Health and Human Services

Value-Based Payment and Quality Improvement Advisory Committee

February 23, 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.

Value-Based Payment and Quality Improvement Advisory Committee provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services and the wider health care system.

Paul Aslin, Beach City
Dana Danaher, DrPH, Austin
Frank Dominguez, El Paso
Rachel Hammon, New Braunfels
Susan Hood, North Richland Hills
Carol Huber, Chair, DrPH, San Antonio
Aliya Hussaini, MD, Austin
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Karen Love, Fort Worth
Benjamin McNabb, Pharm. D., Eastland
Rachana Patwa, Missouri City
Joseph Ramon III, RPh, Mission
Vernicka Sales, DO, Houston
Shao-Chee Sim, PhD, Missouri City
Karl Serrao, MD, Corpus Christi
Michael Stanley, MD, Fort Worth
Roberto Villarreal, MD, Seguin
David Weden, Buda

1. Welcome and roll call. The meeting was convened by Shao-Chee Sim.

2. Consideration of November 18, 2025, draft meeting minutes. The minutes were approved as drafted.

3. HHSC staff presentations:

Quality Data Analytics and Reporting General Update. Staff shared that the Alternative Payment Model (APM) Results Analysis is nearing finalization, with summary data expected at the next quarterly meeting in May; committee input is welcomed on how to analyze/interpret APM data for value-based care trends.

Jimmy Blanton emphasized the importance of stakeholder input as HHSC prepares for upcoming legislative work and other major agency cycles. He also flagged a major upcoming requirement: Medicaid's move toward "digital quality" by 2030 (NCQA/CMS), requiring coordinated action across HHSC, MCOs, providers, HIEs/data aggregators; noted past progress has been uneven but national developments (TEFCA, FHIR) and lessons from the HIE connectivity project create new opportunities.

House Bill (HB) 26, 89th Legislature, Regular Session, 2025 Implementation

Summary House Bill 26 (Joelle Jung, DSQI) implementation update focused on the authorizing of Medicaid MCOs to offer evidence-based nutrition support services as In Lieu of Services/Settings (ILOS) when medically appropriate and cost-effective.

The bill includes a pilot (through Aug. 31, 2030) for pregnant managed care members with chronic conditions contributing to high-risk pregnancy (e.g., gestational diabetes, hypertension, obesity) and requires annual reporting on all Medicaid ILOS plus a one-time pilot report.

HB 26 service categories were discussed: nutrition counseling/instruction for all managed care members; medically tailored meals (with counseling/instruction) for high-risk pregnancy pilot population; other evidence-based nutrition support services for the pilot population.

Stakeholder engagement plan: HHSC is developing a draft proposal based on literature review and existing programs; feedback will be requested in spring 2026 via survey (target late March; closing in April) from the State Medicaid Managed Care Advisory Committee (SMMCAC) and external stakeholders. The targeted effective date is September 2027 (SFY 2028 contracts).

Clarification was sought on “other evidence-based nutrition support services”: literature suggests medically tailored groceries and produce prescription models are the most likely candidates.

Related to MCO In Lieu of process: HHSC aims to align nutrition ILOS operations with existing ILOS processes (not create separate processes), recognizing the operational readiness approach may evolve by the SFY 2028 timeframe.

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Presentation

The bill:

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 certain pregnant women 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 11/06/25 https://capitol.texas.gov/tlodocs/89R/billtext/pdf/HB00026F.pdf#navpanes=0

Implementation:

In Progress – Literature review and research on existing Medicaid nutrition support services in Texas and other states.

In Progress – Development of a draft support services. proposal of the ILOS nutrition •

Spring 2026 – HHSC will request feedback from the SMMCAC and other key external stakeholders on the draft public comment period.

SMMCAC and External Stakeholder Engagement. HHSC's goal is to engage the SMMCAC and key external stakeholders during this draft development stage before the proposal for the new ILOS is finalized. HHSC will request feedback on the following categories of nutrition support services to implement in lieu of a Medicaid state plan service.

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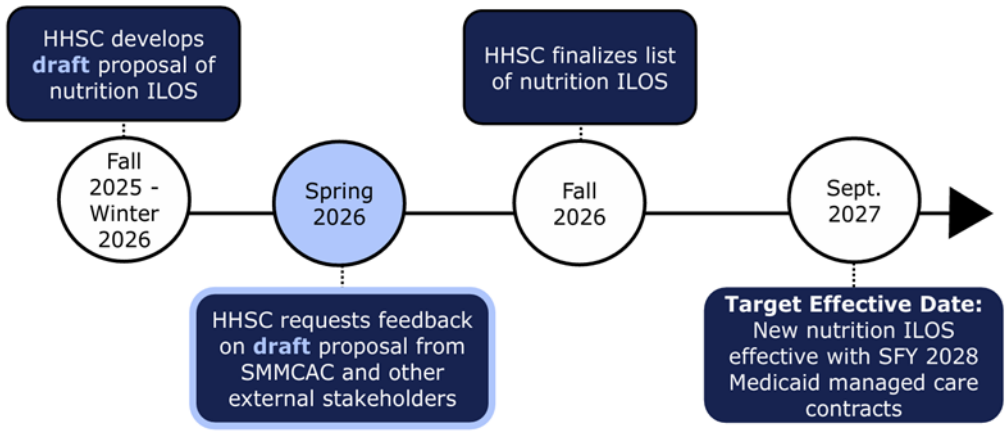
H.B. 26 Nutrition Support Services ILOS Categories

	ILOS 1	ILOS 2	ILOS 3
ILOS Category	Nutrition Counseling and Instruction (NCI)	Medically Tailored Meals + NCI	Other evidence-based nutrition support services
Target Population	Medicaid managed care members	Medicaid managed care members with a high-risk pregnancy	Medicaid managed care members with a high-risk pregnancy

Implementation Timeline



Next Steps:

- March 2026: HHSC sends survey to the SMMCAC and external stakeholders to provide feedback on the draft nutrition ILOS proposal.
- March/April 2026: Survey closes.
- May 2026: Next SMMCAC meeting

Discussion.

Other evidence based nutrition support services. What is the meaning of this. Staff stated that the legislation is guiding the effort. The bill allows the exploration of other evidence based. "Produce prescription" or other wording differences can fall into the "other" bucket.

Will the process for in lieu of services approval change? Staff stated that they are working with approval department. The target effective date is not until 2027 and there

could be additional operational processes added. There should not be a separate set of approval processes.

Update on the State's Implementation of the One Big Beautiful Bill Act, Rural Health Transformation Program, Section 71401 of Public Law 119-21, Rural Texas Strong Program

Summary. Claire Steeg (HHSC) presented an update on the Rural Texas Strong program, part of the Federal Rural Health Transformation Program. Texas was awarded $281.3 million for budget period one, with a potential for $1.4 billion over five years She outlined six initiatives outlined:

- Community-based prevention, wellness, and nutrition programs
- Patient portal and health technology investments for rural providers
- AI and telehealth tools for reducing administrative burden and improving care
- Provider workforce recruitment/retention and local career path development
- Cybersecurity infrastructure for rural healthcare organizations
- Infrastructure/capital improvements within CMS guidelines

There are restrictions to the funding: new construction capped is at 20%. There are also limitations on certain tech purchases and five-year workforce commitments were required

Stakeholders are encouraged to follow updates via the dedicated website and email list

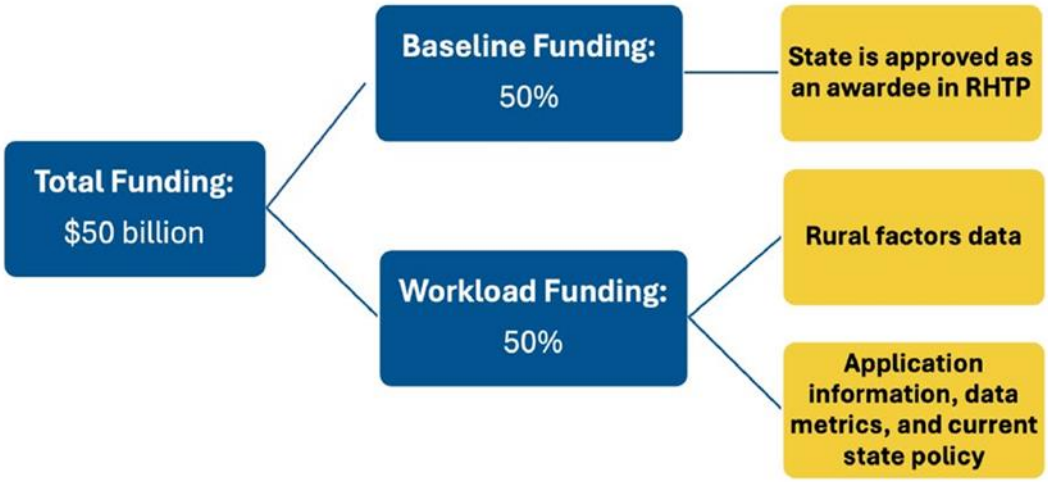
Presentation

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.

What amounts are designated for each initiative. Staff stated that the website has the breakout of the funding.

On initiative one, the competitive grants will be in year two.

Rural Health Stabilization and Innovation Act, House Bill 18, 89th Legislature, Regular Session, 2025 Update. HB00018F.pdf

Summary. Rural Health Stabilization and Innovation Act / HB 18 (April Farino): Office of Rural Hospital Finance is now permanent in statute and defines rural county/hospital.

Rural Hospital Officers Academy: planned statewide leadership development (≥100 hours), free to rural hospital leaders with travel reimbursement. The curriculum will be developed by an interagency advisory committee (appointments in progress with first meeting anticipated for early spring. The committee sunsets upon curriculum adoption or by Sept. 1, 2027). The academy is administered by four contracted higher education institutions with defined catchment areas.

HB 18 grant programs overview: Financial Stabilization Grant (non-competitive; up to $25M per fiscal year; based on Financial Vulnerability Index updated every two years; enrollment closed ~8–10 days prior; HHSC reviewing roadmaps/milestones and moving toward contracting and awards); Innovation Grant (competitive; $25M per fiscal year; spring opening anticipated; must improve access/quality/financial stability and be sustainable); Rural Hospital Support Grant (funding via other monies; supports entities that help HHSC with rural hospital support efforts); Grant of Last Resort (typically non-competitive, one-time, as funds available; bridge funding to prevent closure due to temporary crisis, not long-term financial issues); Pediatric Teleconnectivity Resource Program for Rural Texas (modified by HB 18; $10M annually; summer release anticipated; supports telemedicine/pediatrics specialty/subspecialty access).

The Financial Vulnerability Index update cadence will target an update by end of the year (December).

Academy participation criteria: initially focused on CEO, CFO, COO, CNO and leaders identified for succession planning; potential future expansion discussed.

Presentation

Rural Health Stabilization and Innovation Act Dedicated support for rural hospitals at HHSC began in 2021 and H.B. 18 ensures the Office, and its functions continue to provide technical assistance to rural hospitals and health systems.

Definitions

Rural county - a county with a population of 68,750 or less.

Rural hospital - a health care facility licensed under Chapter 241, Health and Safety Code, that:
(A) is located in a county with a population of 68,750 or less; or

(B) has been designated by CMS as a critical access hospital, rural referral center, or sole community hospital and:

(i) is not located in a metropolitan statistical area; or

(ii) if the hospital has 100 or fewer beds, is located in a metropolitan statistical area.

Note: Rural hospital definition remains the same and is now in statute.

Rural Hospital Officers Academy The bill authorizes creation of an academy to provide professional development and continuing education for rural hospital leaders. The Academy must offer at least 100 hours of coursework and technical training.

HHSC has contracted with 4 Institutions of Higher Education (IHEs).

- University of Texas System
- Texas A&M University System
- Texas State University System
- Texas Tech University System

Appointing members to the interagency advisory committee is in progress. The first committee meeting will be in spring 2026. The Committee will expire the date it adopts curriculum or on Sept. 1, 2027 (whichever occurs first).

Financial Stabilization Grant Program	Up to $25 million per fiscal year. Qualified hospitals identified as moderate or high vulnerability on the Financial Vulnerability Index. • Moderate or high risk of financial instability. • Determination made using financial vulnerability index. Index is updated every 2 years. • Index rankings based on 4 domains with 20 indicators. (Finance, Operations, Market/competition, and Community Support)

	• Up to $22 million allocated for FY 26 to be distributed only to qualified hospitals.
Innovation Grant Program	Up to $25 million per fiscal year. Awards will be for projects that accomplish specific goals with priority given to proposed projects that reach certain populations. Awards will be for projects that: • Provide access to health care and improve quality • Improve financial stability • Sustainable without future grant funding Priority given to projects impacting: • Pregnant women or those who recently gave birth • Persons younger than age 20 • Older adults living in rural counties • Persons who are uninsured
Rural Hospital Support Grant Program	Grants awarded to eligible entities that assist HHSC with information, data, and research support to support rural hospitals Grants awarded to eligible entities that assist HHSC by providing information, data, and research support that enhances the Commission's efforts in supporting rural hospitals.
Emergency Hardship Grant Program	Grants awarded to applicants that have experienced man-made natural disasters or unforeseeable or unmitigable circumstances. Shared funding with Financial Stabilization grant program. FY 26 up to $3 million allocated. Grants awarded to applicants that have experienced man-made or natural disaster or unforeseeable or unmitigable circumstances that likely results: • in the facility's closure, or • an inability to fund payroll expenditures for facility's staff

	during the 180-day period from the date the facility submits a grant application.

Pediatric Tele-Connectivity Resource Program for Rural Texas

Purpose: To award grants to facilitate connections with pediatric specialists and pediatric subspecialists who provide telemedicine medical services.

Competitive grant, all rural hospitals and certain rural health clinics are eligible

FY 26-27 - $10 million annually

Funding can be used to:

- Purchase equipment necessary for a telemedicine service
- Modernize the hospitals or clinics' information technology infrastructure
- Pay a service fee to a pediatric tele-specialty provider
- Pay for other activities, service, supplies, facilities, resources, and equipment HHSC determines necessary for telemedicine.

Grant-Related Questions HHSCRuralHospitalFinance@hhs.Texas.gov
Technical Assistance Questions RuralHospitalHelp@hhs.Texas.gov

HB18 Fiscal Note.
This bill amends the Government Code to add requirements for the Rural Hospital Strategic Plan; codifies the State Office of Rural Hospital Financing; establishes the Texas Rural Hospital Officers Academy; codifies the existing grant programs for rural hospitals; and creates an add-on payment for rural hospitals that have a department of obstetrics and gynecology; codifies the Medicaid definition of a rural hospital; requires the Health and Human Services Commission (HHSC) to regularly update certain reimbursement rates for rural hospitals participating in Medicaid based on the most recent cost information; expands the Pediatric Tele-connectivity Grant Program to rural hospitals; Additionally, this bill amends the Health and Safety Code to establish the Rural Pediatric Mental Health Care Access Program and repeals certain provisions related to the Pediatric Tele-connectivity Grant Program. This bill would be effective immediately if it receives a vote of two-thirds of all the members elected to each house, otherwise the bill would be effective September 1, 2025.

This analysis assumes the Health and Human Services Commission (HHSC) would require $22,216,112 from the General Revenue Fund ($45,636,100 from All Funds) and 10.5 full-time-equivalents (FTEs) in fiscal year 2026 and $21,933,096 from the General Revenue Fund ($46,646,841 from All Funds) and 10.5 FTEs in fiscal year 2027 to implement the provisions of the bill, which include establishing the Texas Rural

Hospital Officers Academy, an add-on payment for Medicaid services related to obstetrics and gynecological services provided in rural hospitals, and establishing the Rural Pediatric Mental Health Care Access Program.

Included in the amounts above are assumed FTE costs totaling $2,025,535 from the General Revenue Fund ($2,295,485 from All Funds) and 10.5 FTEs in fiscal year 2026 and $1,944,873 from the General Revenue Fund ($2,196,616 from All Funds) and 10.5 FTEs in fiscal year 2027. This includes $83,223 from the General Revenue Fund ($101,787 from All Funds) in fiscal year 2026 for one-time costs related to the implementation of provisions of this bill.

This analysis also assumes HHSC would require $4,918,123 from the General Revenue Fund ($4,918,123 from All Funds) in fiscal year 2026 and $5,003,583 from the General Revenue Fund ($5,003,583 from All Funds) starting in fiscal year 2027 to establish and initiate Texas Rural Hospital Officers Academy.

Additionally, this analysis assumes HHSC would require $15,612,620 from the General Revenue Fund ($38,876,046 from All Funds) in fiscal year 2026 and $15,845,716 from the General Revenue Fund ($39,446,642 from All Funds) in fiscal year 2027 to establish and implement an add-on payment for rural hospitals that have a department of obstetrics and gynecology and to regularly update certain reimbursement rates for rural hospitals participating in Medicaid based on the most recent cost information. In determining this add-on payment, the agency assumed an approximately two percent (2%) increase applied to all rural hospital inpatient and outpatient services, overall. According to the agency, this is the same approach used for other add-on payments within the Medicaid program.

This analysis assumes these costs would be partially offset by an estimated $340,166 to the General Revenue Fund in fiscal year 2026 and an estimated $861,076 to the General Revenue Fund in fiscal year 2027 from client services payments through managed care that are assumed to result in an increase to the General Revenue Fund from insurance premium tax revenue and revenue adjusted for assumed timing of payments and prepayments, all of which results in increased revenue collections. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue collection is assumed to be deposited to the credit of the Foundation School Fund ($113,388 in fiscal year 2026 and $287,025 in fiscal year 2027).

While the bill establishes various grant programs for Texas rural hospitals, there is insufficient information available to determine the full costs of those programs; therefore, this analysis does not contemplate the costs associated with the actual grants but does include cost estimates for the administration of those grants.

According to the Texas Child Mental Health Care Consortium, the Consortium would require $2,500,000 from the General Revenue Fund ($2,500,000 from All Funds) each fiscal year in the 2026-27 biennium to make necessary changes to the existing electronic data system and to add additional providers for expanded services relating to implementing the provisions of this bill.

Bill Analysis

1. Establishes the State Office of Rural Hospital Finance within HHS to provide technical assistance and financial support for rural hospitals participating in Medicaid and other state or federal programs.

2. Creates a Rural Hospital Financial Vulnerability Index and Needs Assessment to evaluate the financial health of rural hospitals and guide funding allocations.

3. Creates four targeted grant programs:
    a. Financial Stabilization Grants to support rural hospitals, districts, and authorities at moderate to high financial risk.
    b. Emergency Hardship Grants for hospitals facing sudden crises like disasters or payroll shortfalls.
    c. Innovation Grants to support sustainable healthcare initiatives, especially for vulnerable populations.
    d. Rural Hospital Support Grants for ongoing operational stability and long-term viability.
4. Launches the Texas Rural Hospital Officers Academy, which will provide 100+ hours of annual training for rural hospital leaders on financial management, regulations, and organizational leadership through partnerships with higher education institutions.

5. Implements cost-based reimbursement rates updated biennially and establishes an annual add-on reimbursement for rural hospitals with obstetrics and gynecology departments.

6. Creates the new Rural Pediatric Mental Health Care Access Program to use telehealth services to identify and assess pediatric patients seeking mental-behavioral health needs. Parents, legal guardians or adult with whom the child lives with must give prior written consent for their minor child or guardian to receive these services.

The committee substitute added language to ensure that dollars received under the grant programs are given to rural hospitals and not the system the hospital is a part of.

Discussion.

What is the timing of the financial vulnerability index. Staff stated they hope to update it by December 2026.

What are the requirements for the academy. Staff stated the C Suite is the focus and those who would be replacing them. It is targeting succession planning.

How will this office work with the office of rural health in the Department of Agriculture. Staff stated they have been and will continue to coordinate with that office.

4. Stakeholder Presentation: Texas All Payor Claims Database

Summary. Lee Spangler (UTHealth Houston School of Public Health) explained APCD purpose: standardized administrative claims database to support research on utilization and costs across payers. APCD was established by the Legislature in 2021; early progress was slow due to limited funding until recent legislative funding enabled ramp-up. The current scale: ~20–21M Texans represented; ~13.5B claim lines with data available from 2019 to present.

Coverage examples: 2024 includes ~10.3M covered lives in commercial + Medicare Advantage; ~5.2M Medicaid covered lives; Center also has access to Medicare fee-for-service data (~2.6M persons for 2023); overall ~80% of insured Texans are represented.

Data submission: monthly payer submissions (eligibility and provider files plus medical/pharmacy/dental claims where applicable)100 payers registered, with top 7–8 capturing 80–90% of covered market.

Key limitations: no clinical results (labs/imaging/vitals), no premium payments, limited demographics (race/SES often absent), unclear dependent relationships, ERISA self-funded plans not mandatory (voluntary only), federal program data (VA/IHS) excluded, uninsured/cash-pay not captured.

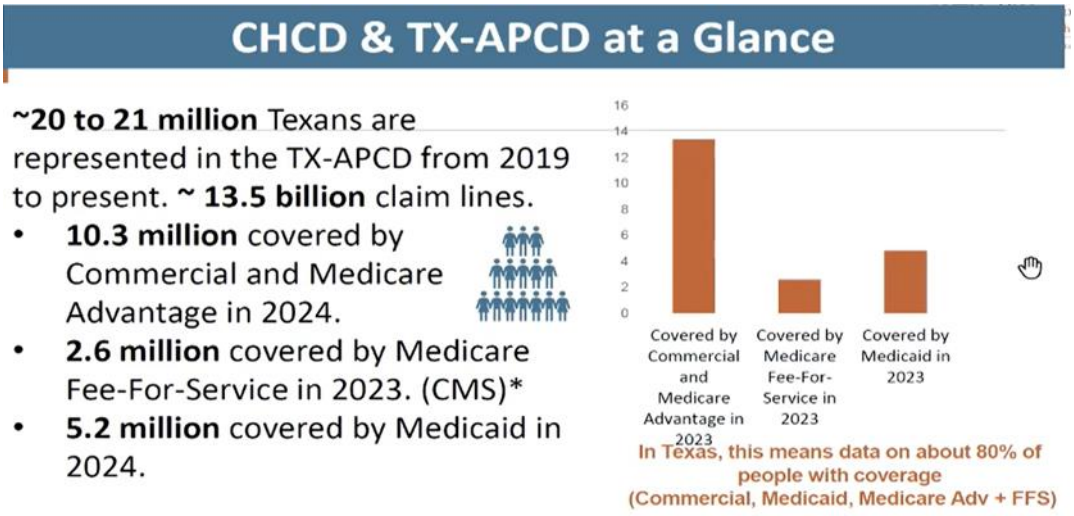
The Implementation phases are: data submission and automation; data enhancement (patient index/provider registry, linkage); data availability.

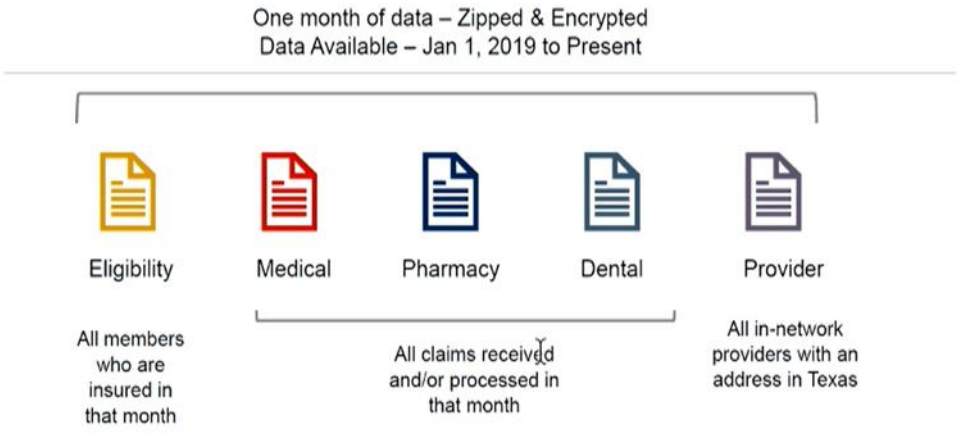
External researcher access opened last month: 13 inquiries, 3 completed applications received, 2 projects approved. A public portal is planned that will be de-identified, aggregated GeoZip-based information on cost/access and basic public health measures targeted by end of year. The researcher eligibility categories:

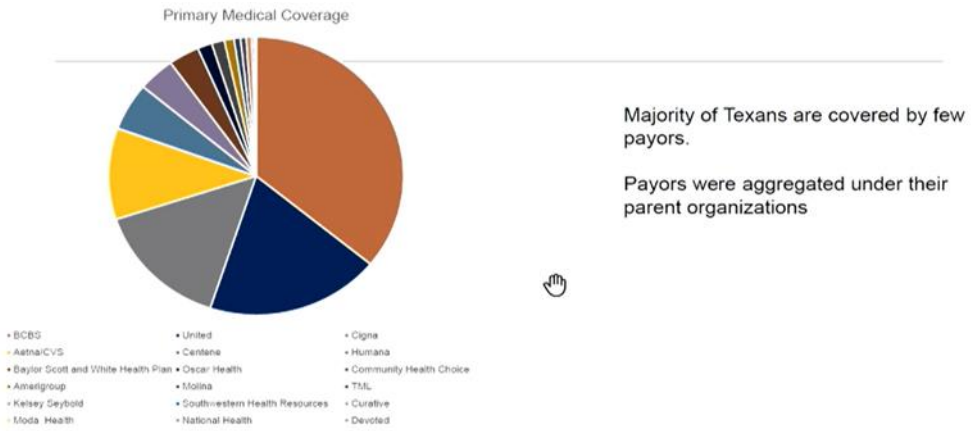
- 501(c)(3) public-interest researchers
- US-based higher education institutions
- Texas healthcare providers for quality/cost research.

The access process includes online request form; pre-application review, full application with IRB documentation; formal agreement; secure enclave/VM access (no data copies); export review with suppression rules; no international server access.

Presentation



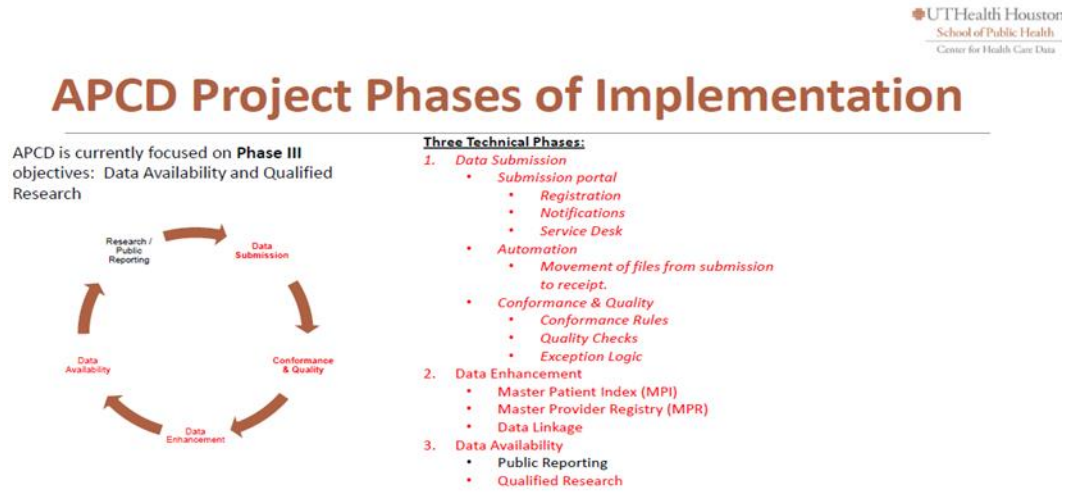




Unavailable Data

- The database does not contain clinical information such as laboratory results, imaging values, or patient vital signs.
- It does contain health information – for instance the data shows tests were ordered, and diagnosis codes provide some insight into the patient's condition.
- TX-APCD also lacks financial information about insurance premium payments and uncovered out-of-pocket spending on over-the-counter medications since those transactions never appear on claims forms.
- Demographic information, such as race and ethnicity, is also often completely absent or incomplete, as payors seldom collect this information in their regular administrative processes. Relationships within households (partners – married – dependents) are also difficult to come-by. θ ERISA Self-funded information is voluntarily submitted.

- Rendering Provider Specialty is also often missing 6 θ The Uninsured and Cash-Pay patients are not within the database.



Who may request TX APCD Data

Non-Profit Organizations (501(c)(3)): These are tax-exempt organizations involved in public interest research concerning health care delivery in Texas. The research must somehow aim at improving the quality and cost of health care in Texas.

Institutions of Higher Education: This category includes colleges and universities conducting public interest research on health care delivery in Texas.

Texas Health Care Providers: These are health care providers in Texas working to enhance the quality and reduce the cost of health care. Must be licensed, certified, or hold some express authorization.

Submitting a Data

Request Online Submission Process All data requests must be submitted online via the official CHCD Data Request Form ensuring standardized collection.

Compliance and Transparency The system ensures compliance with legal and ethical standards of our various datasets by maintaining records for auditing and reporting.

Consistent Access Centralizing requests promotes a consistent, transparent entry point for all users.

Completing Required Applications

Two-Stage Application Process The application includes a Pre-Application Review for feasibility and a Full Application for detailed review and compliance.

Pre-Application Review CHCD staff assess project concept, dataset suitability, and regulatory barriers early to avoid wasting requestor time and resources.

Service Quote The pre-application also permits the CHCD prepares service quotes covering labor, timelines, and costs.

Helps Compliance with Multiple Requirements Often, more than one dataset is requested, and the additional information permits staff to review and harmonize multiple dataset requirements.

Full Application and Approval

Comprehensive Application Review CHCD performs detailed evaluation of applications verifying ethical, institutional, and technical criteria for sensitive data access.

Compliance and Privacy Assurance The review ensures strict adherence to federal and state privacy laws, internal policies, and contractual data obligations. All TX-APCD applications must include Institutional Review Board documentation.

Approval CHCD issues formal approval decisions. We will work with applicants so that research purposes are clear or that modification to the research question at issue is refined (may also aid affordability for the researcher)

Contract Development

Formal Agreement Establishment Contract development formalizes agreements with requesters including terms and timelines.

User Agreement Compliance All data users sign agreements to ensure accountability and adherence to data security requirements.

Payment Payment for extract development, security, storage, and costs.

Accessing Data and Prohibited Activities

Controlled Data Access Access to CHCD datasets is limited to authorized users under the IRB-approved protocol with completed agreements.

Secure Data Environment Data access occurs only through UTHealth Houston's secure servers via VPN without transferring data externally.

Prohibited Activities Storing data on personal devices, accessing data outside the U.S., and saving files externally are strictly forbidden. Agreement not to engage in anti-trust activities.

Data Export Reviews Only UTHealth personnel can export information from the VPN/Enclave environment. We review all reports and tables before export to ensure compliance with cell suppression rules and that the research performed was the research proposed in the application.

Discussion No discussion

5. Subcommittee updates:

Non-Medical Drivers of Health (NMDOH).

Areas of Interest

- Evaluate pathways to reimburse providers for NMDOH screening.
- Learn more about evidence-based NMDOH interventions and models.
- Interest in H.B. 26 (89th Leg) implementation.
- Broaden the scope of H.B. 1575 (88th Leg). (Improve the quality and efficiency of data collection; Identify next steps based on insights from screening data).
- Explore alternative strategies to support community-based organizations (CBOs).
- Assess the impact of the One Big Beautiful Bill Act (OBBBA) on SNAP coverage for Medicaid populations.

Plans are to have MCO-led panel discussion concerning H.B. 1575 (88th Leg) implementation

Value-Based Care in Rural Texas

Areas of Interest

- Managed care organizations (MCOs) continue to face challenges surrounding workforce, reimbursement, and access to care.
- Explore opportunities to improve access to care for individuals with complex chronic care needs.
- Community alternatives to address the nursing workforce shortage in rural areas.
- Consider rural health initiatives from other states.

Alternative Payment Models in Texas Medicaid

Areas of Interest

- Evaluate the performance of prominent clinically integrated networks (CINs) within Texas.
- Expand CIN participation among safety net providers.
- Determine next steps based on results from the Comprehensive Health Homes for Integrated Care (CHIC) Kids Pilot Program.
- Identify APM opportunities that address chronic disease prevention rather than chronic disease treatment.
- HHSC has a new Alternative Payment Network data. The workgroup will work with HHSC to look at that data
- Capitation rates setting often miss some value opportunities and long term drivers of health. The workgroup would like to look at incentives that may not be customary items.

Timely and Actionable Data.

Areas of Interest

- Follow up on Emergency Department Encounter Notification (EDEN) system use cases.
- Assess quality of EDEN data.
- Support hospitals in prioritizing EDEN connectivity.
- Look to other states for strategies to address health information exchange (HIE) and data-sharing issues.

Additional items

- Movement to digital quality measures as per federal requirements
- Public data transparency

6. Public comment. No public comment was offered

7. Discussion: 2026 priorities and timeline

Value-Based Payment and Quality Improvement Advisory Committee (VBPQIAC) Report Timeline	
Milestones	**Due Date**
VBPQIAC reviews draft recommendations, conducts vote	5/18/2026
Draft Report shared by liaison with committee members	8/10/2026
VBPQIAC reviews final recommendations and votes on draft report (concurrent item)	8/17/2026
Draft report sent to HHSC SMEs for review (concurrent item)	8/17/2026
HHSC SMEs complete content review and feedback and return to liaison (9 business days)	8/28/2026
Chair makes nonsubstantial edits as needed and sends report to liaison	9/1/2026
Draft report sent to QDAR Director/VBI Manager for review	9/3/2026
Draft report reviewed by QDAR Director/ VBI Manager and returned to liaison	9/10/2026
Liaison gets packet ready for submission to DAC	9/10/2026
Draft sent to DAC for review (5-10 business days)	9/14/2026
Draft sent to DEC for review (5 business days)	9/30/2026
Draft sent to SMD for review (20 business days)	10/12/2026
Final report sent to EC (10 business days)	11/11/2026
Report published and posted to website	12/1/2026

8. Action items for staff and member follow-up.

- Subcommittee workgroups will be meeting to develop recommendations for the May meeting.
- Updated workgroups items of interest
- Additional presentations
- HB1575 implementation
- New member solicitation is still within the interna routing process

Future Meetings

- May 18, 2026

- Aug. 17, 2026
- Nov. 16, 2026

9. Adjourn There being no further business, the meeting was adjourned.