MCO-Hospital/Clinic Leadership Forum

Co-Sponsored by Episcopal Health Foundation and TORCH

EPISCOPAL HEALTH FOUNDATION

TORCH

Texas Organization of Rural & Community Hospitals

TORCH/TARHC Fall Conference – 8/25/2026

Where the money comes from — and where it lands

$50B

Rural Health Transformation Program

OBBBA §71401 · $10B/yr, FY2026–FY2030. Half split equally among approved states; half by CMS workload + technical score. No state match required.

$281M

Texas, year one — largest award of any state

Awarded Dec 29, 2025. Texas anticipates ~$1.4B over the full five years, distributed as subawards to providers rather than kept at the state.

202

of Texas' 254 counties are rural and eligible

Roughly 1 in 10 Texans. In 2024, one in five rural Texas counties had no licensed primary care physician.

Six initiatives — three award contracts straight to rural providers (1, 4 & 6)

1 Make Rural Texans Healthy Again

Chronic disease + wellness. Six pathways: wellness centers, transport, food access, remote monitoring, after-hours clinics, dual-eligible enrollment.

2 Rural Texas Patients in the Driver's Seat

Competitive RFP · CINs, ACOs, cooperatives

Consumer-facing health technology and patient engagement tools.

3 Lone Star Advanced AI and Telehealth

Competitive RFP · CINs, ACOs, cooperatives

AI-enabled telehealth and remote monitoring to close service gaps.

4 The Next Generation of the Small Town Doctor and Team

Recruitment, scholarships, relocation, training. At least one award per rural county.

5 Unified Care Infrastructure and Rural Cyber Protection

RFO · state-listed security vendors

Cybersecurity and shared care infrastructure, procured through DIR-listed MSSPs.

6 Infrastructure and Capital Improvement for Rural Texas

Equipment and facility upgrades: hospitals, clinics, behavioral health, IDD programs, EMS, pharmacies, substance abuse programs, public health offices, ECI programs

Sources: AMA summary of OBBBA §71401; CMS award announcement, Dec 29, 2025; Texas HHSC / DSHS RHTP program update, Feb 11, 2026; Office of the Governor releases (Initiatives 1, 4, 6); The Texan.

IMPLEMENTATION · WHAT WE EXPECT TO GET HARD

Once the money is awarded, the hard part starts!

1 Cost reimbursement meets thin cash reserves

Reimbursement-based awards require grantees to spend first and collect later. Many rural hospitals and clinics operate on weeks of cash on hand, not months. A funded project can stall — or quietly not start — because the organization cannot float the outlay. This is the single clearest threat to continuity and sustainability of funded work.

2 A rushed application window produced concepts, not plans

Three initiatives released within weeks, all due in 4-6 weeks. Applicants provided what they could in the time available. Partners, staffing models, workflows, vendor selection and measurement plans remain incomplete.

3 Technical assistance is not a nice-to-have

Grantees need help with project management, reporting and data infrastructure, vendor diligence, and designing for value. TA is an allowable use of funds. Meanwhile for-profit vendors have moved aggressively on rural hospitals, which raises real questions about where dollars land.

4 Performance is re-scored every year

CMS reviews state progress and sets the following year's funding on that basis. The discretionary half of the program can be redistributed. Texas' year-two and year-three dollars are not guaranteed by year one — slow implementation carries a funding consequence, not just a delivery one.

"To begin with the end in mind means to start with a clear understanding of your destination."

Stephen R. Covey from "The 7 Habits of Highly Effective People"

Sources: HHSC Initiative 4 and Initiative 6 request-for-application postings; KFF Health News reporting on RHTP implementation timelines; Texas Medical Association. Cash-flow and application-timeframe concerns reflect field experience with grantees.

Initiative 1: Make Rural Texans Healthy Again

Eligible applicants: Texas Rural Hospitals · Project period Sept 1, 2026 – Sept 30, 2031 · Target conditions: diabetes and obesity (primary focus), cardiovascular and chronic respiratory disease

$280M	$3.5M	$181M	$7.5M	No
total available, Part 1	maximum per grantee	total available, Part 2	maximum per grantee	match required

Approved project types — implement one or more

- Community wellness center — chronic disease screenings, gym equipment, group exercise, nutrition classes
- Pop-up grocery markets with regional grocers, farmers markets or food pantries; healthy cooking demonstrations
- After-hours primary care clinic to reduce non-emergent emergency department visits
- Low- or no-cost chronic disease screenings and primary care visits
- Non-emergent transportation to pharmacies, grocery stores and care appointments
- Active remote monitoring systems for high-acuity patients
- Technology at community partner sites so dual-eligible individuals can research and enroll in coverage
- Other strategies expanding access to healthy food, prescriptions and health-related items

Minor renovations qualify — interior walls, lighting, HVAC, accessibility, security. Construction, building expansion and cosmetic upgrades are not allowable.

Outcome measures and pay for performance

HHSC tracks two outcomes

- Diabetes-related emergency department visits (county level)
- Adults completing diabetes education (non-metro statewide)

Targets against baseline

- Year 4 (CY2028): ED visits −1% vs. CY2024; diabetes education +1% vs. CY2022
- Year 5 (CY2029): an additional −2.5% and +2.5% — −3.5% and +3.5% cumulative

Service Delivery targets (numbers can vary based on applicant)

- XXX unique individuals — obesity intervention services
- XXX unique individuals — diabetes management or intervention services

Pay for performance — Years 4 and 5 only

- All measures met → 100% of that period's pay-for-performance funds
- 50% of measures met → 50% of that period's pay-for-performance funds
- None met → 0%

Measured with DSHS data: TxS2 syndromic surveillance (ED visits) and the Behavioral Risk Factor Surveillance System (obesity, diabetes education).

Award flow Year 1 · Year 3 (cost reimbursement) → Years 4 and 5 (pay for performance)

Now What? Sustaining the Plan After 2031

Grant funds stop September 30, 2031 — and the RFA bars any sustainability plan that assumes new state general revenue or federal dollars.

Questions to answer well before 2031

- **Whose budget line is this on October 1, 2031?** Name the owner and the department now, not in Year 5.
- **What is the annual run-rate once grant dollars stop?** Staffing, space, transportation, equipment refresh.
- **Which pieces pay for themselves — and which are permanently subsidized?** Fund the first; decide early what happens to the second.
- **Fewer ED visits and better-controlled diabetes, obesity and other chronic conditions save money — but for whom?** If the savings land with payers, can we capture a share through MCO value-based arrangements, chronic care and remote monitoring billing, or shared-savings terms?
- **Does the district need a tax-rate conversation?** If so, when does that vote have to happen to matter?
- **Which partnerships outlive the grant?** Schools, food retailers, EMS, county, employers, philanthropy.
- **What do we sunset if nothing replaces the grant?** Decide the floor while the money is still flowing.

Year 1
Sustainability plan is required

Year 3
Mid-point read on cost versus benefit

Years 4–5
Board chooses the post-2031 funding source

Sept 30, 2031
Grant ends; unobligated funds revert

2032–2033
Post-grant reporting to HHSC continues

How Medicaid Managed Care Works

- Managed care works just like insurance—every month, HHSC pays a health care premium to the MCO for each person they cover (PMPM, per member per month)
- HHSC actuaries set the premium every year based on historical claims and the rates are certified by an independent actuary and by CMS
- MCOs are **obligated to pay for all medically necessary services**, even if it means the rates they receive from HHSC will not fully cover their costs
- MCOs take on **full financial risk**—if in any given year a plan incurs losses, that plan absorbs those losses
- **Texas caps profits** and requires health plans to **share savings** back to the state
- Texas also **caps administrative spending**

Payment Strategies

- Covered benefit
- Medically necessary
- Eligible member
- Eligible provider
- Eligible location
- When it is not currently covered MCOs can explore coverage through pilots, quality improvement, value-added services and other mechanisms
- Bottom line – must be able to show ROI
- Important to identify what is reimbursable for future sustainability conversations

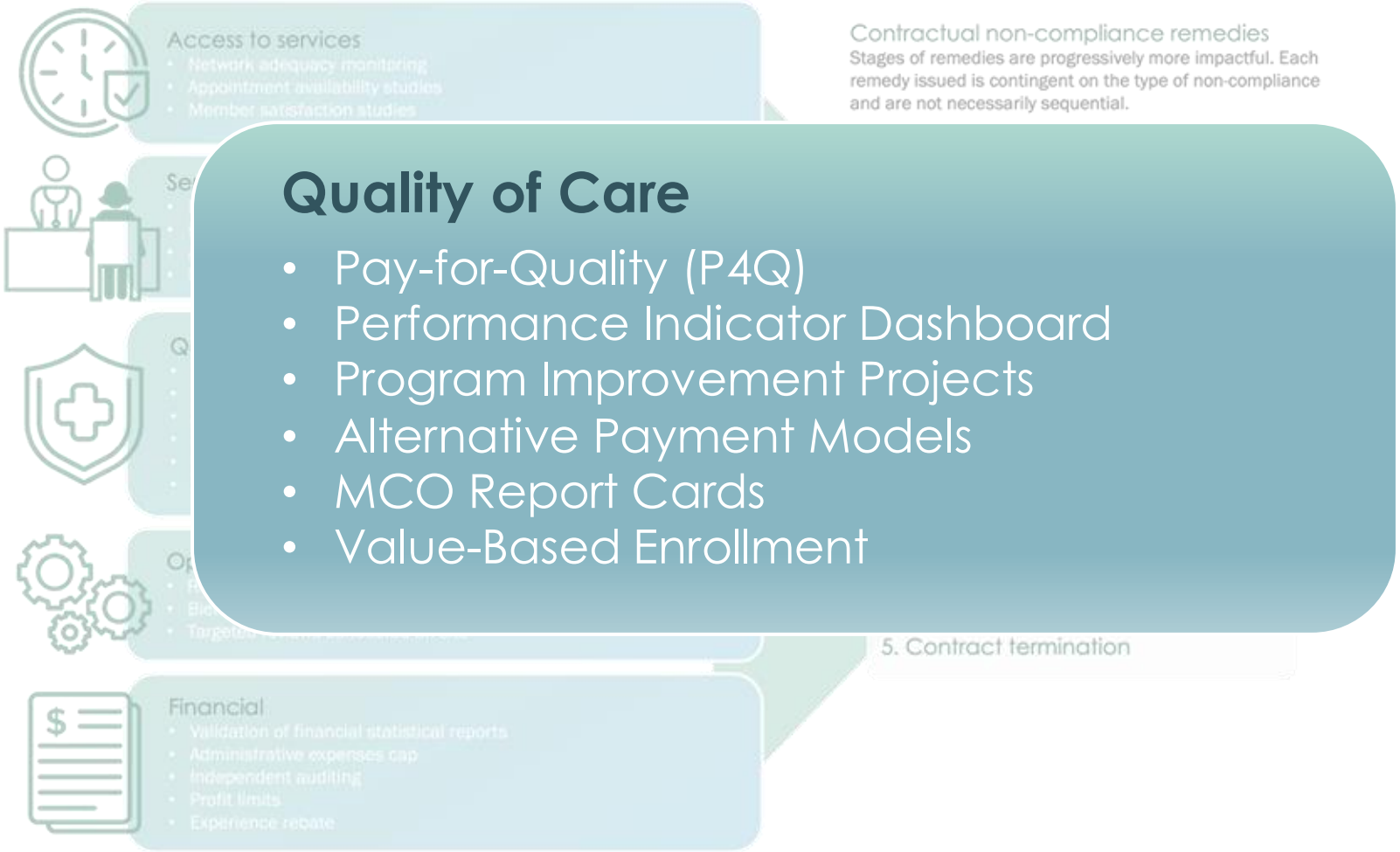
HHSC Medicaid Managed Care Quality Strategy

Icon	Goal
	Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address the root causes of poor health.
	Strengthening person and family engagement as partners in their care to enhance respect for individuals' values, preferences, and expressed needs.
	Providing the right care in the right place at the right time to ensure people can easily navigate the healthcare system to receive timely services in the least intensive or restrictive setting appropriate.
	Keeping patients free from harm by building a safer healthcare system that limits human error.
	Promoting effective practices for people with chronic, complex, and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs.
	Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services, and supports providers to participate in team-based, collaborative, and coordinated care.

Medicaid Quality & Performance Measures

- **HEDIS** Measures
- **Pediatric and Prevention Quality Indicators** monitor hospital admissions that might have been avoided through high-quality outpatient care and appropriate follow-up care after discharge
- **CAHPS Surveys** collect standardized information on client experiences
- **Potentially Preventable Events** identify services that might have been avoided with higher quality and greater access to care
- **Potentially Preventable Emergency Room Visits** identify patterns and may suggest areas where primary care services should be improved
- **Cost Efficiency –** Medical cost and administrative costs

Quality of care



APM Performance Framework Domains

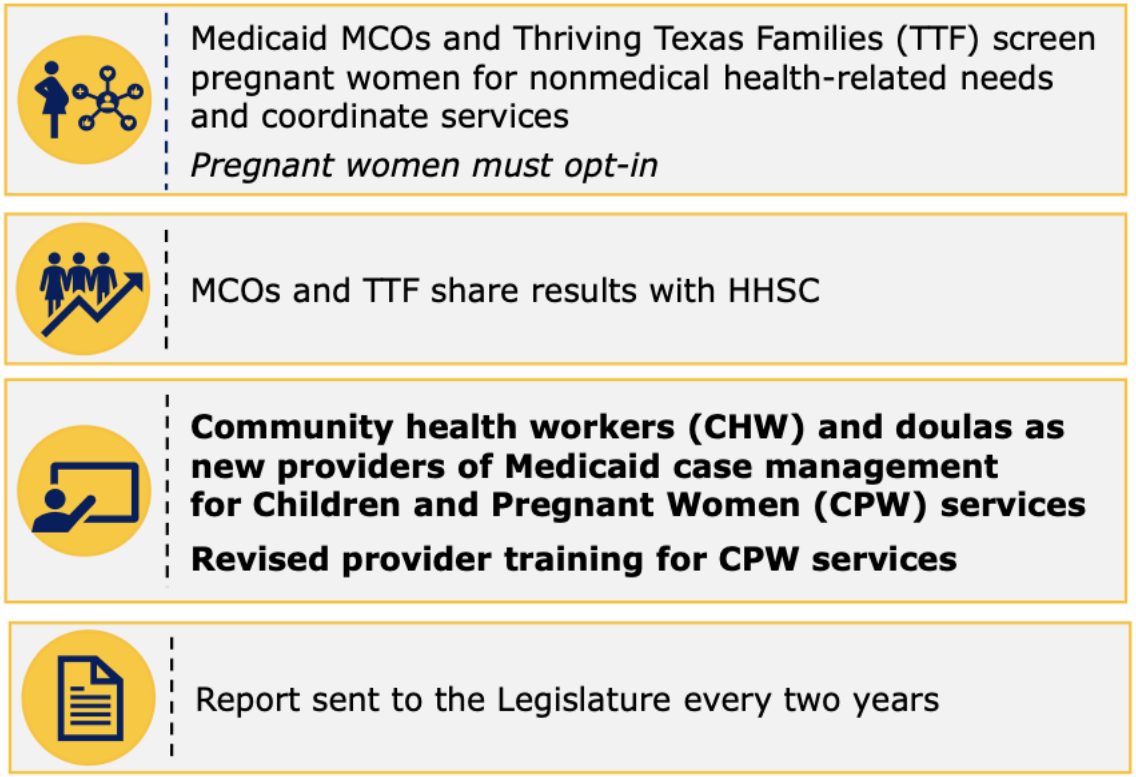
- Flexibility for MCOs to advance value-based strategies and initiatives, while maintaining alignment with the HCP-LAN
- APM Performance Frameworks for STAR/CHIP, STAR+PLUS, and STAR Kids programs
- MCOs earn points across five APM Domains over four years:
    - Achievement levels
    - Quality Performance
    1. APM Priorities
    2. APM Pilots/Initiatives
    3. APM Support
    4.
    5.

APM-PF Domain Three

- **APM Priorities**
  - Rural or Non-metro providers
  - Non-Medical Drivers of Health (NMDOH)
  - Primary and Behavioral Health Integration
  - Medication Therapy Management
  - Reduce Preventable Emergency Department Visits

HB 1575 (88th Legislature) – Screening and Case Management for Pregnant Women & Children

HB 1575 Summary



HB 26 (89th Legislature) – In-Lieu of Nutrition Support Services

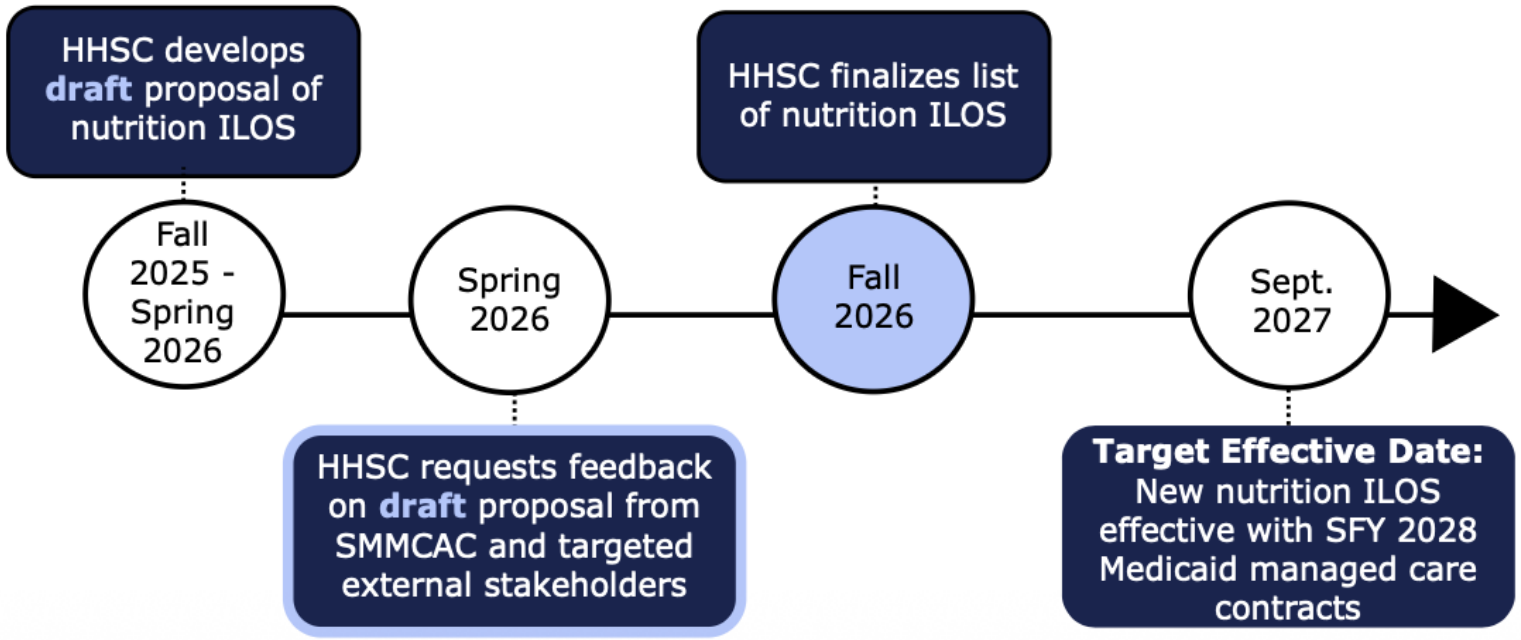
HB 26 Summary (89th TX Leg.)

- Requires HHSC to permit Medicaid managed care organizations (MCOs) to offer medically appropriate, cost-effective, evidence-based **nutrition counseling and instruction services** in lieu of services specified in the Medicaid state plan.

- Allows HHSC to establish a pilot that permits MCOs to offer the following in lieu of services (ILOS) to pregnant women with high-risk pregnancies through August 31, 2030:
  - **nutrition counseling and instruction services,**
  - **medically tailored meals**, in combination with nutrition counseling and instruction services,
  - **other evidence-based nutrition support services.**

- Requires HHSC to submit to the Texas Legislature:
  - annual report on all Medicaid ILOS,
  - one-time report on pilot ILOS.

ILOS Nutrition Support Services



Diabetes Prevention Programs

- MAHA movement focused on preventing disease
- Tie between diabetes and dementia – Dementia Prevention & Research Institute of Texas
- HHSC 2026-2027 Budget includes a budget rider directing HHSC to study the feasibility of Medicaid covering the Diabetes Prevention Program (DPP)

Medicare

- Payors are rated on measures including preventive screening, chronic disease management (diabetes, cardiovascular kidney health), medication adherence
- Medicare currently covers **Diabetes Prevention Programs**
- Medicare covers **CHW services -** through a specific pathway (Community Health Integration, CHI)
- **Value-Based Payment** arrangements
  - Shared savings/risks tied to total cost of care
  - Global or partial capitation
  - Quality withholds/bonuses
  - Increasing use of specialty/episode-based VBP

Other Priorities

- Improving maternal health
- Infrastructure
- Interoperability
- Telehealth
- What else?