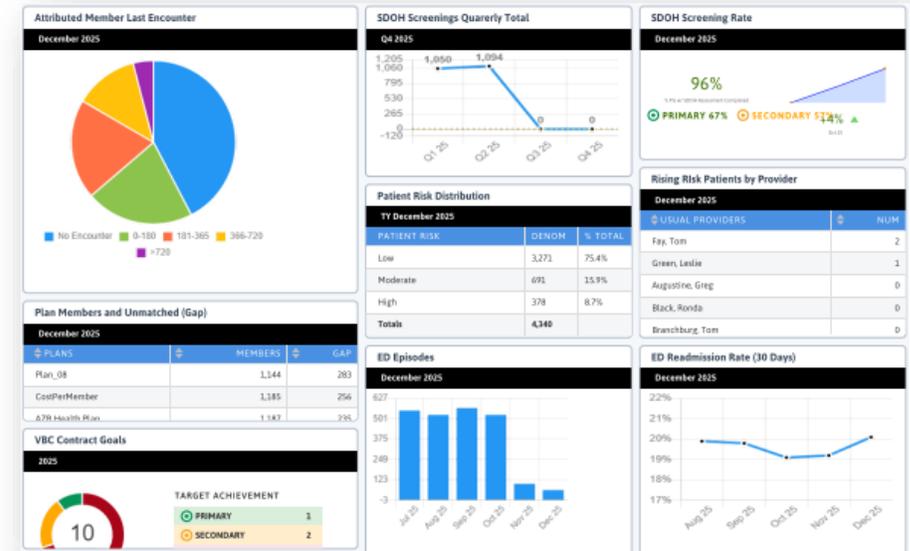
38 HCs

24 HCs



Data analytics platform for the network combines **EHR, health plan, & HIE data**

Certified vendor for supplemental data



Network Participants



62 Health Center Participants

Established as a network for all Texas health centers

- ~70% of Texas health centers participating in the network
- 80% of centers with prior value-based care experience
- Data analytics platform for the network combines health plan, HIE, and health center data



Certified vendor for supplemental data

Tier 1: 38

Tier 2: 24

Tiers indicate readiness and experience in advanced alternative payment models

VBC Contracting



Shared Savings

- Preferred glide path to share risk while building long-standing health plan partnerships

Quality Incentives

- Aligning HEDIS/STARs measures with health centers' demonstrated success in UDS outcomes

Infrastructure

- Shared investment in advancing health centers' outcomes and engagement

CMS Accountable Care Organization Participant

- Improving the care experience for Traditional Medicare beneficiaries

Contracting Priorities

- ✿ Medicaid
- ✿ Medicare Advantage
- ✿ Marketplace
- ✿ Outcomes-Based Arrangements

Strategy to Perform in VBC



Risk Adjustment

- Coding accuracy & opportunities
- Annual patient diagnosis review (& AWW)
- Accurate reporting of patient complexity & risk factors

Quality

- STARS, UDS & HEDIS CQMs
- Care coordination & follow-up
- Preventive screening gaps

Supporting Health Centers

- Implementing best practices & protocols
- Data integration
- Action planning for improvement
- 1:1 health center engagements

Cost & Care

- Care management for high risk & high-cost patients
- Transitions of care to prevent readmissions
- Preventing avoidable ED

Membership & CIN Operations

- Panel management & attribution
- Reaching assigned but unestablished patients
- HC-TACHC collaboration & roles

Questions

Contact:

Steve Ramirez, MD, MHA, FAAFP, FACHE
Chief Innovation Officer
sramirez@tachc.org

State and Federal Policy Priorities

Shelby Tracy

Chief Policy Officer, Texas Association of
Community Health Centers

Jamie Dudensing

CEO, Texas Association of Health Plans

TACHC Legislative Priorities

FQHC Incubator Program/Primary Care Access Pilot



FQHC Incubator- \$40 million

- Provides funding to FQHCs for infrastructure, expansion, and capital projects to support growth.
- Funded projects include new sites, maternal health/BH/dental expansions, new pharmacies, etc.
- The program has two funding pools through DSHS:
 - \$1 million grants for new access points (FQHCs or new entities)
 - \$650,000 grants for expansion projects

FQHC Primary Care Access Pilot

- In the 88th session, SB 2193 created the FQHC Primary Care Access Program pilot.
- Pilot program to provide uninsured working adults employed at small businesses access to primary care through a DPC-like arrangement with FQHCs.
- No appropriation yet so pilot has not been created.

State Priorities: Strengthen the Primary Care/BH Workforce

Allow Medicaid Reimbursement for Behavioral Health Associates



SB 469 (Sparks)/ HB 1716 (Darby) last session

Other strategies to support more primary care workforce

- Allows behavioral health associates (LMFT-A, LPC-A, and LMSW) to be reimbursed by Medicaid while completing their supervised clinical hours.
- Passed the House twice but not made it through the Senate.
- More than 30 states already allow this and the legislation has no fiscal note.
- Increases the pipeline of fully licensed providers serving vulnerable populations.

State/Federal Priority: Protect Affordable Drug Access
Protect 340B for Health Center Patients



Require drug manufacturers to allow the use of contract pharmacies in the 340B program

Support safety-net providers and their patients by protecting 340B

Exclude health centers from rebate models

- Health centers use 340B to purchase low-cost drugs for their patients.
- 340B allows us to offer affordable medications and reinvest savings back into patient care.
- 21 states have passed contract pharmacy bills.

Other Federal Priorities



Community Health Center Funding

- Federal grants support care for the uninsured.
- Texas FQHCs see higher uninsured than national average.
- CHC grant funding recently extended through the end of CY26 with a \$300 million increase nationally.

Coverage and Access

- Concerns about end of EPTCs and more FQHC patients selecting high-deductible plans or losing coverage.
- Make America Healthy Again opportunities
- Rural Health Transformation Program-ensuring rural FQHCs are key to state solutions

The text "Networking Activity" is centered within a green rectangular box. This box is layered on top of a larger, semi-transparent green rectangular background that extends further to the left and top. The text is white and uses a clean, sans-serif font.

Networking Activity

Networking Activity

Please introduce yourself and your organization.

Based on what you have heard today or your experience with your organization:

- What is the greatest opportunity to partner?
- What initiatives or conversations most interested you?
- What is the biggest pain point, either discussed today or from your experience, should we prioritize addressing?

Related to Alternative Payment Model Framework and discussions:

- FQHCs - what has been the biggest struggle with implementing/negotiating APMS?
- If an FQHC wants to partner with an MCO what are recommendations from MCOs? What does your MCO want to see?
- Any opportunities or thoughts about exploring primary care capitated arrangements?

Activity Discussion

Closing Remarks

Laurie Vanhooose

Principal, Treaty Oak Strategies

Shao-Chee Sim

Executive Vice President for Health Policy,
Research and Strategic Partnerships, Episcopal
Health Foundation

FQHCs and MCOs: Fostering Collaboration and Improving Healthcare Access for Texans

On February 20, 2026, the Episcopal Health Foundation, together with the Texas Association of Community Health Centers, the Texas Association of Health Plans, and the Texas Association of Community Health Plans, hosted a joint meeting and networking event bringing together representatives from Texas health plans and federally qualified health centers (FQHCs). Nearly 100 participants from FQHCs, health plans, statewide associations, and HHSC attended. The purpose of the convening was to create a space for both MCOs and FQHCs to discuss shared challenges, highlight successes, outline priorities, and explore opportunities to strengthen collaboration across their organizations.

Federally Qualified Health Centers (FQHCs) serve as essential safety-net providers offering comprehensive, high-quality primary care and mental health services to Texans, including those who are low-income or uninsured. Beyond clinical care, FQHCs support their communities by helping individuals enroll in health coverage, connecting them to resources, addressing food insecurity, and responding to other non-medical drivers of health. With 79 FQHCs operating more than 700 sites statewide, they play a critical role in expanding access to care and vital services.

Health plans in Texas also carry responsibility for ensuring access to care for their members and have launched various initiatives to address both medical and non-medical needs. Sixteen Medicaid managed care organizations (MCOs) administer the state's Medicaid program, and more than 30 health plans operate in the Medicare, commercial, and Marketplace sectors. Their ability to compete depends heavily on the quality of care and access they deliver, and HHSC both contractually and financially holds Medicaid MCOs accountable for achieving these standards.

Collaboration between MCOs and FQHCs is crucial to improving health outcomes, **expanding access, and supporting the shift from volume-based care to value-based care.** By combining the trust and community reach of FQHCs with the data and operational capabilities of MCOs, these partnerships can strengthen care coordination, preventive care, and efforts to address both medical and non-medical factors influencing health.

MCO and FQHC Convening

The convening began with remarks from the CEOs of the Texas Association of Community Health Centers and the Texas Association of Community Health Plans. Both leaders, Janet Walker and Jana Eubank, expressed appreciation for the strong turnout and emphasized the need to deepen relationships to address the pressing challenges facing the healthcare sector.

Two FQHCs—**HealthPoint and Lone Star Circle of Care**—shared overviews of their operations along with major pain points and concerns, including:

- Credentialing and contracting delays that cause care disruptions and add administrative burden.
- Unreimbursed costs for outreach, enrollment, patient navigation, education, and expanded primary care models.
- Data challenges that limit early intervention, risk management, and the achievement of value-based outcomes.

FQHC leaders also identified areas where stronger partnerships could be built, such as:

- Improving communication and care coordination.
- Increasing investments and creating more flexible primary care reimbursement models.
- Planning joint infrastructure to meet member needs effectively.

Several MCO representatives—including leaders from **Parkland Health Plan, Molina Healthcare of Texas, and UnitedHealthcare**—shared their priorities, pain points, and partnership opportunities. They acknowledged the concerns raised by FQHCs and committed to working internally to address them. All representatives agreed that better coordination is essential, especially given the value FQHCs contribute to their communities. FQHC attendees noted their appreciation for the genuine comments from Parkland’s CEO on wanting to learn more and the need to build better relationships with FQHCs and Dr. Vasquez’s (Molina) perspective since she works both for a health plan and an FQHC.

FQHC Clinically Integrated Network (CIN) and HHSC Alternative Payment Models (APM)

MCOs continue to recognize the value of developing payment models with FQHCs, though both sides understand the challenges of implementing such arrangements. Jimmy Blanton, Deputy Director of Quality and Program Improvement at HHSC’s Medicaid and

CHIP Services division, provided an overview of the MCO APM framework and shared several insights:

- **Seven MCOs across 10 service areas included FQHCs as APM participants in 2023.**
- FQHCs participated in both risk-bearing and non-risk models, earning at least \$7 million in incentive payments.
- MCOs reported that their APMs aim to:
 - Strengthen primary care and medical homes
 - Advance primary and behavioral health integration
 - Improve rural health
 - Support clinical integration
 - Reduce emergency department utilization.

These findings demonstrate there is a need to continue expanding APMs between MCOs and FQHCs.

Following lunch, **Dr. Steve Ramirez, Chief Innovation Officer at TACHC, presented on *My Texas, My Health*—the Texas FQHC clinically integrated network. The FQHC CIN plays a particularly important role in increasing APM participation across Texas.** With 62 participating health centers, it is now the largest FQHC-led CIN in the nation. Dr. Ramirez shared updates on infrastructure development supporting APM readiness, including a robust analytics platform that integrates EHR, health plan, and HIE data. He emphasized that the CIN is prepared to deepen relationships with MCOs, and the convening served as a catalyst for initiating these discussions. The group also recognized the need to work collaboratively to address non-CIN related operational challenges that can hinder progress.

State and Federal Policy Priorities

Before transitioning to breakout discussions, Shelby Tracy (TACHC) and Jamie Dudensing (CEO- TAHP) presented their organizations' policy priorities. Both groups highlighted coverage and access as key themes, noting that federal policy changes continue to affect access and the affordability of insurance and that state leaders are looking for more affordable solutions and value the role that FQHCs play in the Texas healthcare landscape.

Work Sessions and Major Findings

The convening concluded with regional work sessions designed to strengthen relationships between MCOs and FQHCs and to identify actionable next steps for continued collaboration. Key takeaways, recommendations, and next steps are summarized below.

1. Improve Communication and Ongoing Collaboration

- MCOs and FQHCs must continue building relationships and improving communication.
- Both groups need a deeper understanding of each other's operations, priorities, and challenges.
- FQHCs expressed interest in learning more about MCO pain points to better design programs that address those needs.
- Health plans need support in increasing members' understanding of available benefits. One opportunity for joint work is improving awareness and use of the Medicaid transportation benefit, which remains underutilized despite being widely recognized as a key tool for reducing access barriers.
- The discussions also revealed policy areas where the associations can partner more effectively.

Actionable Next Steps:

- TAHP, TACHP, and TACHC should continue meeting to explore collaborative efforts that improve communication and address key issues.
- FQHCs need more complete and accurate contact information for MCOs—such as who to contact for billing issues or for initiating discussions about APMs.
- FQHCs should invite MCO representatives to participate in regional meetings.
- MCOs should include FQHC representatives in their provider advisory boards.

2. Improve Data Sharing and PCP/FQHC Member Attribution

- Data limitations remain one of the largest barriers to developing successful APMs, and FQHCs are hesitant to take risk without access to real-time data from MCOs.
- More standardized and streamlined processes are needed for both entities to exchange meaningful, actionable data.
- Member attribution continues to be a major challenge; without improvements in attribution accuracy and timeliness, MCOs and FQHCs can not effectively implement APMs.

Actionable Next Step:

- Establish a joint workgroup between FQHCs, MCOs, and HHSC to address attribution challenges and build the infrastructure needed to support both CIN operations and APM development.

3. Improve Credentialing and Contracting Processes

- FQHCs continue to experience delays and complications in contracting and credentialing with some health plans, though some noted improvements since the passage of HB 3151.
- Ensuring timely credentialing is critical, as FQHCs must be able to bill for Medicaid clients and are federally required to serve all patients regardless of insurance status or ability to pay.

Actionable Next Step

- FQHCs should share real examples of credentialing and contracting issues so MCOs can identify root causes. Once identified, the groups can collaboratively develop recommendations to address them.

There was broad enthusiasm for building momentum from the convening and setting concrete goals. At the same time, participants expressed some skepticism about what would follow. To maintain trust, it will be essential for key stakeholders to continue these conversations and advance the actionable steps identified during the meeting.

Please see meeting slides for additional details.