MY TEXAS MY HEALTH

2026 OPERATIONAL STRATEGIC PLAN

Whitepaper - April 2026

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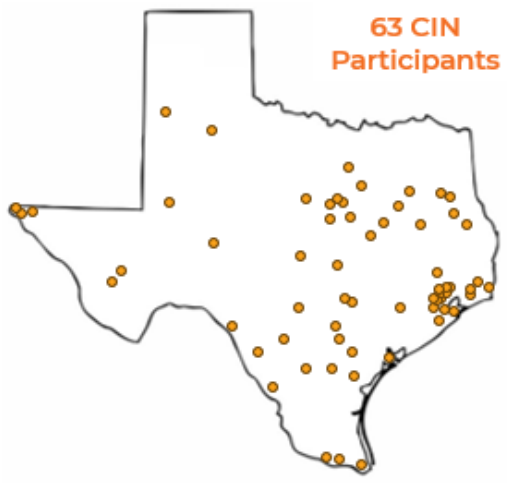
EXECUTIVE SUMMARY

Federally Qualified Health Centers (FQHCs) play a foundational role in Texas's health care ecosystem. Of the 79 health centers operating statewide, nearly 2 million Texans receive care across approximately 700 clinical sites spanning 131 counties. These centers account for more than 7.2 million patient visits annually and together form the largest primary care delivery network in the state.

Despite their scale and community impact, FQHCs face persistent and compounding challenges. Narrow operating margins, workforce shortages, fragmented data infrastructure, administrative complexity, and payer mix constraints make sustained performance increasingly difficult. At the same time, the health care system continues its rapid transition toward value-based payment (VBP) models. Participation in VBP is no longer optional for health centers - it is both a financial and strategic imperative.

My Texas My Health is a clinically integrated network (CIN) launched by the Texas Association of Community Health Centers (TACHC) in 2023 to address these challenges. As of 2026, the CIN includes 62 participating health centers, representing nearly 80 percent of all Texas health centers, making it the largest Primary Care Association-led CIN in the nation.



Through aligned incentives, shared infrastructure, and collective contracting, My Texas My Health enables FQHCs to engage in value-based arrangements at scale. The CIN supports quality improvement, strengthens financial sustainability, and ensures that shared savings and incentive dollars are reinvested directly into patient care, workforce stability, and the communities health centers serve.

This whitepaper outlines the next phase of My Texas My Health's operational strategy. The CIN will focus execution across four priority domains: **risk adjustment, quality, cost of care, and membership and operations.** Together, these domains establish a unified framework for improving performance, strengthening value-based capabilities, and positioning the CIN and its members for long-term success in increasingly complex payment environments.

BACKGROUND

VBP models, including the Medicare Shared Savings Program (MSSP) and Medicaid transformation initiatives, increasingly dominate health care financing in the United States. In Texas, Medicaid managed care organizations (MCOs) have been required since 2012 to progressively increase the proportion of payments tied to alternative payment models. By 2021, 50% of MCO payments to providers were required to be in APMs for most program types.[1]

These models emphasize sustained improvements in quality, reductions in total cost of care, and meaningful patient engagement. Unlike fee-for-service reimbursement, success under VBP depends on consistent performance over time rather than isolated or episodic outcomes. As the primary providers of preventive and primary care for Medicaid and other vulnerable populations, FQHCs are uniquely positioned to succeed in value-based care. However, success requires payment models, infrastructure, and support systems that recognize the realities of safety-net care delivery.

My Texas My Health was established to meet this need. The CIN was designed to support FQHC participation in value-based arrangements by aligning incentives, building shared infrastructure, and creating scalable strategies that allow health centers to perform collectively in a rapidly evolving payment landscape.

CURRENT STATE

Texas serves more than 4.1 million Medicaid enrollees, 97 percent of whom receive care through managed care organizations across 13 service areas.[2] With 1 in 17 Texans and 1 in 8 Medicaid/CHIP patients utilizing FQHCs for health care, FQHCs are pivotal for the success of value-based care in Texas.

While more than 90 percent of TACHC members report some experience with value-based contracts, performance outcomes vary widely across the network. Health centers differ significantly in size, staffing models, leadership experience, data maturity, and technical infrastructure. Many centers have been forced to self-fund value-based care efforts, absorbing unreimbursed costs associated with analytics, workforce investment, and care coordination while waiting months or years for shared savings payments.

As of 2026, My Texas My Health encompasses more than 1.6 million patients, approximately 67% of whom are covered by Medicaid, Medicare, or commercial insurance. Member participation currently spans a range of value-based models, including Medicare Shared Savings, Medicaid shared savings, and pay-for-quality arrangements.

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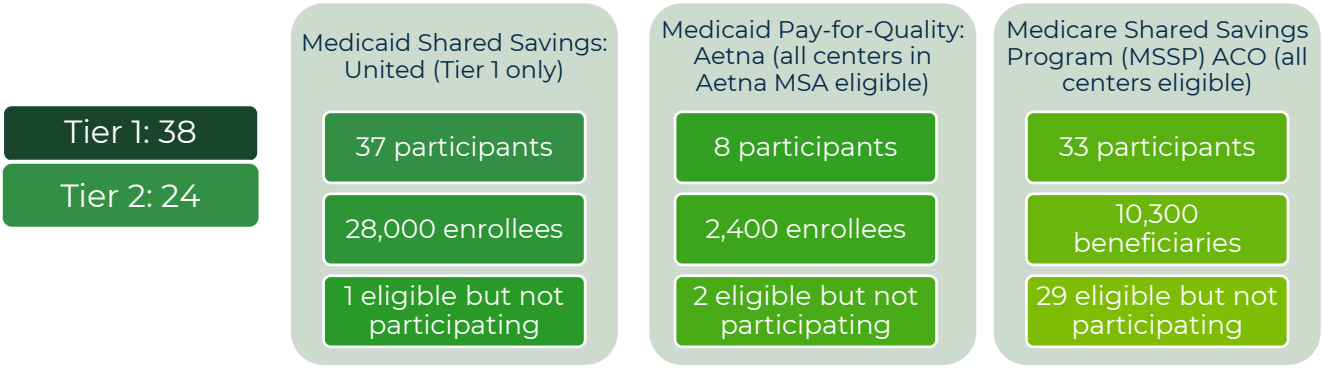
[1] https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/value-based-care

[2] EHF/JSI My Texas My Health Evaluation Report, Spring 2026

MY TEXAS MY HEALTH PARTICIPATION



CHALLENGES & OPPORTUNITIES

My Texas My Health operates within a large, diverse, and resource-constrained environment. Health centers face inconsistent access to timely and actionable data, uneven technical infrastructure across electronic medical record systems, and ongoing workforce recruitment and retention challenges. Financial instability driven by unreimbursed investments in value-based care has limited many centers' ability to scale or sustain performance improvements.

In addition, there is significant variation in operational readiness, engagement, and experience with value-based workflows. Without coordinated, network-level intervention, these challenges limit the CIN's ability to perform consistently across contracts and constrain its capacity to pursue more advanced, risk-bearing arrangements.

A health center-led clinically integrated network presents a critical opportunity to change this trajectory. By aggregating participants and performance, My Texas My Health can keep value-based incentive dollars within the safety net, improve care quality through data-driven interventions, and ensure that savings are reinvested directly into patient care and community health.

Importantly, demonstrated success in a non–Medicaid expansion state positions My Texas My Health as a national model for FQHC-led value-based care. The CIN's scale, governance structure, and focus on financial stability for health centers create a strong foundation for long-term sustainability and growth.

STRATEGIES FOR SUCCESS

As My Texas My Health enters its next phase of growth and optimization, data infrastructure remains a central strategic priority. Participating health centers operate across multiple electronic medical record systems, requiring a unified approach to data aggregation and analysis. Azara has been selected as the CIN's analytics platform to serve this function, providing near real-time insights that support transparency, accountability, and performance improvement.

As of today, 62% of Tier 1 and Tier 2 CIN members are integrated with Azara. Full integration of prioritized centers is essential, as timely and actionable data is foundational to success across all value-based domains. The CIN will continue to focus resources on accelerating integration and adoption to ensure consistent access to performance insights.

In parallel, TACHC and My Texas My Health are making targeted investments in leadership and operational capacity. These include the recruitment of a dedicated CIN Executive Director, expansion of full-time medical leadership, and the introduction of Practice Facilitators whose sole focus is to support health centers in executing value-based care strategies. The CIN is also exploring shared care management and care coordination resources to address one of the most significant barriers to generating shared savings in risk-bearing contracts.

THE PLAN

As outlined above, My Texas My Health operates within an environment that presents both significant opportunity and substantial challenge. Success in value-based care is inherently complex and requires sustained effort, discipline, and coordination across multiple stakeholders. However, because this work is a joint effort between the TACHC and the health center-led CIN, meaningful and durable financial success is well within reach.

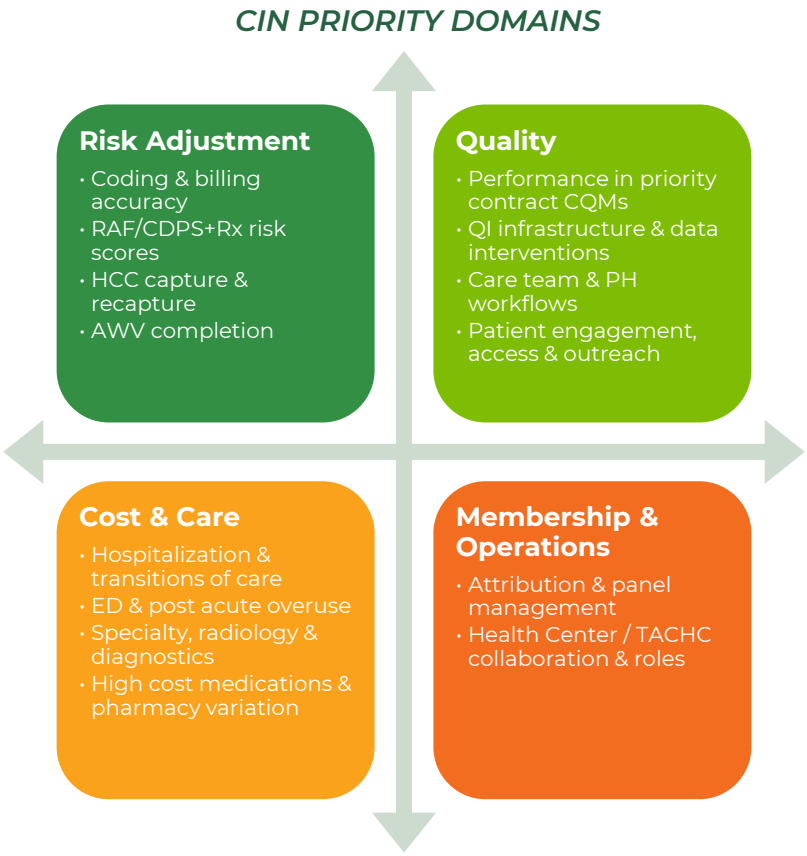
To move the CIN from opportunity to execution, My Texas My Health's next phase of work is organized around a clear and intentional framework. This framework begins with the identification of the key performance domains that will guide and measure success in value-based payment arrangements. It then clearly defines the responsibilities and commitments that TACHC and My Texas My Health will assume to support performance across the network. Finally, it establishes the expectations and accountabilities of participating health centers, recognizing that consistent engagement and ownership by CIN members is essential to achieving shared success.

DOMAIN IDENTIFICATION

To mitigate variation and drive sustained performance improvement, My Texas My Health has identified four priority domains that guide execution and measurement across value-based arrangements.

- **Risk Adjustment** focuses on accurately capturing patient disease burden through complete and specific diagnostic coding. Many health centers currently underestimate patient risk, limiting the financial resources allocated to support care delivery. Improving documentation, coding accuracy, and annual wellness visit completion is essential to ensuring appropriate reimbursement and shared savings potential.

- **Quality** performance remains a central pillar of all value-based contracts. While health centers have long-held experience reporting UDS metrics, success in payer-defined quality programs requires standardized workflows, timely data validation, and consistent performance monitoring.
- **Cost & Care** domain addresses the opportunity to reduce avoidable utilization, particularly among patients with high medical and social complexity. Through improved care coordination, transitions of care, and targeted interventions for high-risk populations, health centers have significant potential to generate shared savings.
- **Membership & Operations** encompass both attribution and operational readiness. Ensuring appropriate patient attribution, engagement, and dedicated staffing for value-based efforts is critical to executing consistently across contracts.



Below is an example of how a health center may be assessed across the CIN Priority Domains and some potential recommended actions.

Domain	Metrics	Grade	Trend	Actions
Risk Adjustment	• RAF / CDPS+Rx Score • HCC Capture / Recapture • AWV Completion	B	↑	• Provider coding champion training • AWV scheduling
Quality	• Contract CQM Primary & Secondary Goal Attainment	B	→	• Patient text outreach campaigns • Standing delegation orders
Cost & Care	• Proportion of High-Risk Patients to Membership • In-patient & Avoidable ED Rates	C	↓	• Band 4-5 scheduling • TCM & CM workflows
Membership & Operations	• Number of Attributed Lives • Health Center Engagement • Dedicated VBC Staffing	B	→	• Membership growth strategy • Provider champion identification

TACHC/MY TEXAS MY HEALTH COMMITMENT

As part of TACHC's and the CIN's role in executing the plan, a suite of resources and operational tools has been developed to meet health centers where they are in their VBC journey. These tools are designed to provide flexible, targeted support aligned with performance needs across the CIN Priority Domains.

A. Interventions by Intensity – Health centers are offered targeted interventions aligned to identified priority focus areas across the CIN Priority Domains. The level of support is tailored based on performance, readiness, and available resources. The graphic below outlines examples of low-, medium- and high-touch interventions.

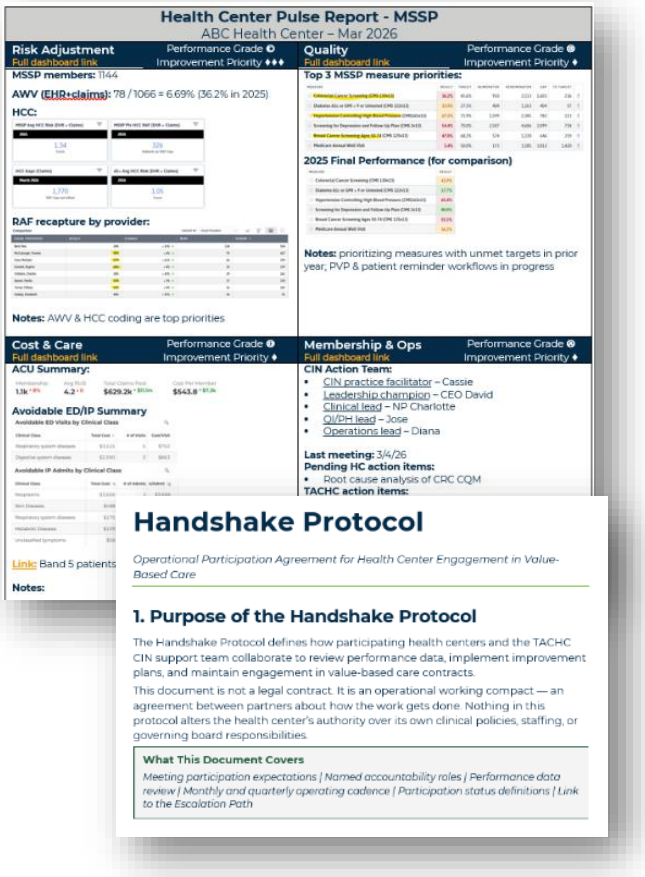
Light Touch *30 days*	Medium Touch *60 days*	High Touch *90 days*

• Data review with recommendations
• Self-paced CIN Resource Library
  ○ Toolkits & handouts
  ○ eLearning Modules
• Peer network
	• Light support, plus:
	  ○ Assessment
	  ○ Customized training
	  ○ Goals & 1:1 coaching towards achievement
		• Light, medium, plus:
		  ○ Intensive audit & corrective action support
		  ○ Peer support & accountability
		  ○ Handshake protocol levers

B. Resource Library – The CIN is developing a centralized resource library to house both synchronous and asynchronous training materials, providing on-demand access to education, toolkits, and best practices. Below is an example of the resources and topics to be addressed in the Cost & Care domain.

101 - Refresher	201 – Emerging	301 – Advanced	401 - Expert
• Basic post-discharge follow up calls • Informal TOC activity relying on discharge summaries • After hours nurse triage • Patient education on appropriate ED usage • Provider education on appropriate imaging and labs	• Standardized TOC workflow and defined rapid access appt slots • Defined high risk criteria • Care Management for high-risk patients • SDoH screening and referrals at hospital discharge • Protected same/next day access • Proactive outreach after missed appointments • Defined after hours care model • Preferred specialist and imaging directory • Standard referral templates and criteria • Clinical pharmacist support • Targeted medication adherence outreach	• Predictive readmission risk scoring • Proactive outreach to rising risk population • Embedded BH and SDoH referrals as part of TOC • Targeted outreach to frequent ED utilizers • BH crisis pathways for ED diversion • eConsults and referral utilization management	• Real-time ADT alerts triggering automated workflows • Closed-loop TOC management with documented outcomes • Predictive modeling for future ED overuse • Integrated urgent care pathways • Closed-loop referral completion and outcome tracking • Formulary and specialty pharmacy strategy • Deprescribing optimization • Diagnostic stewardship governance

C. Pulse Report – A core practice facilitation tool that summarizes health center performance across the four CIN Priority Domains using key metrics. Each Pulse Report is supported by detailed Azara dashboards and deep-dive reports, along with an accompanying action plan outlining required and recommended next steps.



D. Handshake Protocol – An operational execution document that defines roles, responsibilities, and engagement cadence between TACHC/My Texas My Health and participating health centers, ensuring clarity, accountability, and consistent execution.

E. **Practice Facilitation** – Structured, ongoing support from an assigned CIN/TACHC Practice Facilitator who assesses health center performance across the four CIN Priority Domains and recommends targeted actions to drive improvement.

F. **Care Management & Care Coordination** – A critical set of services supporting health center performance in the cost and care domain. These services address care coordination and utilization management needs that are often difficult for individual health centers to staff given current funding constraints.

HEALTH CENTER COMMITMENT

As a condition of CIN participation, health centers commit to the following responsibilities to support effective execution of VBC activities.

- **Value-Based Care (VBC) Action Team** – Each health center will identify and dedicate two to three staff members to serve as its VBC Action Team. This team will act as the primary point of engagement with the CIN and will participate in training, performance review, and ongoing population health management activities.
- **Health Center Touchpoints** – To ensure consistent communication, performance review, and training support, health centers will participate in regular touchpoints with the CIN. This includes monthly clinical operations meetings with the VBC Action Team and quarterly strategic meetings with health center leadership to review contract performance, discuss progress, and identify opportunities or challenges.

During the transition to the enhanced CIN strategy, each health center in the initial cohort will participate in an introductory onboarding meeting. A key outcome of this process will be the formal identification of the VBC Action Team. Team composition should align with team-based care models and support ongoing engagement in monthly touchpoints.

Provider Champion Role – The first required member of the VBC Action Team is a provider champion, such as a physician or advanced practice clinician. This individual will be trained across all four CIN Priority Domains, including risk adjustment and coding, AWVs, quality performance, and dashboard utilization. Provider champions are expected to serve as resident experts within their organization and support peer education and adoption of value-based workflows. To offset potential productivity impacts, the CIN will recommend adjustments to the provider's schedule to prioritize enhanced revenue generating visit types such as AWVs, telehealth visits, and transitions of care visits.

Supportive VBC Team Roles – A second recommended member of the VBC Action Team may include a medical assistant, care coordinator, or community health worker who will receive training on quality metrics, dashboard utilization, patient population identification, and engagement strategies. An optional third team member may be an RN or LVN to support care management and care coordination activities focused on high-risk or high-utilization patients. Depending on staffing availability and attribution levels, this role may be deferred and addressed through future CIN-led care management models, as outlined in the Future State and Timeline (2027).

In alignment with the Handshake Protocol, an annual virtual engagement cadence will be established to include monthly clinical operations meetings with the VBC Action Team and quarterly strategic meetings with health center leadership. Health centers will also receive targeted training and support interventions for identified staff as performance needs arise. The figure below describes the proposed annual cadence.

Touchpoints & Engagement	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Monthly VBC Ops Meeting with VBC Action Team	•	•		•	•		•	•		•	•	
Training / Support Interventions with Identified Staff	•		•	•			•			•	•	
Quarterly Strategic Meeting (QSMs) with Leadership			•			•			•			•
Semi-Annual Performance Summary to CIN Board				•						•		

NEXT STEPS

To operationalize the enhanced CIN strategy, 10 health centers will be selected to participate in an inaugural cohort for targeted practice facilitation. Selection for this initial cohort will be informed by attributed membership size, cost of care associated with attributed populations, and prior engagement patterns with TACHC.

Once selected, each health center in the initial cohort will be assessed and “graded” across the four CIN Priority Domains. This assessment will establish a clear baseline of performance, identify strengths and gaps in core value-based capabilities, and inform the development of targeted intervention strategies. Focusing on the Priority Domains allows the CIN not only to evaluate performance consistently across participants, but also to tailor support in ways that align with each health center’s specific needs and readiness.

During this initial phase, each participating health center will be assigned a CIN staff member serving as a dedicated Practice Facilitator. The Practice Facilitator will establish working relationships with designated health center staff, conduct a structured assessment of workflows and performance, and collaborate with the health center to identify specific training and intervention recommendations. These

recommendations will be designed to enhance performance, strengthen operational readiness, and position health centers for sustained success in current and future VBP arrangements.

FUTURE STATE

As practice facilitation expands and at least 50% of CIN health centers have received structured support, the CIN will transition to a more differentiated performance framework. At that point, health centers will be grouped into performance pools based on their VBC maturity and demonstrated ability (or potential) to perform across the CIN Priority Domains. These pools will allow similarly performing health centers to advance together, support peer learning, and more effectively pursue enhanced contracting opportunities, including models that incorporate upside risk.

This approach recognizes an important reality of network-based value-based care: while many health centers are progressing and demonstrating strong engagement, a small number of disengaged or underperforming participants can disproportionately affect aggregate CIN performance. The development of performance pools creates a mechanism to protect overall network performance while still supporting continuous improvement across all participants.

To move the CIN toward more financially meaningful opportunities, the network must ultimately transition beyond quality-only incentives and into models that include shared financial risk. At present, the CIN's incentives are primarily tied to quality performance. If the CIN were to assume cost-based risk today, overall performance would likely be negatively impacted, as most health centers have not yet developed the infrastructure, workflows, or tools required to consistently monitor and manage cost of care. Practice facilitation, combined with scalable care management and care coordination resources, represents the primary pathway to closing this gap and achieving the level of performance necessary for sustained shared savings across the CIN.

Finally, many existing value-based contracts are not designed with large, health center–led clinically integrated networks in mind. By leveraging the scale and collective strength of My Texas My Health, the CIN will work with payers to establish realistic financial and performance benchmarks that reflect the unique realities of health center care delivery. This includes consideration of Prospective Payment System (PPS) reimbursement, historical coding practices, workforce constraints, and the significant influence of social and non-medical drivers of health. Unlike private equity-backed arrangements that often provide upfront resources with repayment expectations, the CIN's approach emphasizes sustainable capacity-building, risk alignment, and long-term financial viability for participating health centers.

TIMELINE

TACHC will initiate the CIN enhanced improvement strategy in Q2 2026, launching targeted practice facilitation with ten prioritized health centers. During this initial implementation period, tools, intervention menus, communication pathways, and documentation structures will be actively refined and optimized to support consistent execution and scalability.

Following the 2026 startup period, the strategies, processes, and operational levers piloted with the initial cohort will be expanded to all health centers participating in the CIN. Newly participating health centers will formalize engagement through execution of the Handshake Protocol as part of their onboarding process and will complete the New Participant Road Map within 90 days of joining the CIN.

The timeline below outlines the key milestones and objectives that will guide CIN implementation and growth over the next three years.