Health and Human Services

Medicaid Advisory Committee

February 12, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

Medicaid Advisory Committee formerly known as the Medical Care Advisory Committee, is federally mandated to review and make recommendations to the state Medicaid director on proposed rules that involve Medicaid policy or affect Medicaid-funded programs.

HHSC has established a Beneficiary Advisory Council (BAC) as required by CFR § 431.12 and operates as a standing subcommittee of the MAC. As outlined in 42 CFR 431.12(f)(1) BAC members are not required to include their names in a BAC membership list and meeting minutes.

Members:

Doug Svien, MAC Chair
Provider
Mary Helen Tieken, RN, BSN, MAC Vice Chair
Registered Nurse
Salil Deshpande, M.D.
Managed Care Organization Representative
Lou Driver
Nursing Home Administrator
Lisa Wright
Community Health Choice
President/CEO
Robert Hilliard, Jr., M.D.
Physician, Ob/Gyn
Sandy Crisp
LPC Private Practice
Licensed Professional Mental Health Therapist
Donna S. Smith
Physical Therapist
Christina Paz
Centro San Vicente
Doctor of Nurse Practice/NP-CEO
Joseph Modesto
Dream Therapy Center
President and CEO
Carol Daulton
Texas Health Resources
Senior Director Supplemental Payment Program

1. Call to order, opening remarks, introductions, and roll call. The meeting was convened by Doug Svien, MAC Chair. A quorum was present.

2. Consideration of November 13, 2025, draft meeting minutes.
The minutes were approved as drafted.

3. Medicaid and Children's Health Insurance Program (CHIP) activities update.

Provider enrollment: about 50,000 providers experienced delays in re-validating after COVID. The PEAMs (Provider Enrollment) system is under renovation after the legislature provided funding to improve the system through TMHP. There are four steps in the process:

- Provider feedback
- Root cause analysis
- Process by process redesign
- Rebuilding the system
- Rollout of new system in 2027

Improvements are being made on the existing system while the new system is being developed. Flexibility has been provided for provider re-validation. Office of Inspector General is engaged in the effort. Through May 31st of this year, a 180 day extension is available to providers.

Discussion.
Do you have a sense of how many providers that may have fallen through and not re-validated? HHSC stated that there could be more than 10% but they are still enrolled because the flexibilities have been allowed.

Program Integrity (Reducing fraud, waste and abuse) has been listed as an interim charge and HHSC is actively looking at this. The OIG has been engaged in getting the word out regarding identifying fraud waste and abuse. The OIG is involved on the front end when developing a new service. Data that looks weird is sent to the OIG. Background checks on providers are done, and electronic visit verification helps confirm the legitimacy of service provided

Discussion.

Are there site visits? HHSC answered in the affirmative.

The activities are not new; how do you see the current expectations changing? HHSC stated that policy reviews are being conducted as well as the ongoing utilization review. The Governor's letter has some specifications and HHSC will get more information for the Committee.

Will recommendations from HHSC be considered when looking at the program integrity? HHSC stated that HHSC input is considered related to data anomalies.

4. One Big Beautiful Bill Act (OBBBA) (Public Law No. 119-21; Effective 07/04/2025) update (Impact to Medicaid and CHIP)

Summary. Clare Middleton and Hilary Davis presented impacts of the federal HR1/"One Big Beautiful Bill Act" on Medicaid and CHIP. HR1 delayed implementation of several CMS eligibility rules; delayed use of Social Security data for MSP application and family size rules. There were changes to immigration eligibility for Medicaid/CHIP effective Oct 2026, limiting eligible statuses. In addition, there were:

- Shortened prior coverage from 3 to 2 months for Medicaid starting Jan 2027; CHIP option requires legislative direction.
- Repeal of federal nursing facility staffing ratios; reporting requirements remain.
- New address and death record verification requirements codified.
- Limits placed on state-directed payment programs capping at 110% Medicare rates by 2028; Texas process for phased reduction.
- Section 1115 waiver budget neutrality impact unclear, awaiting CMS clarification.
- Strategic opportunities: $10B for rural health (2026–2030), new HCBS waiver option, discussed need for legislative direction for new waivers.

Committee Q&A included data requests on provider revalidations, eligibility impacts, new waiver potential, and impact of marketplace subsidy expiration.

Presentation

Four Categories of Changes

Policy & Eligibility Changes

Federal Requirement Summary	Effective Date
Delay of Medicare Savings Program Rule	
Delays new Medicare Savings Programs (MSP) eligibility and enrollment rules - includes expanded family size for eligibility and using Low-Income Subsidy (LIS) data as an application.	October 1, 2034
Delay of Certain Medicaid and CHIP Eligibility & Enrollment Rules	
Delays some provisions of the streamlined Medicaid and CHIP rules. Provisions in the rule include items such as: Predictable expense projections for Medically Needy; Aligning renewal requirements for Modified Adjusted Gross Income (MAGI) and non-MAGI groups; Timeliness standards; Returned mail handling.	Varies Based on Effective Date
Change to Immigration Criteria for Medicaid & CHIP	
Limits eligibility to lawful permanent residents, certain Cuban or Haitian immigrants, and persons admitted under Compacts of Free Association (COFA).	October 1, 2026
Change to Coverage Periods	
Reduces prior-month Medicaid coverage from three to two months. Adds a state option to provide a two-month prior coverage period for CHIP.	January 1, 2027
Delay of Federal Nursing Facility Minimum Staffing Ratios	
Delays enforcement of the federal minimum staffing ratios for nursing facilities, this has now been fully repealed so will never be implemented. Compensation reporting for direct care and support staff still applies.	October 1, 2034
Medicaid Work Requirements	
Requires states to implement work or community engagement requirements for certain adults. *Note: Work requirements do not apply to Texas Medicaid.*	January 1, 2027 *Notify individuals by October 1, 2026*

The Compacts of Free Association and Living in the United States

As provided for under the Compacts of Free Association, referred to as the Compact or
Federated States of Micronesia (FSM), the Republic of the Marshall Islands (RMI), and th
admitted to the United States and its territories and possessions as nonimmigrants to
establish residence for duration of stay. The FSM, the RMI, and Palau are referred to co
(FAS).

On March 9, 2024, H.R. 4366 or the 2024 Consolidated Appropriations Act which includ
Amendments Act of 2024 was signed by President Biden and became Public Law 118-4
Compact and updating federal programs services for another twenty years. Find the fu

Find links to guidance and fact sheets from the U.S. Citizenship and Immigration Servic
Administration (SSA), and other agencies to support citizens from the FSM, RMI, and Pa
to school in the United States per the Compacts of Free Association.

The Compacts of Free Association and Living in the United States | U.S. Department of the Interior

Systems & Operations Integrity

Federal Requirement Summary	Effective Date
Address Updates & Duplicate Participation Checks	
States must obtain updated addresses from USPS, National Change of Address (NCOA), and Managed Care Organizations (MCOs).	January 1, 2027
States must submit Social Security Numbers (SSNs) and other identifiers monthly to CMS for duplicate participation checks. The Public Assistance Reporting Information System (PARIS) will no longer be required.	October 1, 2029
Deceased Individual & Provider Verification	
Recipients: Quarterly Social Security Administration (SSA) Death Master File (DMF) check.	January 1, 2027
Providers: Death Master File (DMF) check before and during enrollment.	January 1, 2028
Payment Reduction for Erroneous Excess Payments	
Expands the definition of "erroneous excess payment," to include payments where insufficient information is available to confirm eligibility and puts new limits on the amounts of penalties the Secretary may waive through good faith effort.	October 1, 2029

Finance & Payment Provisions

Federal Requirement Summary	Effective Date
Limits on State Directed Payments	
Cap at 110% of Medicare for non-expansion states.	Immediately
10% reduction for grandfathered programs.	January 1, 2028
Section 1115 Waiver Budget Neutrality	
New or renewed Section 1115 waivers must be certified budget-neutral by the CMS Chief Actuary.	January 1, 2027

Strategic Opportunities

Federal Requirement Summary	Effective Date
Rural Health Transformation Program	
$10 billion per year for federal fiscal years 2026–2030. 10% may be used for administration.	Award to States Announced December 29, 2025
New Waiver	
States may create new Home and Community-Based Services (HCBS) waiver for individuals not meeting institutional level of care.	July 1, 2028

Discussion.

New Waiver. Will HHSC be exploring this? HHSC stated the waiver allows states to have an HCBS waiver not based in institutional level of care. They will be looking to the legislature for direction.

On directed payment programs, have we projected impact? HHSC stated they could present on this in the future.

Regarding eligibility check and death master files (DMF) , what impact do we expect? HHSC stated we currently use the bureau of statistics. With the use of the new DMF, we don't assume there is going to be any major change.

Market place subsidies. Do we know how many people will now be eligible for Medicaid? HHSC stated they do not have data on this.

Item 5 was moved to the end of the agenda

6. Progress update on Senate Bill (S.B.) 989, 88th Texas Legislature, Regular Session, 2023, relating to Medicaid coverage of biomarker testing

Summary. Sarah Gonzaga presented on SB 989: Medicaid biomarker testing coverage. Implementation began Sep 2024 with addition of nine new biomarker testing codes. They used an expedited process for benefit additions via topic nomination; new PLA codes will be considered on a case-by-case basis.

The next round of tests (including kidney transplant rejection monitoring) are under review. The process target is to reduce implementation time from 18–24 to 12–18 months. Public comment from Myriad Genetics advocated for coverage of GeneSight Psychotropic and HHSC invited resubmission of updated evidence.

Presentation

Initial Implementation (Phase I) – September 1, 2024 Texas Medicaid adds coverage for nine new biomarker testing procedure codes.

- Several single-gene tests not previously covered
- Whole genome sequencing (WGS)
- Expanded carrier screening (ECS)

Genetic Services policy, provider procedure manual, and related materials were updated to add general biomarker coverage language directly from the bill.

Ongoing Implementation Plans and Activities (Phase II) – October 1, 2025 New Genetic Testing policy has been created establishing general overarching policy language for genetic testing benefits. The policy captures existing genetic testing benefits currently listed only in the Texas Medicaid fee schedule without existing benefit language and serves as a general location for future genetic testing benefit language that may not require an independent policy.

An expedited request and evaluation process was rolled out that leverages HHSC's existing topic nomination process outlined on the Medicaid Medical and Dental Policies | Texas Health and Human Services webpage. Modifications are intended to streamline coverage decisions and implementation timelines to more effectively maintain the coverage required by S.B. 989.

Biomarker Codes are targeted for May 1, 2026iImplementation. Texas Medicaid will add coverage for 11 new biomarker testing procedure codes.

Cancer biomarker tests

- FoundationOne Liquid (0239U) and Solid (0037U)
- Breast Cancer Index (81518)
- ClonoSeq (0364U)

Transplant rejection tests

- AlloSure Heart Care (81595 and 0540U)
- Prospera Heart (0493U)

Enhanced Liver Fibrosis (81517) and Whole Exome Sequencing (81415, 81416, and 81417)

Discussion.

Expediting the process is appreciated. Please comment on the other markers being pursued. HHSC stated kidney rejection monitoring could be one.

There is a growing evidence base for supporting these tests. We should make them efficiently available.

7. Update on Medicaid and CHIP eligibility and enrollment trends

Summary

- 10-year caseload trends reviewed for Medicaid and CHIP (kids, perinatal).
- Medicaid caseloads declined until COVID and then surged during the emergency due to suspended disenrollments. They are now declining again subsequent to the unwinding.
- CHIP caseloads declined during the pandemic (fewer Medicaid-to-CHIP transfers) but are now recovering.
- STAR Plus/Kids declines are driven by SSI determinations from the federal side; policy changes (e.g., neglect definitions) impacted STAR Health numbers.
- No significant differences by region have been observed, but committee requested data by service area for potential provider outreach.
- Future Medicaid growth is expected to align with Texas population growth; recent in-migration has not been seen impacting Medicaid

Presentation

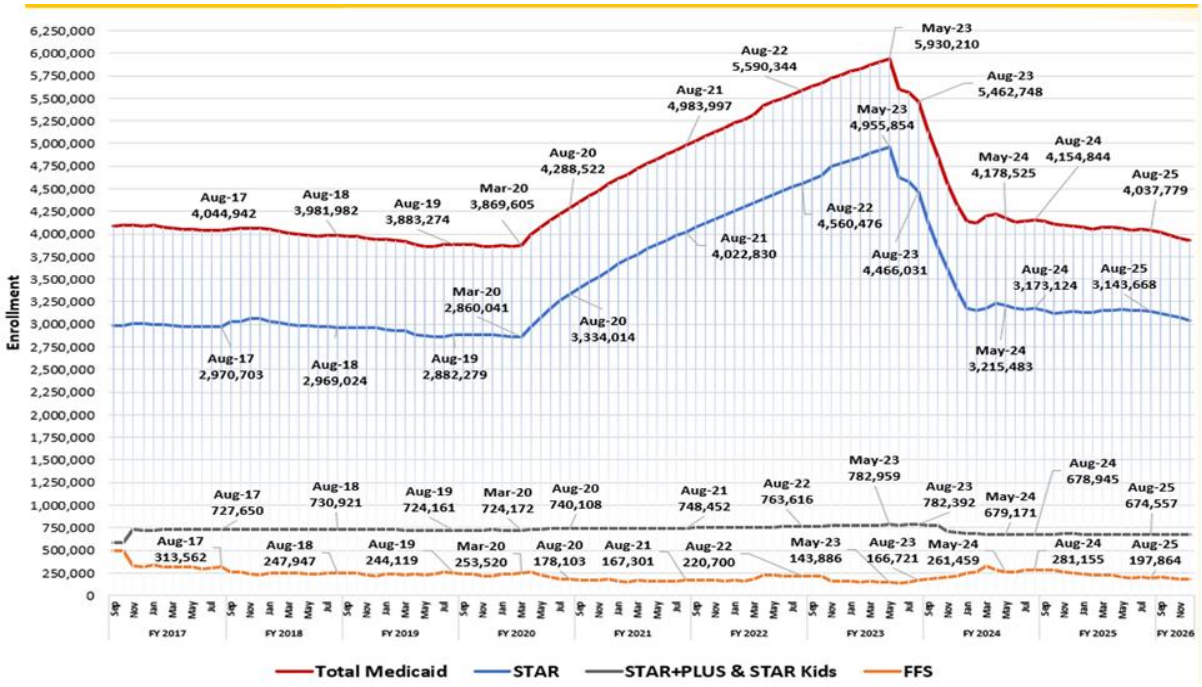
Medicaid Full-Benefit and CHIP Caseload

	FY 2017-2026 YTD Average Monthly Caseload by Medicaid Program & CHIP								
	STAR	STAR+PLUS	STAR Kids	STAR Health	FFS	Total Medicaid	CHIP (Traditional)	Perinatal	Total CHIP
FY 2017	2,986,241	567,281	136,033	32,091	345,734	4,067,380	390,625	34,458	425,082
FY 2018	3,010,752	568,946	162,646	33,752	245,590	4,021,686	410,419	32,696	443,115
FY 2019	2,916,688	566,905	159,585	33,263	238,571	3,915,011	377,421	30,856	408,277
FY 2020	2,996,918	570,249	159,764	33,092	224,944	3,984,967	340,731	28,670	369,401
FY 2021	3,732,953	573,072	169,057	42,143	165,594	4,682,819	238,849	25,916	264,765
FY 2022	4,320,314	586,326	169,339	45,268	190,129	5,311,376	98,971	27,716	126,687
FY 2023	4,740,474	606,938	169,954	47,034	163,240	5,727,639	53,605	26,997	80,602
FY 2024	3,368,635	553,740	147,607	25,777	250,050	4,345,808	138,495	26,314	164,810
FY 2025 Est	3,144,325	538,035	137,809	21,284	233,235	4,074,687	169,747	27,148	196,895
FY 2026 YTD	3,082,299	536,561	136,717	22,280	190,408	3,968,265	174,380	24,528	198,907

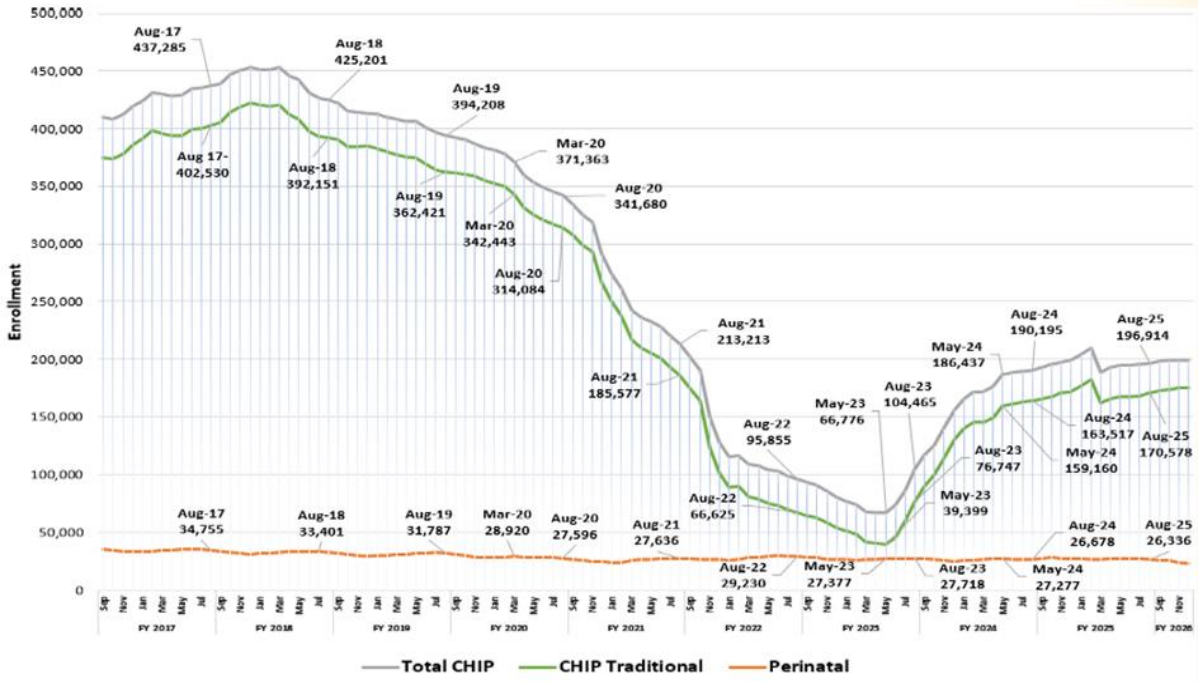
Data as of January 2026, FY 2025 is estimated based on incomplete data and FY2026 is based on year-to-date data from September to December.

STAR+PLUS includes Dual Demo. Total CHIP includes CHIP Perinatal. FY2020-2024 figures are impacted by federal Covid PHE policy impacts.

Medicaid Full-Benefit Caseload



Total CHIP Caseload



1604 SAN ANTONIO, AUSTIN, TEXAS 78701 TEL: 512-944-8994 WWW.TXINSIGHT.COM

Discussion

How do you see the state budget impacting Medicaid going forward. HHSC stated they see a stabilization in the growth. When they look longer term, that is the assumption they will make, aligning the projections with population growth. External economic factors are harder to accommodate.

How do you see percentage of Medicaid growth given the population moving into Texas? HHSC stated that low income population growth trends tend to be a little higher, but the growth has slowed down.

The Comptroller has stated there are 1,500 new people coming into Texas daily. HHSC stated they are not seeing impact.

Looking at the absolute numbers, what is going on with STAR Plus and STAR Kids and STAR Health. STAR Plus and STAR Kids. HHSC stated that this is driven by SSI eligibility . STAR Health is driven by policy changes like the change in definition of neglect and what qualifies.

Are you seeing declines more in different areas? HHSC stated they have data at service delivery area. The pattern of decline appears to be evident across the state.

8. 89th Texas Legislature, Regular Session, 2025, Medicaid and CHIP updates

House Bill (H.B.) 136 relating to Medicaid coverage and reimbursement for lactation consultation services

As directed by H.B. 136, lactation consultation services will be added as a covered benefit of Texas Medicaid. The following will be needed to implement:

- New provider type
- Agency rule amendments
- Medicaid state plan amendment
- New medical policy

Policy update requirements and timeline:

- Stakeholder engagement – providers, advocates, Managed Care Organizations (MCOs)
- Updates to the Texas Medicaid and Healthcare Partnership (TMHP) claims system and Provider Enrollment and Management system
- Updates to the Breastfeeding Support Services Handbook in the Texas Medicaid Provider Procedures Manual

Discussion.

Is a particular licensure required for this provider type? HHSC stated that there will be a certification requirement but no licensure. The certification will be required for reimbursement.

H.B. 426 relating to Medicaid and CHIP coverage and reimbursement for cranial remolding orthosis for children

Updates to Texas Medicaid coverage include:

- Add plagiocephaly and brachycephaly as covered diagnoses for children meeting certain criteria defined in the bill. Requires the addition of CHIP coverage
- Benefit must be equivalent to Medicaid. Target implementation: September 1, 2026

Next Steps:

- Spring 2026 – Post updated CRO medical benefit policy for public comment.
- July 2026 – Post 45-day provider and MCO notice
- September 1, 2026
    - Medical policy updates in effect
    - CHIP managed care contract amendments in effect

H.B. 3940 relating to Medicaid benefits in relating to enrollment procedures for newborns and sharing of information

Use of Mother's Medicaid ID HHSC must notify Providers and Managed Care Organizations (MCOs) annually that the mother's Medicaid ID may be accepted on any claim for reimbursement until a separate ID has been assigned for the newborn.

Updated Educational Materials Hospitals, birthing centers, physicians, and midwives must provide new or expectant mothers with updated educational pamphlets that include:

- Newborn Medicaid benefits
- Eligibility requirements
- Application process
- How to report a birth for enrollment

New Written Notice Providers must distribute a new written notice stating:

- Newborns are automatically eligible for Medicaid, and
- The mother's Medicaid ID may be used for billing purposes until a separate Medicaid ID has been assigned for the newborn.

Providers must document distribution and retain records for five years.

Published on the Health Publications DSHS Maternal & Child webpage Maternal and Child Health Publications | Texas DSHS – December 1, 2025

- Resource pamphlet and parent guide (English & Spanish)
- New written notice for parents (English & Spanish)

9. Update on the Rural Health Transformation Program (OBBBA; Public Law No. 119-21 (07/04/2025), Chapter 4, Sec. 71401)

Summary. Staff Presented on the Rural Texas Strong Program and $281.3 million CMS award for the first budget period; there is a potential for ~$1.4B over five years depending on state performance.

Funding expenses must be sustainable and long-lasting, focusing on prevention, workforce, tech, infrastructure, behavioral health, and collaboration.
Restrictions include limits on construction, provider payments, EMR, and workforce funding stipulations. HHSC is waiting on final CMS approval and will update the program website as guidance is received. There are six major initiatives proposed:

- Community-based wellness programs
- Consumer-facing health tech
- AI/telehealth solutions

- Provider recruitment/retention
- Cybersecurity/unified infrastructure
- Equipment/capital improvement

Stakeholders are encouraged to sign up for updates; hiring for program staff ongoing.

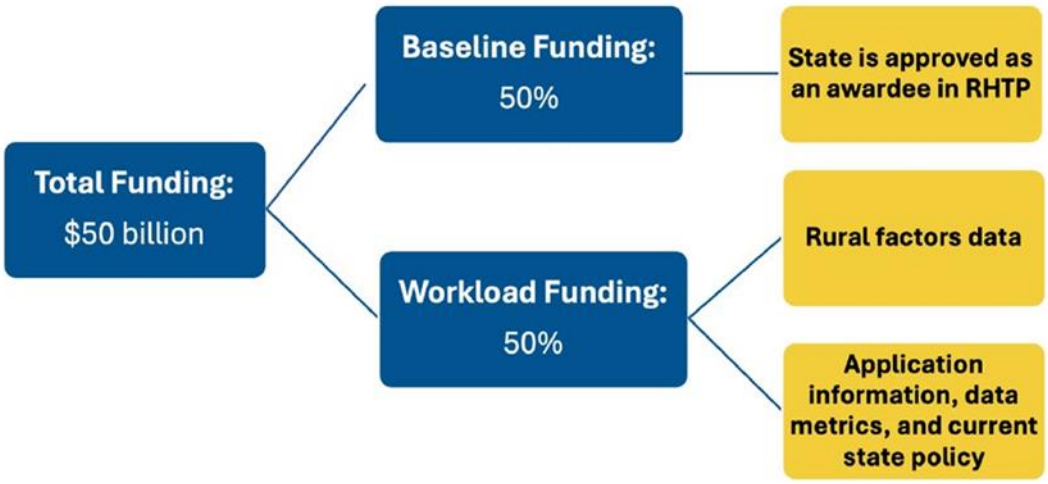
Questions addressed regarding fund spend-down periods, performance affecting future awards, inclusion of various hospital types, and cyber procurement details. The Committee discussed potentially increasing meeting frequency or extending meeting time but was cautioned about procurement-related conflicts of interest for applicants as well as quorum and logistic issues. HHSC legal and procurement teams will draft guidance to help committee members avoid conflicts.

Presentation

Stevens Amendment: Texas' Rural Health Transformation Program, Rural Texas Strong, is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $281,319,361 in budget period 1 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Disclaimer: At this time, HHSC is not meeting with potential vendors or applicants so that we can maintain fairness for all interested participants and protect future procurements related to the federal Rural Health Transformation (RHT) Program. Actual eligible participants, including the definitions that will be used to evaluate eligibility, and a final determination of who is eligible will be a contracting and procurement function. Procurement details will be finalized as we work through the approval processes for our project design with CMS and then ultimately the internal procurement and contracting processes. We are unable to discuss or answer questions related to procurement and eligibility information. Please see the "How to Stay in Touch" slide for additional information on how to sign up for updates as they are released.

RHT Program Funding Distribution



Use of Funds

1. Prevention and chronic disease: Promoting evidence-based, measurable interventions
2. Provider payments: Payments to health care providers for the provision of health care items or services.
3. Consumer tech solutions: Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic diseases.
4. Training and technical assistance: Providing training and TA to improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies.
5. Workforce: Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for a minimum of 5 years.
6. IT advances: Providing technical assistance, software, and hardware.
7. Appropriate care availability: Assisting rural communities to right size their health care delivery systems.
8. Behavioral health: Supporting access to opioid use disorder treatment services, other substance use disorder treatment services, and mental health services.
9. Innovative care: Support innovative models of care that include value-based care arrangements and alternative payment models.
10. Capital expenditures and infrastructure: Investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades.

11. Fostering collaboration: Initiating, fostering, and strengthening local and regional strategic partnerships between rural facilities and other health care providers

**Note: Additional details on the use of funds can be found in the CMS Notice of Funding Opportunity*.

Funding Limitations and Unallowable Costs

- New construction is unallowable. Minor renovations or alterations are allowed if clearly linked to program goals; funding cannot exceed 20% of the total funding CMS awards States in budget period.
- Limits on using funding for EMR systems. No more than 5% of total funding CMS awards to a state in budget period.
- Purchase of covered telecommunications and video surveillance equipment for households.
- Limits on provider payments. Cannot use funds to replace payment for clinical services that could be reimbursed by insurance.
- Clinician salaries or wage supports for facilities that subject clinicians to non-compete contractual limitations.

**Note: This is not an exhaustive list of restrictions. Additional details can be found in the CMS Notice of Funding Opportunity and on the CMS RHT website.*

Rural Texas Strong Update

- HHSC submitted its Rural Texas Strong application for the RHT Program to CMS on November 3, 2025. The submitted application and other materials are posted to HHSC's Rural Health Transformation Program website. Rural Health Transformation Program | Provider Finance Department
- CMS requested additional budget information in December, before announcing awards on December 29, 2025.
- Texas was awarded $281.3 million for budget period 1 of the program. An approximate $1.4 billion over five years. All future funding figures are estimates as CMS has not issued final budget awards for the remaining budget years of the program.
- HHSC must provide an updated budget to CMS since every state was required to draft an application using a hypothetical $200 million per year. Revisions were due to CMS on January 30, 2026.

- CMS will take up to 30 days to review the updated information, ask questions, and provide additional guidance on the terms and conditions of the award.

Initiative 1 Make Rural Texans Healthy Again

- **Eligibility**: Rural hospital districts.
- **Procurement process**: Direct awards.
- **Description:** Funding will be used to enhance or create community-based prevention, wellness and nutrition programs, or services aimed at improving chronic disease conditions (diabetes, cardiovascular disease, chronic respiratory disease or obesity).

Table 1: Implementation Options

Community wellness center (exercise, nutrition classes, etc.)	Non-emergent transportation support to improve access to pharmacies (to improve medication adherence), grocery stores, and primary or preventive healthcare appointments
Grocery stores, farmer's markets, or local food pantries to increase access to fresh U.S.-grown produce, dairy, and meat (Funds cannot be spent on meals themselves, per CMS)	Active remote monitoring for high acuity patients
After-hours primary care clinic to reduce non-emergent emergency department visits	Support and technology for enrolling individuals who are dually eligible for Medicare and Medicaid in care plans that include local behavioral and preventative care providers
Low or no-cost chronic disease screenings (prevention) and low or no-cost primary care visits	Other strategies, as approved by HHSC

Initiative 2 Rural Texas Patients in the Driver's Seat

- **Eligibility**: Two or more clinically integrated networks, accountable care organizations, or similar cooperatives supporting hospitals, clinics/physicians, and behavioral health providers
- **Procurement Process:** Request for Proposal, Competitive Procurement.
- **Description**: Funds will be used for patient portal creation, health information exchange (HIE) compatibility and advancement, and other consumer-facing-facing health technology equipment and applications.

Initiative 3 Lone Star Advanced AI and Telehealth

- **Eligibility**: Two or more clinically integrated networks, accountable care organizations or similar cooperatives.

- **Procurement Process**: Request for Proposal, Competitive Procurement.
- **Description**: Fund HIE and electronic medical record compatible artificial intelligence tools, including ambient listening, to improve patient record keeping, correct coding, and streamline medical administrative costs; support creation and establishment of telehealth networks for specialty and behavioral health services.

Initiative 4. The Next Generation of the Small Town Doctor and Team

- **Eligibility**: Rural health care providers, with at least one award per rural county.
- **Procurement Process**: Request for application.
- **Description:** Funding will support locally driven efforts with a focus on at least one of four approaches, described on the next slide.

Locally driven efforts will focus on at least one of four approaches:

1. Developing career paths for local high school students.
2. Providing scholarships for recent high school graduates.
3. Offering relocation or signing bonuses for early, mid, or late career professionals.
4. Creating a new residency training program, fellowship or combination program, including partnering with academic institutions or an existing teaching hospital.

Initiative 5. Unified Care Infrastructure and Rural Cyber Protection

- **Eligibility**: Vendors listed as a Managed Security Services Provider with the Texas Department of Information Resources.
- **Procurement Process:** Request for offer.
- **Description**: Funding will be used to establish a unified care infrastructure and bolster cybersecurity defenses across rural providers. By deploying a managed security solution
    - — including endpoint detection and response; comprehensive, all-time security operations center monitoring, and comprehensive user training
    - — risk can be significantly reduced, ensuring the security of sensitive patient data, and enhancing the overall security of an organization

Initiative 6. Infrastructure and Capital Improvement for Rural Texas

- **Eligibility**: Rural hospitals, rural health clinics, behavioral health providers, opioid and substance abuse programs, emergency medical services (EMS), pharmacies, public health offices and other eligible providers.
- **Procurement Process**: Request for Application.

- **Description**: Provide funding for providers to add and replace the equipment they need to improve patient care, within the required limitations on new construction and remodel projects.

The HHSC Rural Health Transformation Program website has been established and will be updated with new opportunities and information about the program.

New email: RuralTexasStrong@HHS.Texas.gov . . Rural Health Transformation Program | Provider Finance Department

HHSC is actively working on hiring a new dedicated team, with postings available online at Jobs at HHS
Jobs at HHS | Texas Health and Human Services

Stakeholders, applicants, and vendors are encouraged to sign up for the new Rural Texas Strong Gov Delivery , where HHSC will issue public notices and announce procurement opportunities. Texas Health and Human Services Commission

Procurement opportunities will also be posted to the Electronic State Business Daily website. ESBD Solicitations

Discussion

As a mayor, I never got information about this during the pandemic. HHSC stated that the notice was sent out through the dot Gov website.

There was a condensed timeframe. With respect to the 6 initiative areas? Will those be the same over the five year period and will year one determine the implementation. HHSC stated this is a one-time application per CMS. These are the initiatives approved by CMS.

Will HHSC have only one procurement over the initiatives? HHSC stated that they have different procurements per the type of vendor and the website provides more information.

What is the timeframe for the initiative? HHSC stated that updates will be made to the website and these are still in development.

10. Hospital Payment Advisory Committee (HPAC) update

1. HPAC Officer election
a) Vice-Chair, Kathleen Sweeney
b) Chair, Michael Nunez

2. Rural Hospital Advisory Committee (RHAC) February 3, 2026 meeting recap

a) OBBBA Rural Health Transformation Program Status update

b) FY 2024 / 2025 Grant Updates, House Bill1, Regular Session, 2023, Rider 88

c) Rural Health Stabilization and Innovation Act, House Bill 18, 89th Legislature, 2025 Update

3. Comprehensive Hospital Increase Program (CHIRP)

a) September and October Managed Care Organization (MCO) capitation payments (September / October/ November and December revenue capitation payments were paid to Managed Care Organizations in December 2025).

b) Re-adjudication timeline for September and October 2025 (MCO's have until early February 2026, to re-adjudicate Medicaid claims with dates of service back to September 1, 2025).

c) Intergovernmental Transfer (IGT) refund process for 2023 recoupments (SFY 2023 IGT refunds are being worked on).

d) One Big Beautiful Act (OBBBA) Medicare Average Commercial Rate (ACR) to Medicare Equivalency definition update (HHSC is working through the OBBBA language and seeking guidance as to 110% of Medicare calculation, as the annual 10% reduction from Average Commercial Rate (ACR) which will begin in 2028).

e) Preprint submission timeline for SFY 2027. (Preprint submission to CMS is anticipated for early May 2026).

4. Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA)

a) State Fiscal year 2025 final payment schedule date and percentage (Final payment to MCOs was made in October 2025. The MCO's have twenty days to make payment to providers).

b) State Fiscal year 2026 payment timeline

- 20% payment in January 2026
- 20% payment in April 2026
- 60% payment in October 2026

5. Aligning Technology by Linking Interoperable Systems (ATLIS) program year 2026 update

a) Per HHSC Commissioner Young, the SFY 2026 ATLIS program is not active. With new HHSC Commissioner, they will be looking for new opportunities.

6. Disproportionate Share Hospitals (DSH) / Uncompensated Care (UC)

a) 2026 Medicaid DSH reduction updates

- Recent update. The House of Representatives just passed the Reconciliation Bill and is being sent to President Trump for signature.
- HHSC will continue to make interim based on current law in effect.
- Any changes from the House Reconciliation Bill will be planned for June / July 2026.

7. General Medicaid funding and supplemental updates

a) Discussion of Advanced Payments revisions for supplemental payment programs. (Feedback on 2027 advanced payments are currently being requested from the industry).

b) State of Texas Electronic Provider System (STEPS) (New STEPS program was released on Monday, February 3, 2026, and is ready for use).

c) Inpatient Rebasing update (2027 modeling will be available when all 12/31/2025 hospital cost reports have been filed and publicly available – May / June 2026).

d) All-Patient Diagnosis Related Group (APDRG) Grouper update (No update, as HHSC is working through this).

8. Proposed next meeting a) Tuesday, May 5, 2026

Discussion

Regarding the end of ATLIS, Does HPAC have an idea what they would want a replacement program to look like? HPAC stated that it is unlikely something can be salvaged for 2026, but perhaps there can something ne in place for 2027. HHSC is soliciting ideas for the ATLIS replacement.

11. Beneficiary Advisory Council (BAC) update.

- November 2025 meeting minutes were approved and will be posted following the MCAC meeting in compliance with CFR requirements.
- The Beneficiary Advisory Council had no specific recommendations yet for the annual report but may provide input in the future.
- Next council meeting is scheduled for May 5th at 10:00 AM.

12. Public comment (Occurred after Agenda Item 7).

Gene McCLaus, Myriad Genetics . Myriad Genetics Company Site commented on biomarker testing. She urged GeneSite Psychotropic testing to be included.

HHSC stated that they had received a request for consideration but that it did not meet the criteria for inclusion.

5. Discuss first annual report (required by 42 Code of Federal Regulations Section 431.12(i)) (Discussion)

The discussion is built on what the committee would like to move forward. Members had been notified and some responded with recommendations and items for consideration. This is the first report of this group.

Members stated that they were unclear about how to participate in the report development.

The ability of the committee to give timely feed back on medical policy has been a concern in the past and ongoing. The meeting schedule (quarterly) does not allow

feedback since HHSC cannot wait for the committee to meet. One recommendation would be to increase the frequency of the MAC meeting to 6 times per year.

There was also discussion about making some of those meetings in person. The meetings now are a hybrid of in person and remote. In person meetings are often more fruitful. Travel is an issue however and so some meetings could be virtual only.

There was developing consensus on increasing the frequency of meetings. Giving meaningful feedback is viewed as very important.

The issue of engagement is important. There is a handful of members who give feedback. In the old days, in-person meetings made for more meaningful discussion.

HHSC may have an idea of what the cadence should look like.

The committee can make recommendations regarding the composition and the cadence of committee meetings.

Staff stated that at one time rules came through this committee before going to the Executive Council. The approach changed to bringing concepts to the committee to solicit input on the front end.

MAC (MCAC) has not had a report requirement in the past, but the federal requirements now include reporting. March 12th is when feedback is requested from the members of the committee.

The report should provide more than meeting logistics. The handouts and minutes could be used to address the substantive policy issues for the report.

The chair will be calling a couple members to address report writing.

13. Review of action items and agenda items for future meeting.

Future meeting dates

- May 19, 2026,
- August 12, 2026,
- November 12, 2026,

No agenda items were proposed

14. Adjourn. There being no further business the meeting was adjourned.

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