Abstract for CMS - RHT- 26-001

Rural health challenges in Texas are as vast as the state itself. Rural Texans face higher rates of illness with fewer resources than their urban counterparts, despite powering the nation with agriculture, energy, and economic contributions. The Rural Texas Strong project is a comprehensive, statewide strategy designed to reach residents in 100% of Texas's rural counties and make rural Texans healthy again. Under the revised Budget Period 1 approach, Texas will prioritize startup implementation funding for local chronic disease initiatives, accelerated workforce investments, and infrastructure and emergency preparedness improvements that can be timely obligated, disbursed for allowable costs, and liquidated in accordance with CMS guidance. Our initiatives are designed to have a statewide impact that will better the lives of all Texans. It combines emerging technologies like artificial intelligence, homegrown workforce solutions, and aligned efforts around software and capital infrastructure that accelerate implementation while avoiding duplication. These projects were designed to maximize the impact – and the funds – awarded to Texas and ensure long-term sustainability. This application represents a transformative investment in rural Texans' wellness, one that matches the Texas-sized obstacles with the Texas grit to overcome them.

> "Together, we will expand rural healthcare like never before – that is my promise to Texas, to rural communities, and to the American people." – **Secretary Robert F. Kennedy, Jr., in Austin on Aug. 8, 2025**

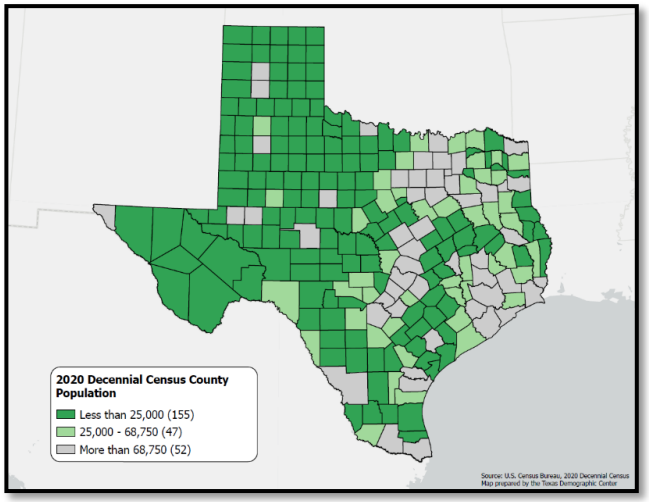
Rural Health Needs and Target Population

Demographics

Texas has more rural residents, 4.3 million people,[1] [1] than any other state in the nation and is the second largest state by geographic area, creating unique challenges to reach and serve every Texan, because every Texan matters.[2] With 254 counties, spread across a land area of over 260,000 square miles, population size, county population density, and unemployment rates can vary greatly, [2] while higher education attainment tends to be concentrated in urban areas.[3, 4,5,6] The Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration identifies 241 counties in Texas with at least one census tract categorized as rural

[1] Nearly 15% of the total population, as defined in Data Factors A.1 and A.3. See Index in the Endnotes.
[2] Maps illustrating population size, county population density, unemployment rates, and education attainment are shown in Figure 1, Figure 2, Figure 3, and Figure 4 in the endnotes.

Figure 1 Rural Texas Strong Counties



and 195 as fully FORHP rural. According to the U.S. Department of Agriculture (USDA), Texas ranks in the top ten states with land area and population that are classified as frontier and remote level one. Over 500,000 residents, in 152 different zip codes, across 27% of the state's land area, travel an hour or more to urban areas of 50,000 or more people. [3] [7] For the purposes of the *Rural Texas Strong* application, Texas will define 202 of 254 counties, or 80%, as rural counties. The 202 counties each have a population of 68,750 or fewer persons according to the 2020 U.S. Census.[4] [8,9]

On average, Texans in rural communities are older, more likely to be low income, and more likely to have at least one disability.[5] [10] Their mortality rate is higher as are the incidence rates of chronic diseases, including heart disease, cancer, stroke, and unintentional injuries. [6] [11,12] These are issues that can be intensified by lower income levels, which can result in a lower quality diet and fewer resources to spend on preventive measures for treating chronic illness. One in three adult Texans and one in five children ages 10 through 17 are obese, with access to unprocessed food and healthcare being contributing factors.[13,14] Rural populations have a higher percentage of

[3] The USDA frontier and remote levels describe territory with low population and high geographic remoteness, defining areas by the time it takes to travel by car to the edges of urban areas. While remoteness can be a highly-cherished benefit, it also creates economic and social challenges.
[4] Consistent with the population threshold defined by Texas Government Code for a population-based definition for determining that a hospital is considered rural.
[5] See Figure 5 in the endnotes for the Percent of the Population 65 Years and Older by county.
[6] See Figure 6, Figure 7, and Figure 8 in the endnotes for maps of rates of heart disease, cancer, and stroke by county.

residents receiving benefits from the Supplemental Nutrition Assistance Program but are less likely to have access to healthy food.[15,16] Women living in rural communities are more likely to suffer complications in childbirth and delay necessary preventative and postpartum care.[17] These challenges to addressing healthcare needs are aggravated by issues of access in rural areas.

Rural Texans' access to high quality local healthcare has been an ongoing priority for Texas with the state appropriating general revenue for various initiatives intended to support these communities. The One Big Beautiful Bill Act (OBBBA) will help Texas speed up the efforts already begun at the local and state level. The systemic or structural issues that present obstacles in rural Texas exist in spite of rural Texans' efforts to improve health outcomes in their communities. *Rural Texas Strong* will help communities hurdle the barriers and prepare for generations of healthier Texans.

Healthcare Access and Coverage

In rural Texas, a lack of commercial health insurance and less local healthcare providers, combined with long distances, can limit access to healthcare. Rural hospitals serve a higher percentage of Medicare patients than urban counterparts, and insurance coverage rates can vary across counties, with rural counties having a higher percent with Medicaid or CHIP and Medicare coverage.[7] [18,19] Understanding this, Texas has established a minimum fee schedule for rural hospital services for individuals enrolled in Medicaid/CHIP managed care. In the long term, we hope Medicare Advantage and commercial

> "…Frontline healthcare in rural pharmacies is saving lives, saving ER resources and keeping care close to home.
> **– Crystal McIntyre, Owner and Operator of two pharmacies in Shamrock and Wheeler.**

[7] See Figure 9, Figure 10, and Figure 11 in the endnotes for coverage by insurance type across the state.

health plans will join us in establishing foundational reimbursement rates for rural providers that promote long-term financial stability and quality improvements.

Those without insurance may have an even more difficult time getting care.[20,21] Uninsured residents may also be less likely to seek out timely preventative services, increasing potentially preventable emergency visits (including uncompensated visits) at already strained hospitals.[22] Rural residents travel an average of 59 miles (which may equate to more than an hour of drive time) from their rural hospital to the nearest large referral center. However, that amount can vary significantly by hospital referral regions. For example, in West Texas some patients may travel as many as 109 miles.[23]

Figure 2 Rural Texas Strong Rural Hospitals

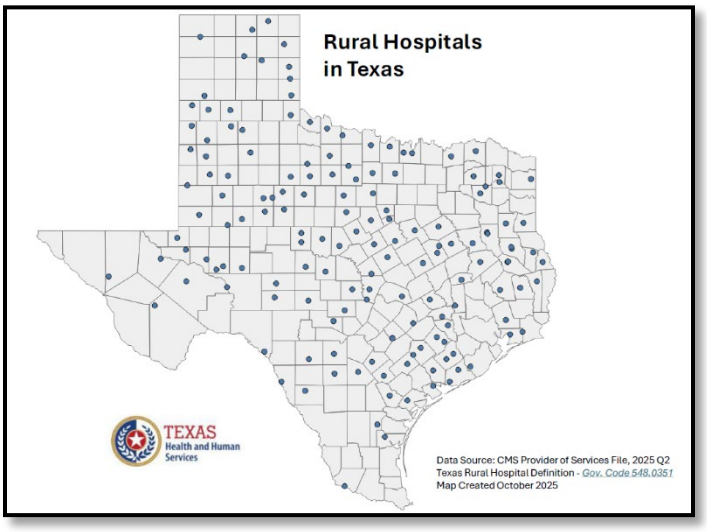


Figure 2 shows the distribution of rural hospitals across Texas.[8] [24] In many counties, women may travel up to 70.5 miles to the nearest labor and delivery hospital.[25] The farther a woman must travel for maternity care, the higher the risk of maternal morbidity and adverse infant outcomes.[26]

While the supply of physicians and other mid-level practitioners in Texas is expected to increase, it is not keeping pace with anticipated demand.[27] As of 2024, nearly one in five rural Texas counties did not have a licensed primary care physician. [9] [28] Texas will need to not only

[8] See Figure 12 and Figure 13 in the endnotes for a map of Federally Qualified Health Centers and rural health clinics in rural counties.
[9] See Figure 14 in the endnotes for the Ratio of Primary Care Physicians

educate more primary care clinicians but also incentivize providers to call rural counties home. This is also true for mental health providers,[10] community health workers, pharmacists, and licensed paramedics.[29]

Limited access to public transportation can also inhibit healthcare access.[30] While there are rural public transportation systems operated by local governments, nonprofits, and public operators across much of the state, many cover wide geographic areas, and non-emergency medical transportation may be largely unavailable to most rural Texans.[31] A lack of access to the internet can also prevent persons from accessing healthcare services using consumer technology to connect to their doctors, as well as restrict their ability to participate in telehealth options.[11] [12] [32,33] When combined, this presents the need for innovative solutions that prioritize increasing opportunities for care and practitioners who are comfortable using technology solutions, mobile care delivery methods, and remote monitoring connected through local hubs to transmit data and information to specialists located elsewhere.

Chronic Disease: Rural residents face higher rates of chronic disease, including hypertension, arthritis, high cholesterol, and diabetes.[34] Rural areas also have higher age-adjusted mortality rates for heart disease, cancer, chronic respiratory disease, and stroke.[35] An estimated 11.3% of U.S. adults and 11.5% of adults in Texas have type 2 diabetes, and nearly a quarter of them may not realize it. It is estimated that only 3% of adults diagnosed with prediabetes have engaged in diabetes prevention programs.[36]

[10] See Figure 15 in the endnotes for the Ratio of Mental Health Providers by County.
[11] The Texas Comptroller of Public Accounts is issuing Broadband grants to bring internet access to rural communities.
[12] See Figure 16 for the Percent of Households without an Internet Subscription by County.

In rural settings, managing complex chronic care can be more difficult. Patients can incur greater out-of-pocket costs from travel, providers operate with fewer resources, and delayed treatment leads to worsening disease progression. According to one study, excess medical spending and productivity loss due to preventable health matters costs the Texas economy $7 billion every year.[37] Each resident, whether sick or healthy, bears the extra costs through higher insurance premiums, greater tax burden to support public health programs, and reduced productivity.[38] Therefore, any improvement to chronic disease severity or prevalence produces financial sustainability through cost reduction to the health system and increased economic benefit for the state.

Workforce Shortages and Aging Equipment and Infrastructure: Texas ranks among the top states facing critical physician shortages, and virtually all rural Texas counties are designated health provider shortage areas (HPSA).[39] The ratio of population to primary care physicians is nearly 60% higher than in urban areas.[40,41] Every rural Texas county is also designated as a HPSA for mental health.[42] The Texas Physician Supply and Demand Projections from 2022-2036 forecast that shortages in primary care, psychiatry, obstetrics, gynecology and other fields will have higher demand than the workforce can meet.[43] The current workforce is also aging, with one-third over the age of 55; retirements will exacerbate future shortfalls and result in a loss of valuable experience.[44]

Workforce recruiting challenges are compounded when a rural health employer is unable to reinvest in its staff and infrastructure. Facilities that have some profit margin can replace stretchers, wheelchairs, CT scanners and lab equipment. Rural providers that barely survive from one pay cycle to the next cannot replace aging equipment. Sometimes repairing it can be a cost out of reach of a small-town practitioner. The potential loss of revenue from outdated or broken equipment results when patients need referral to another facility for lab work or imaging.

> "In rural Texas, we know how to stretch a dollar and when funds are put in our hands, they are spent conservatively and on the most critical needs of our patients."
> **– Kurt Sunderman, CEO of Rice Medical Center in Eagle Lake.**

Rural providers have become experts at making equipment work well beyond its useful life. On the one hand, this scenario demonstrates the commitment and resilience of the smallest and poorest hospitals or clinic providers to find ways to survive. However, "just getting by," comes with consequences. Recruiting potential is diminished when prospective staff make a site visit and see first-hand the aging facility and outdated equipment. Despite the many unseen positive characteristics of rural health providers - the commitment to quality patient care and work culture - it is unlikely a recruit will be motivated to work in this setting, resulting in the rural/urban divide for healthcare staff widening.

Outdated Technology and Limited Cybersecurity Protection: Rural providers recognize the significance of technological upgrades, but some are unable to implement them due to cost. They recognize that their clinicians are practicing with old tools and limited visibility into patients' health history or procedures that were performed at other facilities. This lack of connectivity, especially between behavioral and medical health providers, and an interoperable information

technology system across all health provider types results in an inability to automate quality reporting, analytics, and care management (necessary for success of alternative payment models).

According to a 2022 survey of Texas rural hospitals, plans to increase telehealth offerings are limited without investment in infrastructure and expertise.[45] Some rural hospitals face challenges within their own facilities, including the need for training and space to properly use equipment for enhanced services.[46] Without technology improvements, rural providers lose revenue, have increased administrative burden, and cannot compete with urban providers.

Cybersecurity analysts say rural hospitals and smaller facilities are desirable targets, because it's an easier payday, even if the facilities won't be able to afford a large ransom.[47] Like their urban counterparts, rural providers maintain valuable patient information, but many have aging IT systems that make them prime targets for cybercriminals. Multiple rural Texas hospitals and clinics have paid hefty ransoms as victims of cybercrimes and know first-hand the negative impacts from such an intrusion.[48] Every rural provider wants to avoid paying a ransom from their limited funds because it prevents its use for critical costs, like patient care. [49]

Rural Facility Financial Health

Rural Texas hospitals have a combined 7,650 licensed beds, according to the most recent data.[50] Financial challenges are inextricably connected to low patient volumes. Most rural health facilities experience financial instability, and rural hospitals exemplify the challenges that many rural health facilities experience.

> "Rural hospitals don't ask for a handout; we're asking for a bridge; a bridge between [the] dedication of our people and the realties we face every day."
> **– Melissa Wilson, CEO of Freestone Medical in Fairfield.**

A 2025 study revealed 77% of rural Texas hospitals had negative net income from patient services, four out of ten rural hospitals had negative operating margins and had less than 20 days

cash on hand.[51] Another financial risk exposure specific to rural Texas hospitals is on the balance sheet – capital is weighted toward debt rather than physical assets like buildings and equipment. Long-term debt to capitalization is an important metric of a hospital's financial leverage and risk of insolvency because it measures how much outstanding debt a hospital has compared to its total capitalization, or its total available (unrestricted) assets, less its total liabilities. Around 15% of Texas rural hospitals had long-term debt-to-capitalization exceeding 50%, which indicates most of their capital was debt.[52]

Target Populations

The initiatives identified in *Rural Texas Strong* prioritize nearly 3.7 million citizens living within the 202 rural counties, with a population less than 68,750. [53, 54] In accordance with Texas statute as shown in Table 1, and for purposes of *Rural Texas Strong* initiatives, Texas identifies 155 rural hospitals at the time of this application submission, with 93 Medicare-certified Critical Access Hospitals (CAH), 58 Prospective Payment System (PPS) facilities, and 4 Rural Emergency Hospitals (REH). Endnote Figure 17 shows rural hospital distribution by classification.[55] Ninety-six rural hospitals no longer provide obstetrical services (OB) leaving vast OB deserts across the state that are larger than the combined land mass of Connecticut, Delaware and Rhode Island.[56]

Table 1: Rural Hospital Definition

Texas Government Code Section 548.0351 defines rural hospital as:
(1) located in a county with 68,750 or fewer persons according to the 2020 U.S. Census; or
(2) designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Ares (MSA); or
(3) has 100 of fewer beds, is designated by Medicare as a CAH, a SCH, or a RRC, and is located in an MSA.

In general, *Rural Texas Strong* funds will not be expended on programs or services administered by state agencies or institutions of higher education, including at the Health and

Human Services Commission (HHSC), other than a limited amount for program administration and oversight. This is to ensure that funds are expended at the local community level to the greatest extent possible. However, there are exceptions where funds may be spent to improve technological or clinical infrastructure at other state agencies. For example, in certain jurisdictions, the Department of State Health Services (DSHS) acts as the public health district for a rural community, so DSHS may receive funds related to emergency services transportation needs, or other state agencies may receive allocations for technological improvements necessary to support clinical workforce licensure or credentialing so the workforce incentivized to practice in rural communities can receive practice authority more expeditiously.

Rural Health Transformation Plan: Goals and Strategies

With the input of hundreds of rural Texas stakeholders, HHSC has developed a focused, strategic plan. HHSC reviewed existing and upcoming aligned Texas programs and strategies to ensure that the Rural Health Transformation (RHT) plan combines, but doesn't duplicate, the *Rural Texas Strong* project with the enduring vision, goals and strategies for the Lone Star State. The initiatives described here are synonymous with the strategies HHSC will use to reach our vision and goals.

The *Rural Texas Strong* Project

The *Rural Texas Strong* project in Table 2 includes the state's vision and goal for transforming rural health across the state. Texas will use the strategies, identified in green, to ensure that this once-in-a generation funding means every rural Texan can receive appropriate care for their families where, when, and how it works best for their families. The purpose of the table is to demonstrate how each strategy will impact the transformation plan elements: 1) Improving access and outcomes, 2) Technology use and Data driven solutions, 3) Partnerships, 4) Workforce, and

5) Financial solvency strategies, as well as how the plan will address the causes of rural hospital service reduction and closure. Texas was ground zero for the rural hospital closure crisis between 2010 and 2019 with 26 closures. Governor Greg Abbott and the Texas Legislature have prioritized providing financial support for rural hospitals to protect rural Texans' access to life-saving care. From February 2020 to October 2023, no closures occurred. Since 2023, three hospitals have closed. As a result of the state investments in rural health, HHSC has issued emergency hardship grants to seven hospitals to forestall imminent closures. Through this plan, the state has identified how it will address the elements required by federal statute and align with the RHT program's overall strategic goals.

Rural communities value independence and self-sufficiency, requiring innovative and tailored solutions that are different from their urban counterparts.[57] Rural hospitals will be eligible for funding from the *Rural Texas Strong* initiatives, along with Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), pediatric long-term care providers, independent physician practitioners, pharmacies, emergency services providers, and behavioral health providers if they have a physical address located in the 202 rural counties where rural residents are served.

Rural Texas Strong makes significant investments in improving overall health and wellness. These solutions are not only what is in the best interest of Texans but are also the most likely to reduce the overall costs to the healthcare system. Sustainability for our initiatives includes reinvestment of revenue and reduced costs on the healthcare system. These strategies will directly correspond to the state's proposed initiatives and the federally authorized Use of Funds, which are discussed in greater detail in the Proposed Initiatives and Use of Funds section.

Table 2: Transformation Plan							
The *Rural Texas Strong* Transformation Plan							
Vision:		A healthy rural Texas.					
Goal:		Rural Texans should have the ability to receive appropriate care where, when, and how it works best for their families.					
		Strategies for Transforming Rural Health					
Texas Initiative		***Make Rural Texans Healthy Again***	***Rural Texas Patients in the Driver's Seat***	***Lone Star Advanced AI and Telehealth***	***The Next Generation of the Small Town Doctor and Team***	***Unified Care Infrastructure and Rural Cyber Protection***	***Infrastructure and Capital Investments for Rural Texas***
CMS RHT Strategy		***Make rural America healthy again***	***Sustainable access***	***Innovative Care***	***Workforce Development***	***Tech Innovation***	***Sustainable Access; Workforce Development; Innovative Care***
		How will the above strategy impact the required transformation plan element in the blue box?					
Transformation Plan Element	***Improving Access & Outcomes***	By increasing primary care access points and wellness options to reduce emergency room visits and reverse chronic disease prevalence.	By providing patient access to test results and scheduling functionality to improve health and provider connectivity.	By increasing virtual specialty care so care is close to home and contribute to Improving outcomes for more complex conditions	By increasing the number of physicians and other allied health professionals in rural communities	By reducing vulnerabilities and decreasing system downtime, so health information is available when needed	By modernizing equipment and facility upgrades result in new physical space for telehealth services or other new service lines.

Table 2: Transformation Plan							
	Technology Use & Data-Driven Solutions	By increasing opportunities for patient interactions, combined with patient engagement tools, providers will improve outcomes.	By using a consumer-facing patient portal to manage chronic disease and disseminate structured health data	Developing AI technologies will reduce time consuming tasks that are prone to human error and increase telehealth technology	Newly trained professionals will be equipped with more reliable and up to date technology, improving their ability to treat patients.	By developing a Unified Care Infrastructure and increasing cyber protection	Providers will improve efficiency with updated equipment, and evolve their care pathways, and improve accuracy of recordkeeping and patient monitoring.
Transformation Plan Element	***Partnerships***	This strategy will lead to partnerships between local governments, healthcare providers, and patients to develop community-based solutions that improve health outcomes for their local community.	Using Clinically Integrated Networks (CINs) or similar accountable care organizations (ACOs) to improve purchasing power for a collective of rural providers.	Using CINs or similar ACOs to improve purchasing power. Increasing access to subspecialties through telehealth also allows for clinical partnerships that aren't hindered by geography.	This strategy will strengthen healthcare partnerships between providers through mentoring and developing healthcare worker education systems to increase the pipeline of available workers.	By using CINs or ACOs to improve purchasing power of cybersecurity tools.	Investments in tools and capital equipment can foster partnership with vendors, insurers, and research institutions by enabling rural providers to participate in quality improvement initiatives.

Table 2: Transformation Plan							
	Workforce	By creating opportunities to expand the preventative care workforce, such as dieticians and community health workers, in rural areas.	Upgrading and using efficient ways to manage and communicate with patients will contribute to retaining/recruiting staff and reducing their administrative burden from working with disparate or antiquated systems.	Using AI technology to augment patient care is a feature that will contribute to recruiting and retaining clinical staff. Telehealth will extend the reach of specialists to rural residents	This strategy is devoted to workforce recruitment and retention with five-year commitments to increase the availability of providers in rural counties.	By updating outdated and vulnerable technology, current and future healthcare staff will want to work at a provider with equipment and systems that improve their ability to delivery care and create efficiencies.	Improving and investing in capital equipment is vital to retaining a skilled and satisfied workforce.
Transformation Plan Element	***Financial Solvency Strategies***	By increasing opportunities to reduce the chronic disease burden through community wide and driven solutions this strategy can diversify revenue streams for a hospital.	Consumer-facing portals and HIE will increase efficiency and care coordination between patients, providers, and payers, leading to greater savings and improved communication among healthcare teams.	By increasing access to telehealth within rural communities, the aim is to decrease rural facility bypass and have rural hospitals and providers be a reliable location for access to subspecialties and contribute to a provider's income through a new service line.	By creating a reliable pipeline of workforce talent this strategy aims to reduce rural facility bypass and ensure rural providers are adequately staffed to provide the healthcare their community needs.	By reducing the potential for costly cyber-attacks, it brings rural providers up to modern day standards of safeguarding important healthcare data and it frees up valuable resources that may have been diverted to recovering from a cyberattack.	By bolstering rural Texas providers' ability to make investments in their facilities and staffing will have a positive financial impact. With updated equipment for diagnosis and treatment or providing new services that allow residents to receive specialty care as close to home as possible.

Table 2: Transformation Plan							
	Cause Identification	This initiative will result in a reduction in chronic disease cost burden through improvement of prevention and intervention for chronic diseases.	Consumer tech will make appointment scheduling more convenient and alleviate low-volume utilization and negative operating margin as a cause for rural vulnerability.	Innovative tools will reveal growth opportunities related to patient outmigration for rural providers and improve operating margin.	Rural service lines are at-risk due to the inability to recruit and retain qualified healthcare providers.	Rural hospitals are vulnerable to cyber attack and patients risks will be reduced when this initiative connects health information.	This strategy will help modernize rural facilities and equipment with reinvestment, which has been identified as a driver of rural vulnerability.
Transformation Plan Element	***Strategic Goal Alignment***	*Make rural America healthy again* Allows counties to focus on chronic diseases/condition, by creating new access points aimed at disease prevention, management and new behavioral health access.	*Make rural America healthy again, Sustainable access, Tech Innovation* Promotes preventative health by empowering patients to take control of their health stories and aims to make rural providers a long-term access point for reliable and coordinated care and enable data sharing.	*Tech innovation, Sustainable Access, Innovative Care* Adopts new innovative AI technology and expands telehealth use to promote efficient care delivery, invest in emerging technologies, and promote flexible care arrangements.	*Workforce Development* Attracts and retains high-skilled healthcare workers and recruit a broader set of providers, like community health workers to help patients navigate the healthcare system.	*Tech innovation* Improves data security and ensuring reliable access to data health tools, without the threat of cyber-attacks.	*Sustainable Access* Invests to ensure rural providers are long-term access points for care, with the most up to date resources and capital equipment.

Program Key Performance Objectives

By the end of FY 2031, *Rural Texas Strong* will achieve the overall program performance objectives depicted in Table 3. The evaluation metrics for each initiative will advance towards these goals. HHSC will work with stakeholders to ensure that any performance measures align with the project implementation plans, to meet the needs of individual communities. To the greatest extent possible, HHSC has identified data sources already being tracked. This reduces administrative burden on HHSC and funding recipients and enables HHSC to measure the impact of initiatives more quickly with more easily identifiable baseline data. HHSC, as the state Medicaid agency and lead agency for the RHT Program, confirms it will cooperate with any CMS-led evaluation or monitoring.

Table 3: Program Performance

Initiative	Objective	Baseline (2024)	Target (2031)
1. Make Rural Texans Healthy Again	Reduce Texas Non-Metro Ratio of Population to Dieticians (Population:Dietician)	10,253:1	8,202:1
2. Rural Texas Patients in the Driver's Seat	Increase Remote Patient Monitoring	<10%	>20%
3. Lone Star Advanced AI and Telehealth	AI based automation of fax processing – Decrease % of Rural Texas Hospitals w/ human fax processing	>95% of hospitals	<65% of hospitals
4. The Next Generation of the Small Town Doctor and Team	Reduce Texas Non-Metro Ratio of Population to CHW (Population:CHW)	15,974:1	11,181:1
5. Unified Care Infrastructure and Rural Cyber Protection	Increase % Rural Texas Hospitals w/ Automated Quality Reporting	<10% of hospitals	>40% of hospitals
6. Infrastructure and Capital Investments for Rural Texas	Reduce Texas Rural Hospitals w/ < 10 Days Cash on Hand	48 hospitals	<34 hospitals

Legislative or Regulatory Action

Table 4 includes legislative commitments and current policies related to the state policy actions.

Table 4: Legislative or Regulatory Action		
Factor	**Description**	**Texas Policy**
B.2	Health and Lifestyle	Governor Greg Abbott has committed that all Texas public schools will reinstate and implement the Presidential Fitness Test no later than September 1, 2028. Texas law already requires a fitness test for children in the public schools, and we currently use a research-based tool to assess student health. The new Presidential Fitness Test proposed by President Trump will be incorporated into the state's requirements for physical education as a required part of the Texas public-school curriculum.
B.3	SNAP Waivers	Texas has an approved SNAP Food Restriction Waiver.[58]
B.4	Nutrition Continuing Medical Education	Texas established continuing education requirements in nutrition and metabolic health for licensed physicians, physician assistants, and nurses.[59] The Texas Medical Board will adopt rules no later than Dec. 31, 2026, to implement the new requirement.[60]
C.3	Certification of Need (CON)	Texas does not have any CON or CON-equivalent statutes.[61]
D.2	Licensure Compacts	Texas is an Interstate Medical Licensure Compact Member State serving as State of Principal License.[62] Texas is a Nurse Licensure Compact Member State.[63] Texas is an EMS Compact Member State.[64] Texas is a PSYPACT Participating State.[65] Texas does not participate in the Physician Assistant licensure compact.
D.3	Scope of Practice	Texas Physician Assistants have a moderate scope of practice.[66] Texas Nurse Practitioners have a restricted scope of practice.[67] Texas Pharmacist have restricted authority, 0-3 score (restricted)..[68] Texas dental hygienists have a semi-restricted scope of practice with 3 allowed task types.[69]
E.3	Short-term Limited Duration Insurance (STLDI)	STLDI plans in Texas are not restricted beyond the latest federal guidance. The maximum allowable initial contract term for an STLDI plan in Texas is 3 months. The maximum allowable total coverage period for STLDI plans in Texas is 4 months.[70]
F.1	Remote Care Services	Texas Medicaid covers telemedicine and telehealth services that are provided through the following delivery methods:[71] Synchronous audiovisual technology between the distant site provider and the client in another location (live video).[72] Store and forward technology in conjunction with synchronous audio-only technology between the distant site provider and the client in another location.[73] Texas Medicaid covers home telemonitoring services for certain clients.[74] A physician may not provide telemedicine medical services to patients in Texas unless they hold a full Texas medical license, except for those who held an out-of-state telemedicine license as of Sept. 1, 2022.[75] Texas does not issue telemedicine licenses.[76]

Other Required Information

- **For Factor A.2**: As of Sept. 1, 2025, Texas has a total of 43 Certified Behavioral Health Clinics (CCBHCs), operating at 339 sites. A complete list of all entities within Texas is included in Other Supporting Materials.
- **For Factor A.7**: 31.69% of hospitals in Texas receive a Medicaid Disproportionate Share Hospital (DSH) payment. That equates to 180 out of 568 hospitals for the most recent state plan rate year. Beginning in FY2025, HHSC deemed 100% of rural hospitals eligible for Medicaid DSH.

Proposed Initiatives and Use of Funds

Initiative #1: Make Rural Texans Healthy Again

Description: HHSC will issue grants in two parts. Part 1 will provide direct awards to 80 rural hospital districts and authorities with a publicly owned and operated hospital in their jurisdiction. Part 2 will provide competitive awards to public and private rural hospitals to enhance or create community-based prevention, wellness, and nutrition programs or services aimed at improving diabetes, obesity, heart disease, and maternal health outcomes. For Budget Period 1, Initiative 1 – Part 1 direct awards will be limited to startup implementation funding on a demonstrated-cost basis so that the state can obligate and disburse funds for approved local projects within the timeframe required by CMS. The broader pay-for-performance structure for Initiative 1 will remain in place in later years, with the bulk of outcome-based payments reserved for Years 4 and 5 following verified achievement of approved outcome measures. A hospital district is a local governmental entity that is authorized by the Texas Constitution and state statute. They are voter approved taxing authorities that create hospital systems to provide hospital and medical care facilities and they have full responsibility for providing medical and hospital care to needy inhabitants of a county. Hospital authorities are a local governmental entity, without taxing authority, that operates,

manages, and oversees hospitals and healthcare services. Local governments and rural hospitals that receive this funding will be given significant flexibility in the logistics of implementing solutions to improve outcomes. Local governments and rural hospitals will be required to identify vulnerabilities in the overall local rural healthcare ecosystem and to focus solutions on technological innovation that integrates mid-level practitioners and pharmacists, along with behavioral health and primary care clinics and providers. They will be required to implement one or more of the following options: (1) purchasing equipment, subsidizing the facility cost of, or issuing sub-contracts or sub-grants for a community wellness center. The center may offer preventative chronic disease screenings, gym equipment, group exercise classes, fitness/strength training, and/or nutritional education classes; (2) partner with regional grocery stores, farmer's markets, or local food pantries to sponsor regular pop-up grocery markets to make available fresh U.S. grown produce, dairy, and meat, healthy cooking demonstrations for all ages, and/or nutrition-conscious ready-to-heat meals; (3) establish and operate an after-hours primary care clinic to reduce non-emergent emergency department visits, (4) provide low or no-cost chronic disease screenings (prevention) and low or no-cost primary care visits, (5) provide nonemergent transportation support to improve access to pharmacies (to improve medication adherence), grocery stores that sell U.S. grown produce, dairy, and meat, and primary or preventive healthcare appointments, (6) establish care systems for active remote monitoring for high acuity patients; (7) acquire technology resources (including computers, electronic tablets, etc.) made available at community partner organizations or entities for individuals who are dually eligible for Medicare and Medicaid to use to research and enroll in health coverage options (including integrated plans such as D-SNPs), as well as resources for guidance to individuals about what Medicare options

include local behavioral and preventative care providers to promote continuity of care; and (8) include other strategies designed to increase individual rural Texans' access to healthy foods, prescriptions, and other items related to improving their own health. Funding will not be allowed to go towards payments for food but will support the infrastructure to meet the goals outlined in the options above. Recipients will be required to select health and lifestyle initiatives that are rooted in evidence-based projects with measurable health outcomes. The hospital districts that receive the grants will be authorized to receive grant funds that exceed their demonstrated costs to enable them to retain funds as an incentive for achieving quality outcome measures. Targets for each grantee will be established at the time of grant award, but will be aligned with the overall outcome measures described below. These approaches can improve quality of life, mental health, worker productivity, and health outcomes while reducing patient expenses, hospital utilization and disease impacts. [77]

Depending on the project selected by a local government or public or private rural hospital, multiple RHT strategic goals may align with a given solution. For example, an after-hours clinic or wellness center can create new access points for care; a pop-up grocery store can improve access to healthy food and address root causes of chronic disease; and a community-based prevention initiative can attract and retain a skilled workforce across the healthcare continuum, including physicians, nurses, physical therapists, community health workers, and nurse aides. For Initiative 1 – Part 1, sustainability is strengthened by the existence of local governmental revenue streams and the expectation that improved chronic disease management will reduce overall healthcare cost burdens in the community.

Main Strategic Goals: Make rural America healthy again.

Uses of Funds: A. Prevention and chronic disease, B. Workforce.

Technical Score Factors: B.1, B.2, B.3, B.4, C.1, C.2, D.1

Key Stakeholders: Public hospitals, RHCs, FQHC in rural counties, emergency medical services, all healthcare workers, all residents of participating jurisdiction.

Outcomes: This initiative will continue to monitor all four outcomes identified in Table 5. However, for Initiative 1 – Part 1 direct awards, the principal pay-for-performance determinations in later years will focus on reducing diabetes-related emergency department visits and increasing participation by adults in diabetes self-management education. The remaining two measures, the number of dietitians in rural counties and obesity prevalence, will continue to be tracked as broader indicators of statewide and initiative-wide impact.

Table 5: Outcomes

Local Solution	Proposed Measure	Level	Baseline	Target
Diabetes Related Emergency Visits	ED Visits related to diabetes	County	2024	Decrease prevalence by 2.5%
Increase Dietitians	# of Dietitians in Rural Counties	Non-Metro Statewide	2024	Increase by 20
Obesity Prevalence	% Overall Prevalence of Obesity	Non-metro Statewide	2023	Decrease by 1.0%
Adults taking a course or class in how to manage your diabetes	% taking a course or class in how to manage diabetes	Non-Metro Statewide	2022	Increase by 2.5%

Impacted Counties: For Part 1 - 80 rural hospital districts with a publicly owned and operated hospital in their jurisdiction and public and private rural hospitals, affecting multiple rural counties. For Part 2 – all rural Texas counties that are served by a public or private rural hospital

Estimated Required Funding: $433,524,850 or 31% of federal funding over five years.

Implementation Plan and Timeline: This initiative will be administratively managed within HHSC by the Rural Texas Strong team. The revised allocation for Initiative 1 totals $433,524,850

over the five-year project period and is separated into two parts. Part 1 allocates $280,000,000 over five years for direct awards to 80 rural hospital districts and authorities. In Budget Period 1, HHSC will issue approximately $60,000,000 in startup implementation funding for Initiative 1 – Part 1, averaging approximately $750,000 per participating district if all 80 districts choose to participate. These Budget Period 1 funds must be used for approved local projects and fully expended within the timeframe required by CMS for Budget Period 1 liquidation. Part 2 allocates $153,524,850 over five years for competitive awards to public and private rural hospitals. Budget Period 1 includes $56,250,000 for this competitive component, with application, award, and monitoring activities structured to support timely obligation and allowable disbursement. Smaller implementation and operational support amounts may continue in Years 2 and 3, while the bulk of Initiative 1 – Part 1 funding remains reserved for performance-based payments in Years 4 and 5 following demonstrated and verified achievement of approved outcome measures. The table below illustrates the estimated tasks and timeline.

Table 6: Workplan & Monitoring	
Initiative 1: Make Rural Texans Healthy Again	
Initiative Stage Description	**Typical Actions to Occur in Stage**
Assessment - Stage 0 (Target Completion – Q2 FY 2026)	
<15%	
Reconcile current conditions with Application plans.	Identify changes in initial Initiative assumptions and confirm jurisdiction interest /participation.
Mitigate risks; Identify Task Assignments; Develop Infrastructure to support work - Communications plan, workflows- internal and external.	Identify risks - e.g. verifying total debt at point in time. Initiate contract drafting and communicate details of funding to potential eligible counties. Identify major tasks and owners (e.g. hiring staff); Create communication plans
Project Planning - Stage 1 (Target Completion Q2 FY 2026)	
15%	

Project Kick off meetings.	Kick off meetings internally to accomplish administrative and infrastructure building tasks. Identify key deadlines, processes, and information. Invite eligible jurisdictions to apply for funding. Application will allow for identification of jurisdiction's chronic disease plan.
Develop Strategies for Communications, Timeline, Recruitment/hiring, Identify Procurement steps.	Meet with eligible counties to identify technical assistance needs in refining chronic disease/condition solutions, milestone, and measures. Review/finalize contractual agreements.
Project Initiation and Execution - Stage 2 (Target Completion Q4 FY 2026)	
30%	
Stakeholder Engagement.	Communicate to stakeholders the initiative status, Continue with TA for local leaders. Identify stakeholder input and incorporate as needed throughout project life cycle.
Funding distribution (100% of Part 1 Funds) Prepare procurements for Part 2 Funding	Distribute Part 1 funding. Identify project timelines for local government's work. Draft, review, and finalize competitive application process for Part 2 funding for distribution in Budget Period 2.
Project Monitoring and Controlling - Stage 3 (Target Completion Q2 FY 2027)	
50%	
Local Efforts begin.	Conduct site visits to rural awardees, as applicable.
Technical Assistance (TA)	Provide assistance for project development and execution.
Project Outcomes - Stage 4 (Target Completion Q2 FY 2029)	
75%	
Maintaining and Sustaining Work .	Continue contractor monitoring. Monitor stakeholder engagement between local leaders and community members.
Monitoring milestones; Regular Communication with contractors; TA provided,	Continue to conduct site visits, continue to provide TA to local leaders, as applicable.
Project Closure or Reconciliation - Stage 5 (Target Completion Q4 FY 2030-32)	
100%	
Contract closure or reconciliation activities.	If more funding is available, amend contracts & timelines.

Stakeholder Engagement: Prior to the application period, HHSC will offer technical assistance and work with local governments to coordinate with existing rural community providers, community-based facilities, and other key stakeholders (such as non-traditional health organizations like food pantries or social health providers). HHSC and stakeholders will discuss

how to select the chronic disease/condition and the solution(s) for which the local jurisdiction intends to focus their *Rural Texas Strong* funding and for which they have a viable long-term sustainability path. HHSC will participate to ensure local leaders of preventative care, long-term care, behavioral health, and social health providers are actively engaged, alongside hospital board members and residents in the community to ensure that projects selected are focused on strengthening the entire ecosystem and meet the most critical local need. Upon distributing awards, HHSC will continue to conduct quarterly meetings with grantees to evaluate progress towards outcome measures, with a continued focus on developing novel prevention-focused models that emphasize lifestyle changes, physical activity, and proper nutrition. Through contract compliance oversight, HHSC will also monitor progression towards financial sustainability at the conclusion of the program.

Metrics and Evaluation Plan: The state has established targets that prioritize improving diabetes management and education. Additional performance targets will be embedded in grant agreements and will prioritize coordination with stakeholders and subrecipients to identify realistic and locally driven outcomes that will advance the goal of creating community-based prevention, wellness, and nutrition programs or services aimed at improving chronic disease conditions. The measures below prioritize existing health outcome data. An interagency agreement with DSHS will be executed to increase the sampling of rural residents for the Behavioral Risk Factor Surveillance System to ensure there is enough data to collect outcome measurements. Recipients will be required to affirm and document that the health and lifestyle initiatives selected are rooted in evidence-based projects with measurable health outcomes, including those listed below. For Initiative 1 – Part 1, Texas anticipates using

the diabetes-related emergency department measure and the adult diabetes self-management education measure as the principal measures for future pay-for-performance determinations, while continuing to track the dietician and obesity measures as broader indicators of statewide and initiative-wide impact. Recipients will be required to affirm and document that the health and lifestyle initiatives that are selected are rooted in evidence-based projects with measurable health outcomes, including those listed below.

Table 7: Metrics & Evaluation – Make Rural Texans Healthy Again

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
Outcome Measure*[13]	Diabetes-related Emergency Visits*	Increase the Number of in Rural Counties Profession – Dietitians*	Obesity Prevalence*	Adults taking a course or class in how to manage your diabetes*
Data Source	DSHS Syndromic Surveillance	DSHS Health Profession Supply	Behavioral Risk Factor Surveillance System	Behavioral Risk Factor Surveillance System
Definition	The # of visits to the emergency unit related to diabetes – participating counties	The # of licensed dieticians in eligible counties	Percent of Adults with a BMI greater than or equal to 30 kg/m^2.	Percentage of adults aged 18 and above who have taken a course on managing their diabetes
Baseline	2024	2024	2023	2022
Year 1 - 2026	Planning	Planning	Planning	Planning
Year 2 - 2027	Implement	Implement	Implement	Implement
Year 3 - 2028	Implement	Implement	Implement	Implement
Year 4 - 2029	Decrease emergency department visits by 1%	Add 10 master's level licensed dietitians	Decrease by 0.5%	Increase by1%
Year 5 - 2030	Decrease emergency department visits by an additional 2.5%	Add 20 master's level licensed dietitians	Decrease by an additional 1.0%	Increase by an additional 2.5%

[13] * - Baseline and county/community level reporting. ** - Baseline and target will require provider or subcontractor survey.

Sustainability Plan: Part 1 of this initiative has a built-in financing mechanism through a local jurisdiction's ad valorum tax revenue or other existing revenue streams to sustain the chosen chronic disease/condition solution for its community. In addition to the direct financial support from ad valorem tax streams, the initiatives are likely to produce cost savings that will further enhance the sustainability of the initiatives long-term. Rural public and private hospitals will be required to demonstrate their sustainability plans within the competitive application process.

Initiative #2: Rural Texas Patients in the Driver's Seat

Description: While some rural hospitals, primary care clinics, behavioral health clinics, and pharmacists have simple patient portals and may participate in health information exchange (HIE), others have deferred participation because of cost barriers. Standalone systems can be costly, with limited functionality, and result in mixed patient participation. However, providing patient-specific data can be transformative to a patient and their health outcomes.[78] The creation of a patient-facing healthcare portal that integrates with the provider's electronic medical record and regional or statewide HIE, is a foundational step to improving and advancing positive health outcomes by providing people with access and freedom to improve their own wellness.[79]

This initiative will invest in technology that will establish consumer-facing health portals that engage patients and facilitate HIE between patients, providers, and payers. Through consumer-facing portals, patients can communicate directly with their healthcare team through messaging, access documentation about medical visits, conduct virtual visits, and provide anytime access to their personal health information. Once healthcare portals are established, integration with other applications and consumer technology, such as medication sync and adherence reminders, smart

watches that record heart rates, oxygen saturation levels, and blood pressure; continuous glucose monitors; CPAP/BiPAPs compliance data; portable in-home dialysis equipment; and other remote monitoring technology becomes much more attainable.[80,81]

For healthcare providers, portals and HIE offer improved care coordination between visits, unifying infrequent, sporadic and disconnected visits. HIEs serve as a connecting point for organized initiatives, reduce duplication of services, and reduce operational costs by automating many administrative tasks.[82] Providers can access a patients' health information to facilitate efficient care and payers can make timely coverage decisions. [83] This foundational data is critical to value-based care strategies targeting reductions in preventable and high-cost interventions to improve overall community health. Further, by aligning local or regional providers across the spectrum of acute, long-term, emergency, and pharmacy services, we will open the pathway to two-sided risk models, where providers both the upside and downside risk related to patient care costs and quality, with data available to produce efficacy. Texas has keen interest in advancing alternative payment model options, but reaching two-sided risk models first requires technological solutions to unite the whole ecosystem of health providers. In addition to the patient portal, funds will be made available to purchase and equip consumers with remote monitoring related equipment or other portable health technology that is compatible with the portal.

Funding will not be used to supplant existing programs; HHSC will incorporate lessons learned and extend the reach beyond existing Medicaid Provider HIE Connectivity efforts and

Medicaid managed care incentives like the Medicaid Managed Care Aligning Technology by Linking Interoperable Systems (ATLIS) program.[14]

Main Strategic Goals: Make rural America healthy again, Sustainable access, Tech Innovation

Uses of Funds: F. IT Advances

Technical Score Factors: B.1, B.2, C.1, F.1, F.2, F.3

Key Stakeholders: Rural hospitals, rural health clinics (RHC), FQHC in rural counties, payers, pharmacists, independent physician practices, behavioral health providers, rural communities, patients, and families, consumer tech innovators.

Outcomes: This initiative will use the following reliable, consumer-facing tech outcomes shown in Table 8.

Table 8: Outcomes

Measure	Level	Baseline	Target
Number of Providers Upgrading or Adding Patient Portal System	Subcontractor	2027	40 hospitals & 50 clinics
Number of Appointments initiated through the Portal	County	2027	Increase appointments initiated by 5%
Remote Patient Monitoring (RPM)	State	2027	Increase hospital RPM participation by 5%
HITRUST or NCQA Certification	Community	2027	Increase certifications by 5%

Impacted Counties: All 202 rural counties.

Estimated Required Funding: $150,000,000 or 11% federal funding. (Any EMR expenditures related to a previous HITECH certified EMR system will be limited to 5%).

Implementation Plan and Timeline: HHSC will award funding through a competitive procurement process to two or more clinically integrated networks, accountable care organizations,

[15] HHSC will also use its established engagement framework and activities to involve stakeholders and create a feedback loop of their input to HHSC. This information is detailed in Other Supporting Materials.

or similar cooperatives to purchase, install, and operate healthcare portals with compatible consumer applications and technology integration. This approach will ensure through group purchasing the best value is negotiated. The following criteria will be used to select the entities: (1) subject matter expertise and commitment to improving technology access, specifically, health information exchanges and provider technology solutions and (2) a minimum of the entity's membership is comprised of at least 60% or more of rural providers. HHSC will also use the CMS Health Tech Ecosystem framework for Patient Facing Apps to guide contracting criteria. The applications should support data exchange with patient identity verification, eliminate manual check-in forms, and provide tailored, data-driven support to individuals at risk for or living with diabetes and obesity.[84]

Entities will be restricted to using technology software and hardware that fully complies with CMS's Health Technology Ecosystem criteria and is built to integrate with consumer-facing equipment and applications. Priority will be given to CIN, ACO, or cooperative technology created by companies identified as CMS's Early Adopters, that are willing to take on the challenge of equipping providers and patients with tools to manage and share their health information in a secure and easy to understand way. Sub-contractors must be willing to provide value-added services, such as digital literacy training for rural residents and providers. The contractors will coordinate activities with HHSC and meet at least quarterly throughout rural transformation periods to ensure the implementation plan and timeline below are followed. The goal is that assessment and project planning happen in rapid succession, so contracts can be executed, and advancements make their way to consumers as soon as possible. The table below illustrates the estimated tasks and timeline for completing major milestones for this initiative.

Table 9: Workplan & Monitoring	
Initiative 2: Rural Texas Patients in the Driver's Seat	
Initiative Stage Description	**Typical Actions to Occur in Stage**
Assessment - Stage 0 (Target Completion - Q1 FY 2026)	
<15%	
Reconcile current conditions with Application plans.	Identify changes in initial initiative assumptions and confirm provider interest /participation.
Mitigate risks; Identify Task Assignments; Develop Infrastructure to support work – Communications plan, workflows- internal and external	Identify risks – e.g. Proposed platforms compatible for providers? Number of vendors needed? Identify major and owner of task(s). E.g.: Hire staff, identify procurement steps and initiate them. Engage HHSC Legal to initiate contract drafting.
Project Planning - Stage 1 (Target Completion - Q1 FY 2026)	
15%	
Project Kick off meetings	Kick off meetings internally to accomplish administrative and infrastructure building tasks.
Develop Strategies for Communications, timeline, Recruitment/hiring, Identify Procurement steps	Initiate any needed procurement steps to complete Request for Proposal for organizations. Begin communication with stakeholders.
Project Initiation and Execution - Stage 2 (Target Completion - Q2 FY 2027)	
30%	
Stakeholder engagement	Communicate to stakeholders the initiative status, discuss outcome measurements and identify any challenges or concerns.
Funding distribution begins	Distribute funding to contractors and identify quarterly meeting timeline, obstacles, and provider engagement expectations.
Project Monitoring and Controlling - Stage 3 (Target Completion - Q1 FY 2028)	
50%	
Funding distributed	All funding is distributed to contractor(s).
Local Efforts begin	Monitor contractor(s) milestones for technology implementation, Site visits to awardees, as applicable.
Project Outcomes - Stage 4 (Target Completion - Q1 FY 2029)	
75%	
Maintaining and Sustaining Work; Monitoring metrics	Continue contractor monitoring. Begin data collection to assess outcome progress.
Stakeholder engagement; Communication with contractors	Review contractor plans for patient education efforts for new technology. Sustainability planning & monitor/discuss with grantees.
Project Closure or Reconciliation - Stage 5 (Target Completion - Q1 FY 2030-32)	
100%	
Contract closure or reconciliation activities. Outcome Evaluation	All provider portals are active and begin reporting data. Continue to evaluate progress related to defined

	metrics. If more funding is available, amend contracts and timelines.

Stakeholder Engagement: This initiative will require engagement with consumer technology experts, rural Texans, and providers located in rural communities to ensure patient portals and health information exchanges are meeting the needs of each community. The Early Adopters selected through the procurement process will be key stakeholders in the implementation of this initiative. The CINs and ACOs will be key stakeholders in coordinating efficient and coordinated solutions that are configurable or turn-key, as is necessitated locally. As technological upgrades begin, the grantees or their sub-contractors will be responsible for providing technical assistance and training to end users. HHSC will use established advisory committees to facilitate stakeholder engagement, while HHSC simultaneously conducts contract monitoring and oversight to document progress made toward reaching outcome milestones.[15]

Metrics and Evaluation Plan: The targeted outcomes for this initiative measure the adoption, development, and appropriate usage of consumer-facing health technology for the prevention and management of chronic diseases. While the state has established targets, the goal is to prioritize coordination with stakeholders and subrecipients to identify realistic and locally driven outcomes based on the total funding allotted.

Table 10: Metrics & Evaluation - Rural Texas Patients in the Driver's Seat

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
Outcome*[16]	# of Providers Upgrading or Adding Patient Portal System**	# of Appointments initiated through the Portal*	Remote Patient Monitoring (RPM)**	HITRUST or NCQA Certification*

[15] HHSC will also use its established engagement framework and activities to involve stakeholders and create a feedback loop of their input to HHSC. This information is detailed in Other Supporting Materials.
[16] * - Baseline and county/community level reporting. ** - Baseline and target will require provider or subcontractor survey.

Table 10: Metrics & Evaluation - Rural Texas Patients in the Driver's Seat				
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**
Data Source	Self-Reported; Contractual Reporting	American Hospital Association Annual Survey	Self-reported, Contractual Reporting	HITRUST Alliance; NCQA
Definition	This measure counts the # of providers by county/community upgrading or adding a patient portal system.	Non-face-to-face patient -initiated communication through an online patient portal.	This measure counts the # of rural Texas hospitals utilizing RPM.	Numerator – HITRUST or NCQA Certifications Denominator – total # of participating provider sites
Baseline	2027 - Dependent on the # of contracts issued.	2027 - Dependent on the # of contracts issued.	2027 - Dependent on # of contracts issued.	2027 - Dependent on the # of contracts issued.
Year 1 (2026) Target	Planning	Planning	Planning	Planning
Year 2 (2027) Target	Implement	Implement	Implement	Implement
Year 3 (2028) Target	10 or more rural hospitals and 15 or more primary or behavioral health rural clinics on integrated patient portal.	Increase non-face-to-face communication by 1%.	Increase hospital RPM participation by 1%.	Increase certified rural providers by 1%.
Year 4 (2029) Target	25 or more rural hospitals and 35 or more primary or behavioral health rural clinics on integrated patient portal.	Increase non-face-to-face communication by an additional 2.5%.	Increase hospital RPM participation by 2.5%.	Increase certified rural providers by an additional 2.5%.
Year 5 (2030) Target	40 or more rural hospitals and 50 or more primary or behavioral health rural clinics on integrated patient portal.	Increase non-face-to-face communication by an additional 5%.	Increase hospital RPM participation by 5%.	Increase certified rural providers by an additional 5%.

Sustainability Plan: The most substantial cost of consumer tech solutions is the initial infrastructure investment in development and implementation during the first three years of rural

transformation period. Clinically integrated networks or accountable care organizations comprised of rural providers will work together to aggregate purchasing power, scale participation fees, and negotiate modest ongoing annual maintenance/service fees that enable realistic expectation of renewed and sustained participation among the provider community. If the patient portal and HIE yield expected cost savings, and rural residents adopt the digital tools, providers will begin engaging commercial payers and employers by program year 4 and 5. This engagement is expected to form locally-designed alternative payment models where shared savings in patient costs from reduced duplication of services and improved outcomes will be reinvested to fund participation in ongoing financing for technology maintenance costs. This will produce a win-win-win scenario for patients, providers, and payers alike.

Initiative #3: Lone Star Advanced AI and Telehealth

Description: Rural healthcare providers must overcome barriers related to access, staffing availability, training, unreliable analytics, geography, and efficiency. Artificial Intelligence (AI) can help rural providers in areas that lack the resources by elevating analytics, monitoring trends, and detecting risk earlier.[85] The use of AI can also assist with streamlining back-office functions, reducing administrative cost burden that is passed on to patients, and increase the ability of local, independent providers to assess diagnostic complexities for which they may need to ultimately seek remote specialty service referrals.[86] Virtual care has also proven itself to be a viable service that limits travel burden for rural Texans and increases access, as well as easier exchanges of best practices as enhanced care coordination. However, advancements have been piecemeal rather than at scale in rural communities. AI and telehealth offer tremendous opportunities to predict and

improve patient outcomes, maintain care, and make medication and therapy adjustments efficient for the patient and the provider.[87]

Through this initiative, Texas will establish and deploy Lone Star Advanced Artificial Intelligence and connect disparate pieces of a fragmented specialty care telehealth landscape into a statewide network available to primary care providers and their patients. The goal is to use care delivery innovations to bridge service gaps across rural Texas and address critical barriers to care in rural communities, including limited access to specialty providers, high rates of chronic disease, and health workforce shortages. Not all rural Texans have access to the internet or reliable cellular coverage at home, so this initiative will also include resources necessary to establish patient-focused hubs where they can receive telehealth care nearby at a location equipped with internet or cellular coverage.

AI models can be deployed in emergent and acute clinical settings, be directed to either ambient listening or agentic tools, and can identify patients at the highest risk of poor outcomes and enable earlier, more proactive interventions.[88] Understanding that many HIE and electronic medical record systems include or plan to include AI functionality, this initiative will be operationalized in close coordination with Initiative #2 and Initiative #5, which also prioritize tech innovation. Personalized AI-driven support, in alignment with the CMS Health Tech Ecosystem, can also be used as support for patients. Early focus areas will include maternal health, behavioral health, and preventive screening, by supporting clinicians with administrative tasks; payers will be able to receive appropriate medical information to facilitate faster prior authorization processing, more accurate coding for claim submission and processing, and easier recognition of care coordination opportunities for comprehensive health coverage. Each site will measure

outcomes across clinical quality, patient experience, and cost reduction, creating a rigorous evidence base for scaling.

Telehealth can increase access to specialists, result in faster treatment, allow patients to remain in their community, and alleviate transportation concerns.[89] All telehealth services in this initiative will be directed toward prevention, behavioral health treatment, or remote monitoring of chronic conditions by relevant specialists – because timely care at the acute onset of disease is a proactive way to reduce downstream negative health outcomes and chronic issues. Telehealth can benefit providers by lessening the sense of isolation, while improving patient outcomes.[90] This project aims not only to improve outcomes by county, but to create a scalable, evidence-based model that can endure beyond *Rural Texas Strong.*

Main Strategic Goals: Tech innovation, Sustainable Access, Innovative Care

Uses of Funds: C. Consumer tech solutions, D. Training and technical assistance, F. IT advances

Technical Score Factors: B.1, B.2, C.1, D.1, F.1, F.2, F.3

Key Stakeholders: Rural hospitals, RHCs, EMS providers, FQHC in rural counties, CMHCs, CBHC's, and rural patients, tech innovators.

Outcomes: This initiative will use the following specific outcomes:

Table 11: Outcomes

Measure	Level	Baseline	Target
AI-Based Automation of Fax Processing	Community	2027	Decrease human fax processing by 15%
Access to Specialty Care (Behavioral Health, Radiology, and Maternal Care)	County	2027	Increase by 15%
Digital Literacy Training	Community	2027	Increase by 15%
Telehealth Offerings at Facilities	Community	2027	Increase by 15%

Impacted Counties: 202 rural counties.

Estimated Required Funding: $150,000,000 or 11% of federal funding over five years.

Implementation Plan and Timeline: This initiative will be administratively managed within HHSC by the *Rural Texas Strong* team. HHSC will issue funding as a competitive request for proposals for two or more entities (e.g. clinically integrated networks or other similar accountable care organizations) with subject matter expertise and commitment to improving technology access. Selected entities must devote effort to increasing access to provider-focused ambient artificial intelligence tools that will support clinical documentation, billing, and prior authorization request submissions. Similar to Initiative #2, entities will be restricted to using technology software and hardware that fully complies with CMS's Health Technology Ecosystem criteria and is built to integrate with consumer-facing equipment and applications. Priority will be given to technology created by companies identified as CMS's Early Adopters. The table below illustrates the estimated tasks and timeline for completing major milestones for this initiative.

Table 12: Workplan & Monitoring	
Initiative 3: Lonestar Advanced AI and Telehealth	
Initiative Stage Description	**Typical Actions to Occur in Stage**
Assessment - Stage 0 (Target Completion - Q1 FY 2026)	
<15%	
Reconcile current conditions with Application plans.	Identify changes in initial Initiative assumptions and confirm provider interest /participation.
Mitigate risks; Develop Infrastructure to support work - Communications plan, workflows-internal and external.	Identify risks - e.g. Identify technology barriers or conflicts with eligible entities. Identify major tasks (e.g. hiring staff)., ID procurement steps and initiate.
Project Planning - Stage 1 (Target Completion - Q1 FY 2026)	
15%	
Project Kick off meetings and initial stakeholder engagement.	Create communication plans. Identify key deadlines, processes, and information about entities to invite to bid. Kick off meetings internally to accomplish administrative and infrastructure building tasks.
Develop Strategies for Communications, timeline, Recruitment/hiring, Identify Procurement steps.	Discuss end-user needs and beneficiaries of technology changes to guide procurement; Initiate any needed procurement steps and complete request for proposal.
Project Initiation and Execution - Stage 2 (Target Completion - Q2 FY 2027)	
30%	

Stakeholder engagement.	Communicate to stakeholders the initiative status. Discuss technological needs, potential for AI capabilities, current telehealth landscape.
Funding distribution begins.	Distribute funding to contractors to begin coordinated effort to establish AI and connected telemedicine.
Project Monitoring and Controlling - Stage 3 (Target Completion - Q1 FY 2028)	
50%	
Funding distributed.	All funding is distributed to contractors.
Local Efforts begin.	Monitor contractor milestones for tech implementation, discuss resources used for training. Conduct site visits to rural awardees, as applicable.
Project Outcomes - Stage 4 (Target Completion - Q1 FY 2029)	
75%	
Maintaining and Sustaining Work.	Continue contractor monitoring.
Monitoring metrics; Regular Communication with contractors; stakeholder engagement.	Begin data collection to assess outcome progress. Sustainability planning – continuing the momentum of AI and telehealth developments.
Project Closure or Reconciliation - Stage 5 (Target Completion - Q1 FY 2030-32)	
100%	
Outcome Evaluation and amendments.	All AI technology is operational. If more funding is available, amend contracts and timelines.

Stakeholder Engagement Plan: Artificial intelligence and more advanced telehealth may be uncharted territory for many providers, and digital literacy training will be paramount to success. Engagement will be imperative between HHSC, contractors facilitating advancement, rural providers adopting technology, and patients as the ultimate beneficiaries to develop, deploy, and sustain the technological advancements in this initiative. HHSC will engage providers early to ensure the project is designed with end-users in mind. After selection, contractors will be required to coordinate activities with HHSC and meet at least quarterly throughout rural transformation periods to ensure the implementation plan and timeline below is followed. They will be required to regularly communicate with providers and provide initial and on-going training and technical assistance. Provider collaboration will be imperative for sustaining this initiative. Using existing

advisory committees and agency engagement, HHSC will facilitate conversations so that providers are aggregating their purchasing power.[17] CINs, ACOs, or other cooperatives will be required to establish a communications framework where providers using the technology are able to regularly collaborate to share best practices and troubleshoot challenges as AI and telehealth are integrated into practice models. Additionally, the funding recipients must develop a comprehensive plan to identify how these tools will be used to support the independence of rural providers.

Metrics and Evaluation Plan: For this initiative, outcomes evaluate technology adoption, increased access to rendering telehealth providers through affiliation agreements and telehealth availability, and training for new technologies. Contractors and HHSC will work with stakeholders and subrecipients to identify realistic and locally driven outcomes based on funding allotted.

Table 13: Metrics & Evaluation - Lone Star Advanced AI and Telehealth

	Outcome 1	Outcome 2	Outcome 3	Outcome 4
Outcome*[18]	AI-Based Automation of Fax Processing**	Access to Specialty Care (Behavioral Health, Radiology, and Maternal Care)**	Digital Literacy**	Telehealth Offerings at Facilities*
Data Source	Subcontractor Contractual Reporting	Affiliation Agreements	Self-Reported: Contractual Reporting	American Hospital Survey - Telehealth
Definition	Count of providers automating processes and eliminating fax processing.	Count of new affiliation agreements resulting from expanded telehealth.	Numerator – digital literacy training sessions Denominator – # of participating provider sites	Count of Telehealth Services offered at a Facility.
Baseline	2027 - Dependent on the # of contracts issued.	2027 - Dependent on the # of contracts issued.	2027 - Dependent on the # of contracts issued.	2027 - Dependent on the # of contracts issued.
Year 1 (2026) Target	Planning	Planning	Planning	Planning
Year 2 (2027)	Implement	Implement	Implement	Implement

[17] HHSC will also use its established engagement framework and activities to involve stakeholders and create a feedback loop of their input to HHSC. This information is detailed in Other Supporting Materials.
[18] * - Baseline and county/community level reporting. ** - Baseline and target will require provider or subcontractor survey.

Table 13: Metrics & Evaluation - Lone Star Advanced AI and Telehealth				
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**
Target				
Year 3 (2028) Target	Decrease of human fax processing for reporting providers by 5%.	Increase the # of affiliation agreements by 5%.	Increase digital literacy training sessions by 5%	Increase the Telehealth offerings provided at facilities by 5%.
Year 4 (2029) Target	Decrease of human fax processing for reporting providers by additional 5%.	Increase the # of affiliation agreements by an additional 5%.	Increase digital literacy training sessions by an additional 5%	Increase the Telehealth offerings provided at facilities by 5%.
Year 5 (2030) Target	Decrease of human fax processing for reporting providers by an additional 5%.	Increase the # of affiliation agreements by an additional 5%.	Increase digital literacy training sessions by an additional 5%	Increase the Telehealth offerings provided at facilities by 5%.

Sustainability Plan: Similar to Initiative #2, the most substantial cost of tech solutions is the initial infrastructure investment in development and implementation during the first three years of the rural transformation period. Using a statewide cooperative of rural providers such as an ACO or CIN is a purposeful choice to implement and ensure sustainability. A collective, like an ACO or CIN, will work together to aggregate purchasing power, scale participation fees, and negotiate ongoing annual maintenance/service fees that are realistic to expect renewed and sustained participation among the provider community. Rural networks or cohorts of rural providers will also create a natural sharing of ideas, solutions, best practices and lessons learned in a way isolated rural providers can't achieve and won't sustain. HHSC will use lessons learned from its state funding initiatives. For example, HHSC was appropriated $10 million annually in state general revenue for rural hospitals and certain rural health clinics to receive grant funding for pediatric tele-connectivity for ongoing telemedicine activities for providers with cyber-security protections in place. The provider community will engage health systems, payers, and employer stakeholders

beginning program year 4 to discuss maintaining the leaps in progress. This engagement is expected to form locally designed alternative payment models where shared savings in administrative costs from reduced prior authorization and claim processing appeals and resubmissions can fund ongoing technology maintenance costs.

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

Description: Ensuring the next generation of small town doctors are surrounded by sufficient mid-level practitioners and allied health professionals will give rural residents access to all levels of care in their community. An insufficient supply of mental health providers, community health workers, and licensed paramedics exists across rural Texas.[91] Community health workers (CHW) are a valuable but underutilized healthcare liaison[92] as evidenced by the ratio of population to CHW's in metro (5,618:1) versus non-metro (15,794:1) in 2024.[93] Any successful Texas initiative starts with an element of local control (i.e. stakeholder engagement). Local rural providers who receive grant awards can identify whom and how they want to recruit. This will include the rural counties of Maverick and Polk, where two of Texas' three federally recognized Indian tribes are primarily located. Locally-driven efforts will focus on at least one of four approaches: 1) career path development for local high school students, 2) scholarships for recent high-school graduates, 3) relocation or signing bonuses for early, mid, or late career professionals, or 4) creation of a new residency training program, fellowship, or combination program, including by partnering with academic institutions or an existing teaching hospital. Eligible provider types will include hospitals, behavioral health clinics, RHCs, FQHCs, pharmacies, emergency medical services providers, independent primary care physicians, independent specialty physicians, and other allied health professionals.

Texas takes this initiative two steps further than recruitment. Participating providers, together with community leaders (including local economic development corporations, local governments, philanthropic partners, and schools), will be contractually required (1) develop and update a healthcare worker retention plan and (2) implement retention strategies. Grantees using local funding for relocation grants will be contractually responsible for supporting new physicians and practitioners through training, mentoring, and succession planning by providing value-added services, like: (1) social community engagement opportunities**,** (2) continuing medical education for burnout and resiliency, or (3) local housing (e.g. in-kind or subsidized).

HHSC will issue at least one award per county that is identified as rural with preference given to governmental, non-profit, or privately-held entities headquartered in Texas. HHSC will also issue via an intergovernmental contract to the state Board of Nursing (BON) in Year 2 for information technology upgrades to ensure that web-based licensing, certification, or registration systems for newly-trained healthcare professionals is efficient so they can go from the classroom to the patient's room as soon as possible. The information technology modernization initiatives will strengthen healthcare workforce infrastructure, reduce administrative burden, and improve access to regulatory services statewide. The goal is to improve usability, accessibility, and cybersecurity for nurses, educators, employers, and the public. Expenditures will be limited to those that are absolutely essential and directly related to provider types or professionals identified as a recruitment target for local providers. HHSC will also issue an intergovernmental contract with DSHS for five FTEs associated with the Community Health Worker (CHW) Program. These initiative-based FTEs will process CHW training and certification programs. FTEs will prioritize requests from rural areas to ensure there is sufficient training to increase the number of mid-level

practitioners and allied health professionals in rural areas for the implementation of this initiative. In response to CMS direction regarding Budget Period 1 timing, HHSC will accelerate Initiative 4 funding into Budget Period 1 to support workforce investments that can be timely obligated and liquidated, while preserving the overall five-year funding structure for the initiative.

Rural health initiatives are increasingly relying on and including a strong CHW workforce in rural communities. Rural areas of Texas face significant barriers in preventing and managing chronic diseases that go far beyond the medical condition itself. In the last five years, the demand for CHW certification in Texas has increased 152% from 4,258 in 2021 to 10,757 in 2025. The demand is expected to accelerate in the coming years due to increased recognition of CHWs and funding from the Rural Health Transformation Program. The CHW Program anticipates receiving a large influx of CHW and CHW instructors' applications and/or CHW curricula to review and approve. The five FTEs provided through this program will meet the increasing demands on the program.

Main Strategic Goals: Workforce Development.

Use of Funds: B. Workforce.

Technical Score Factors: B.1, B.2, C.1, C.2, D.1

Key Stakeholders: Rural hospitals, RHCs, FQHCs in rural counties, CMHC's, CBHC's, rural pharmacies, rural nursing homes, public health districts, pediatric long-term care providers, and rural EMS services.

Outcomes: Outcomes are dependent upon the selected workforce solution chosen by a grantee. This initiative will use the following reliable, specific outcomes identified below:

Table 14: Outcomes			
Measure	**Level**	**Baseline**	**Target**
Ratio of Population to Profession – Community Health Workers	County	2024	Improve non-metro ratio by 5%
# of Primary Care Physician	Statewide	2024	Improve number of physicians in a rural county by 40
Ratio of Population to Profession – Emergency Medical Technician (EMT) and Paramedics	County	2024	Improve non-metro ratio by 5%
Mentorship/Coaching & Training Continuing Education Programs	Rural Provider	TBD	Increase rural mentoring by 5%

Impacted Counties: 202 – all rural Texas counties.

Estimated Required Funding: $330,052,381 or 23% of federal funding over five years.

Implementation Plan and Timeline:

This initiative will be administratively managed within HHSC by the Rural Texas Strong team. The revised allocation totals $330,052,381 over five years. Budget Period 1 funding totals $98,889,964.67 and includes $73,585,881.67 for Initiative 4 Part 1 provider-facing awards, $304,083.00 for the DSHS Community Health Worker Program IAC, and $25,000,000.00 for Initiative 4 Part 2 awards focused on behavioral health providers. The Board of Nursing IAC remains budgeted at $0.00 in Budget Period 1 and is projected to begin in Year 2. Initiative 4 is emphasized in Budget Period 1 because workforce investments can be implemented and liquidated earlier in the project period through clearly defined scopes of work, provider-specific budgets, and near-term allowable expenditures.

The DSHS IAC to hire five FTEs associated with the Community Health Worker (CHW) Program will be initiated in Year 1 and continue for the five years of the program. The interagency agreement with the Board of Nursing is planned for execution at the start of Year 2. HHSC will use a competitive procurement process to award funding so at least one provider or entity in each

rural county is selected, with additional awards anticipated due to the increased award. Applicants within a county will compete for their county level award. If only one applicant applies and is eligible they will receive funding. For counties with multiple applicants, HHSC will establish a process to give top applicants an opportunity to make an oral presentation with a selected team of reviewers. Applicants will be selected based on a pre-determined scoring process. In Budget Period 1, HHSC will prioritize workforce activities that can begin quickly, including recruitment and retention investments, provider-specific workforce development plans, and behavioral health workforce support, with quarterly monitoring to ensure funds remain within scope, budget, and allowable-use requirements.

HHSC will provide quarterly monitoring and oversight to awardees and technical assistance to resolve participation and performance issues to avoid negative impact on statewide outcomes. HHSC will conduct annual qualitative and quantitative assessments through survey instruments to awardees, students, mentors, and other affiliated community partners to evaluate the likelihood that the initiative will result in long-term retention of clinicians in a rural community.

To maximize the allocation of funds to eligible providers, providers within counties will qualify based on their HPSA score and with consideration of their anticipated number of additional personnel along with the strength of the application in indicating local need and sustainability. Allocations will range per entity receiving an award up to $725,000 over the lifetime of *Rural Texas Strong*. Prior to funding distribution, each grantee will develop and submit to HHSC for approval a retention and sustainability plan to ensure newly recruited staff are welcomed into a supportive community with an ongoing culture of mentorship. The table below illustrates the estimated tasks and timeline for completing major milestones for this initiative.

Table 15: Workplan & Monitoring	
Initiative 4: The Next Generation of the Small Town Doctor and Team	
Initiative Stage Description	**Typical Actions to Occur in Stage**
Assessment - Stage 0 (Target Completion - Q4 FY 2026)	
<15%	
Reconcile current conditions with Application plans.	Identify changes in initial Initiative assumptions and confirm provider interest /participation.
Identify Task Assignments and Mitigate risks; Develop Infrastructure to support work - Communications plan, workflows- internal and external.	Identify major tasks and owners (e.g. hiring staff); If procurement is needed, identify procurement steps and initiate them. Identify risks - e.g. Barriers and solutions to previous recruitment efforts.
Project Planning - Stage 1 (Target Completion - Q4 FY 2026)	
15%	
Project Kick off meetings.	Kick off meetings internally to accomplish administrative and infrastructure building tasks. . Application will allow for identification of each county's workforce need and solution(s).
Develop Strategies for Communications, timeline, Recruitment/hiring, Identify Procurement steps.	Create communication plans. Identify key deadlines, processes, and information. Invite eligible counties to apply for funding. Initiate any needed procurement steps.
Project Initiation and Execution - Stage 2 (Target Completion - Q4 FY 2027)	
30%	
Funding distribution begins.	Communicate to stakeholders the initiative status, Initiate TA with county officials and providers to review grant application, funding purpose, and reporting requirements. Assist as requested to assess workforce needs and solution.
	Distribute funding to rural hospitals and/or rural providers, as applicable and identify project timelines for their work.
Project Monitoring and Controlling - Stage 3 (Target Completion - Q4 FY 2028)	
50%	
Funding distributed	All funding is distributed.
Local efforts begin	Monitor contractor milestones for technology implementation, Conduct site visits. Awardees will be required to report qualitative and quantitative information about staff vacancy rates, job satisfaction metrics, community engagement metrics, and other data.
Project Outcomes - Stage 4 (Target Completion - Q4 FY 2029)	
75%	
Maintaining and Sustaining Work; Monitoring milestones	Continue contractor monitoring. Follow up as needed about data collection.
TA provided, as needed	Continue to provide TA to rural providers, as applicable.

Project Closure or Reconciliation - Stage 5 (Target Completion - Q4 FY 2030-32)	
100%	
Contract closure or reconciliation activities.	If more funding is available, amend contracts and timelines.

Stakeholder Engagement: HHSC and rural providers are committed to recruiting and retaining talented staff through this workforce initiative. Creating and empowering connections amongst grantees and their partners is the foundation of this initiative's stakeholder engagement plan. In anticipation of the influx of recruited staff working in rural areas across Texas, HHSC envisions creating opportunities for both providers and their recruits to come together at least once a year to network, collaborate, and exchange ideas to improve care delivery and encourage professional networking relationships. Because this initiative promotes recruitment of staff from across the healthcare continuum, the combination of varied groups of providers gathering with other recruits and providers will be an ideal setting for new, innovative ideas and connections to occur. HHSC plans to collaborate with grantees at a regional level to promote professional connections amongst their regional peers and colleagues. Attendance would be required for a meeting once a year to ensure patient care or services are not impacted by attendance. HHSC may leverage its existing resources through the Rural Hospital Finance (RHF) team. The RHF staff may assist their colleagues on the HHSC *Rural Texas Strong* team in the coordination and logistics of these annual meetings. HHSC has a successful proven track record when bringing together rural providers that results in positive experiences through the exchange of key information, the formation of new partnerships and lessons learned.

Metrics and Evaluation Plan:

Table 16: Metrics & Evaluation - The Next Generation of the Small Town Doctor and Team				
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**
Outcome*[19]	Ratio of Population to Profession – Community Health Workers (CHW)*	Number of Primary Care Physicians (PCP)*	Ratio of Population to Profession – Emergency Medical Technician (EMT) and Paramedics*	Mentorship/Coaching & Training Continuing Education Programs**
Data Source	Department of State Health Services – Health Profession Supply	Department of State Health Services – Health Profession Supply	Department of State Health Services – Health Profession Supply	Self-Reported; Contractual Reporting
Definition	Numerator – County Population – Denominator – Total CHW in a county	Total PCP in rural counties	Numerator – County Population – Denominator - Total EMT	Numerator - providers with formal mentoring program Denominator – total participating providers
Baseline	Dependent on the contracts issued.	Dependent on the contracts issued.	Dependent on the contracts issued.	Dependent on the contracts issued.
Year 1 (2026) Target	Planning	Planning	Planning	Planning
Year 2 (2027) Target	Implementation	Implementation	Implementation	Implementation
Year 3 (2028) Target	Improve the ratio of CHW in rural counties by 1%.	Increase the number of PCP in rural counties by 10.	Improve the ratio of EMTs or Paramedics in rural counties by 1%.	Increase rural mentoring by 1%
Year 4 (2029) Target	Improve the ratio of CHW in rural counties by an additional 2.5%.	Increase the number of PCP in rural counties by 25.	Improve the ratio of EMTs or Paramedics in rural counties by an additional 2.5%.	Increase rural mentoring by an additional 2.5%
Year 5 (2030) Target	Improve the ratio of CHW in rural counties by an additional 5%.	Increase the number of PCP in rural counties by 40.	Improve the ratio of EMTs or Paramedics in rural counties by an additional 5%.	Increase rural mentoring by an additional 5%

Sustainability Plan: This initiative has a built-in sustainability mechanism to ensure its longevity. The pre-payment deliverable, the healthcare worker retention plan, and the required implementation of retention strategies are conceived as built-in sustainability activities to be

[19] * - Baseline and county/community level reporting. ** - Baseline and target will require provider or subcontractor survey.

reviewed and updated, as needed, by a community so their efforts do not get stagnant. It is vital to stay current with the needs of staff and reduce barriers to their recruitment.

The value-added services are intended to promote career growth and longevity, through activities like pairing a new physician with an established one to improve retention. The aim is to delay the early retirement and burnout of established physicians, and in turn reduce staff shortages, by placing them in mentorship roles where they can share their workload with newer physician mentees. Partnering health professionals at different levels in their career is intentional so that as the mentor leaves, the mentee becomes the mentor: ready to cultivate and foster the next generation of professionals.

Initiative #5: Unified Care Infrastructure and Rural Cyber Protection

Description: This initiative will establish a Unified Care Infrastructure (UCI) and bolster cybersecurity defenses across rural providers. By deploying a managed security solution—including Endpoint Detection and Response (EDR), Comprehensive, all-time Security Operations Center (SOC) 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. EDR provides real-time, continuous monitoring and data collection from endpoints. Its primary functions include: (1) virus and ransomware protection that actively scans for and prevents known and unknown malware, (2) exfiltration monitoring: detects and blocks attempts to maliciously transfer sensitive data, and (3) indicator of compromise (IOC) and indicator of attack (IOA) analysis that identifies suspicious behaviors and patterns that indicate potential compromise.

By mitigating ransomware and other cyberattacks, this investment preserves access to care, keeps hospital systems online, and prevents workforce disruption and burnout. It also protects

revenue streams and improves financial viability of rural providers by maintaining continuity in billing and operations. The Texas plan will create a shared platform for hospitals, clinics, behavioral health providers, and rural veteran nursing homes for significant, sustained technological advancements. An intergovernmental agreement with the General Land Office will be executed in Year 2 to provide advancements to rural veteran nursing homes.

An added benefit from the Unified Care Infrastructure (UCI) concept is the positive impact it has on the recruitment of healthcare professionals. Many clinicians who train on superior systems in urban settings become dissatisfied quickly in a rural community from the limitations and increased administrative burden of an antiquated system.

Main Strategic Goals: Tech innovation

Uses of Funds: F. IT advances, E. Workforce

Technical Score Factors: B.1, C.1, D.1, F.1, F.2, F.3

Key Stakeholders: Rural hospitals, RHCs, FQHCs in rural counties, behavioral health hospitals, and rural veteran nursing homes, tech innovators.

Outcomes: This initiative will use the following specific outcomes:

Table 17: Outcomes

Measure	Level	Baseline	Target
Automated Quality Reporting	Community	2024	Increase by 10%
System Outages	Statewide	2024	Decrease by 10%
Managed Detection and Response (MDR) Participation	Statewide	2024	Increase by 10%
Security Operations Center (SOC) Participation	Statewide	2024	Increase by 10%

Impacted Counties: 202 rural counties.

Estimated Required Funding: $100,000,000 total - $50,000,000 or 4% of federal funding for UCI. Additional $50,000,000 or 4% of federal funding for cyber protections.

Implementation Plan and Timeline: This initiative will be administratively managed within HHSC by the *Rural Texas Strong* team. Each rural provider has unique needs due to varying levels of resources to devote to cyber security. In year 1, HHSC will begin the competitive procurement process at least two vendors using the Texas Department of Information Resources (DIR) established contracting process to evaluate rural system readiness and vulnerability and make recommendations – both at the provider site and aggregate level for all rural hospitals. Selected entities will be required to prioritize technology that has a cloud-based option utilizing multi-tenant architecture. To streamline procurement and ensure compliance with state standards, HHSC will use DIR's Managed Security Services Provider contracts. This allows HHSC to minimize administrative costs and time, leverage pre-vetted vendors, and ensure that rural Texas receives services from qualified, experienced providers. Also, to maximize the return on this investment and foster a culture of security awareness, a dedicated training component will be included in the vendor contracts. This program is essential for user adoption and for transforming staff into an active line of defense.

In year two, HHSC will leverage its significant purchasing power to help rural hospitals and clinics add endpoint detection and response (EDR) coverage. In year three, HHSC will add security operations center (SOC) for all rural providers. The incorporation of a formal training program and the 24-hour/7 days-a-week SOC monitoring will provide specialized expertise that rural hospitals cannot staff within each facility, directly supporting improved care delivery through proactive threat detection and response. To maximize the return on this investment and foster a culture of security awareness, a dedicated training component will be included in the vendor contracts. Activities in years four and five will be devoted to transferring management of cyber

tools back to a cooperative of participating hospitals and clinics. HHSC will establish a working group with participating providers to develop a transition plan. The plan will explore a cost-sharing model for year four and after, with the goal of rural providers gradually absorbing the operational cost. The table below illustrates the estimated tasks and timeline for completing major milestones for this initiative.

Table 18: Workplan & Monitoring	
Initiative 5: Unified Care Infrastructure and Rural Cyber Protection	
Initiative Stage Description	**Typical Actions to Occur in Stage**
Assessment - Stage 0 (Target Completion - Q3 FY 2027)	
<15%	
Reconcile current conditions with Application plans.	Identify changes in initial Initiative assumptions and confirm provider interest /participation.
Identify Task Assignments and Mitigate risks; Develop Infrastructure to support work - Communications plan, workflows- internal and external.	Identify major/critical tasks and owners (e.g. hiring staff); Identify risks - e.g. Determine number of eligible entities and technology compatibility issues; assess system provider system status and readiness. If procurement is needed, identify procurement steps and initiate.
Project Planning - Stage 1 (Target Completion - Q3 FY 2027)	
15%	
Project Kick off meetings.	Kick off meetings internally to accomplish administrative and infrastructure building tasks; Identify key deadlines, processes, and information about entities to invite to bid.
Develop Strategies for Communications, timeline, Recruitment/hiring, Identify Procurement steps.	Initiate any procurement steps needed. Create communication plans and vehicles for messaging to providers and contractors
Project Initiation and Execution - Stage 2 (Target Completion - Q4 FY 2027)	
30%	
Funding distribution begins.	Communicate to stakeholders the initiative status, Initiate TA with rural providers
Security Operations Center begins.	Distribute funding to contractors and/or rural providers, as applicable and identify project timelines for their work.
Project Monitoring and Controlling - Stage 3 (Target Completion - Q3 FY 2028)	
50%	
Local Efforts begin	Monitor contractor milestones for technology implementation, Conduct site visits to rural awardees, as applicable.

Sustainability and Transition Planning Workgroup	Engage stakeholders to explore a cost-sharing model for beyond the life of the program.
Project Outcomes - Stage 4 (Target Completion - Q3 FY 2029)	
75%	
Maintaining and Sustaining Work; Monitoring milestones	Continue to provide TA to rural providers, as transfer management of the cyber tools back to a cooperative of participating hospitals and clinics.
TA provided, as needed. Sustainability and Transition Planning Workgroup begins.	Continue contractor monitoring. Continuously monitor progress towards sustainability.
Project Closure or Reconciliation - Stage 5 (Target Completion - Q3 FY 2030-32)	
100%	
Contract closure or reconciliation activities.	Transfer of cyber tools to rural providers is complete. If more funding is available, amend contracts and timelines.

Stakeholder Engagement Plan: A technological solution is only as effective as the people who use it. Stakeholder engagement between technology experts, providers, and HHSC will be vital to ensuring advancements are effective and maintained. DIR-approved contractors will be required to coordinate activities with HHSC and meet at least quarterly throughout rural transformation periods to ensure implementation is on track. Rural provider stakeholders will be engaged through existing advisory committees, vendors, and HHSC outreach to evaluate progress and identify obstacles.[20]

Metrics and Evaluation Plan: The outcome metrics seek to measure technological improvements and increased participation in initiatives that will secure rural providers into the future. HHSC will work with stakeholders and subrecipients to identify realistic and locally driven outcomes based on the total funding allotted.

[20] HHSC will also use its established engagement framework and activities to involve stakeholders and create a feedback loop of their input to HHSC. This information is detailed in Other Supporting Materials.

Table 19: Metrics & Evaluation - Unified Care Infrastructure and Rural Cyber Protection				
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**
Outcome*[21]	Automated Quality Reporting**	System Outages**	Managed Detection and Response (MDR) Participation**	Security Operations Center (SOC) Participation**
Data Source	Self-Reported; Contractual Reporting	Self-Reported; Contractual Reporting	Self-Reported; Contractual Reporting	Self-Reported; Contractual Reporting
Definition	Ratio of providers with Automated Quality Reporting.	Count of system outages following initiative implementation.	Count of providers participating in MDR.	Count of providers participating in SOC.
Baseline	Dependent on the contracts issued.	Dependent on the contracts issued.	Dependent on the contracts issued.	Dependent on the contracts issued.
Year 1 (2026) Target	Planning	Planning	Planning	Planning
Year 2 (2027) Target	Implement	Implement	Implement	Implement
Year 3 (2028) Target	Increase the use of automated quality reporting by 2%.	Decrease the # of system outages by 2%.	Increase the use of MDR by 2%.	Increase the use of SOC by 2%.
Year 4 (2029) Target	Increase the use of automated quality reporting by an additional 5%.	Decrease the # of system outages by an additional 5%.	Increase the use of MDR by an additional 5%.	Increase the use of SOC by an additional 5%.
Year 5 (2030) Target	Increase the use of automated quality reporting by an additional 10%.	Decrease the # of system outages by an additional 10%.	Increase the use of MDR by an additional 10%.	Increase the use of SOC by an additional 10%.

Sustainability Plan: Sustaining this initiative will require a shared financial contribution from participating providers. It is worth noting, rural hospitals and clinics currently pay maintenance and expensive interface fees for their underperforming systems. Using *Rural Texas Strong* to facilitate system migration and implementation, results in more reasonable costs of maintaining technological support and security services allowing for sustainability. The providers' funding that was allocated for the current systems will be reinvested to maintain the new technology to ensure its sustainability.

[21] * - Baseline and county/community level reporting. ** - Baseline and target will require provider or subcontractor survey.

The statewide rural collaboration enabled through this initiative allows each participating provider to access pricing to cyber liability protection that would not be available to any of them individually. Moreover, potentially reduced administrative staff costs associated with manual quality reporting processes and reduced insurance premiums for participants may materialize as the new technology demonstrates risk mitigation activities. Lastly, sustaining this initiative is well worth the price when considering the higher cost and risk resulting from maintaining the status quo or being the victim of a cyberattack.

Initiative #6: Infrastructure and Capital Improvement for Rural Texas

Description: Rural hospitals, clinics, behavioral health providers, opioid/substance abuse programs, EMS, pharmacies, and public health offices will be permitted to add and replace the equipment they need to improve patient care, within the required limitations on new construction and remodel projects. A recent study demonstrated significant positive correlation with the ability to reinvest to overall success over time of the hospital's financial stability – a higher correlation than geography, payer mix, community demographics, tax revenue, system affiliation, or other factors.[94] In addition to equipment needs, providers will be able to invest in existing buildings and infrastructure, including minor building alterations or renovations. Funds will be used to replace allowable equipment, including: lab equipment, CT, ultrasound or mammography equipment, stretchers (especially self-loading), wheelchairs, patient beds, telemetry units, nurse call systems, Advanced Medical Bus (AMBUS), generators, defibrillators, crash carts, medication dispensing units, sleep labs, vital sign monitors, and oxygen tanks can all be brought to current standards.

Main Strategic Goals: Sustainable Access

Use of Funds: J. Capital expenditures and infrastructure

Technical Score Factors: C.1, C.2, F.3

Key Stakeholders: Rural hospitals, RHCs, FQHCs in rural counties, behavioral health hospitals and clinics, LMHAs, opioid recovery programs, EMS, pharmacies, pediatric long-term care providers, and public health offices.

Outcomes: This initiative will use the following reliable, specific outcomes:

Table 20: Outcomes

Measure	Level	Baseline	Target
Reinvestment	Community	2026	Improve by 5%
Cash on Hand - Financial stability of rural hospitals, clinics, BH clinics, EMS services, pharmacies and public health offices	County	2026	Improve by 5%
Local equipment and construction savings accounts	Community	2026	5% of participating providers
Hospital Liquidity	Provider	2026	Improve by 5%

Impacted Counties: 202 – all rural Texas counties.

Estimated Required Funding: $192,936,677 or 14% of federal funding over five years.

Implementation Plan and Timeline: This initiative will be administratively managed within HHSC by the Rural Texas Strong team. The revised allocation totals $192,936,677 over five years. Budget Period 1 funding totals $56,263,872.33, which includes:

- $26,263,872.33 for Initiative 6 Part 1 provider-facing awards,
- $20,000,000.00 for the DSHS AMBUS interagency agreement (IAC), and
- $10,000,000.00 for Initiative 6 Part 2 awards focused on Intellectual and Developmental Disability (IDD) providers.

Initiative 6 is prioritized in Budget Period 1 to support allowable capital and infrastructure investments that can be timely obligated and liquidated in accordance with CMS requirements. These investments include emergency preparedness assets, provider capacity improvements, and other capital-related projects consistent with federal funding limitations.

The initiative is structured into two components. Part 1 will make funding available to rural healthcare providers through a competitive procurement process for infrastructure and capital improvement projects. Part 2 will allocate targeted funding through a competitive procurement process specifically for providers focused on IDD services. To the greatest extent possible, HHSC intends to utilize a single, consolidated solicitation to administer both components, while reserving a defined funding allocation for IDD-focused awards.

The intergovernmental agreement with DSHS includes $20,000,000 in Budget Period 1 to procure approximately 10 AMBUS units by September 30, 2027, in alignment with CMS obligation and liquidation timelines.

For Parts 1 and 2, HHSC will utilize a competitive evaluation process supported by a standardized scoring methodology that assesses project urgency, expected impact, financial sustainability, and alignment with Rural Texas Strong program goals. Priority will be given to projects that demonstrate strong implementation readiness, well-defined scope, schedule, and cost estimates, and a high likelihood of achieving intended outcomes. Consistent with federal guidance, preference will also be given, where applicable, to projects utilizing domestically manufactured materials and equipment.

Following award issuance, HHSC will conduct quarterly monitoring and oversight, including financial and programmatic review of expenditures, to ensure compliance with all applicable federal requirements related to capital and infrastructure funding. Budget Period 1 monitoring will place particular emphasis on project readiness, allowable cost verification, expenditure tracking, and timely liquidation of funds within the required performance period.

The table below illustrates the estimated tasks and timeline for completing major milestones for this initiative.

Table 21: Workplan & Monitoring	
Initiative 6: Infrastructure and Capital Investments for Rural Texas	
Initiative Stage Description	**Typical Actions to Occur in Stage**
Assessment - Stage 0 (Target Completion - Q2 FY 2026)	
<15%	
Reconcile current conditions with Application plans.	Identify changes in initial Initiative assumptions and confirm provider interest /participation.
Identify Task Assignments and Mitigate risks; Develop Infrastructure to support work - Communications plan, workflows - internal and external.	Identify major tasks and owners, (e.g. hiring staff); Identify risks - e.g. Determine number of eligible entities and identify project readiness. Identify major tasks and owners (e.g. hiring staff); Identify procurement steps and initiate.
Project Planning - Stage 1 (Target Completion - Q2 FY 2026)	
15%	
Project Kick off meetings	Kick off meetings internally to accomplish administrative and infrastructure building tasks. Create communication plans and vehicles for messaging to providers. Identify key deadlines, processes, and information about entities to invite to bid.
Develop Strategies for Communications, timeline, Recruitment/hiring, Identify Contracting steps.	Initiate contractual steps with Legal and draft grant agreements.
Project Initiation and Execution - Stage 2 (Target Completion - Q2 FY 2027)	
30%	
Procurement/Application Process	Application process starts.
Funding distribution begins	Communicate to stakeholders the initiative status, Initiate TA with rural providers. Distribute funding to rural providers, as applicable and identify project timelines for their work.
Project Monitoring and Controlling - Stage 3 (Target Completion - Q2 FY 2028)	
50%	
Funding distributed	All funding is distributed to rural providers.
Local Efforts begin	Monitor contractor milestones for technology implementation. Conduct site visits, as applicable.
Project Outcomes - Stage 4 (Target Completion - Q2 FY 2029)	
75%	

Maintaining and Sustaining Work; Monitoring milestones	Continue to monitor implementation; site visits as needed.
Regular Communication with awardees.	Continue collecting outcome data.
Project Closure or Reconciliation - Stage 5 (Target Completion - Q2 FY 2030-32)	
100%	
Contract closure or reconciliation activities.	If more funding is available, amend contracts and timelines.

Stakeholder Engagement: Equipment upgrades may require fewer status updates due to their ability to be completed quickly so stakeholder engagement for this initiative will be focused on public reporting about the status of equipment acquisition and construction progress. HHSC will encourage local governments to include an invitation to their regularly scheduled public meetings for providers who receive these funds to provide public, periodic updates about the availability of services that can be delivered from the equipment, along with status updates on capital improvements. Grantees may receive technical assistance from HHSC to ensure project budget and scope are aligned with the grant agreement.

Metrics and Evaluation Plan:

Table 22: Metrics & Evaluation - Infrastructure and Capital Investments for Rural Texas				
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**
Outcome*[22]	Reinvestment*	Cash on Hand - Financial stability of rural hospitals, clinics, BH clinics, EMS services, pharmacies and	Local equipment and construction savings accounts**	Hospital Liquidity*

[22] * - Baseline and county/community level reporting. ** - Baseline and target will require provider or subcontractor survey.

Table 22: Metrics & Evaluation - Infrastructure and Capital Investments for Rural Texas				
	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**
		public health offices*		
Data Source	Cost report – balance sheet	American Hospital Directory	Self-Reported; Contractual Reporting	American Hospital Directory
Definition	Numerator - accumulated depreciation Denominator - Depreciation and amortization expense	Rural Texas hospitals w/ < 10 days	Count of Construction Savings Accounts Established by Rural County	Numerator – current assets Denominator – current liabilities
Baseline	Dependent on the contracts issued.	48 (2024)	Dependent on the contracts issued.	Dependent on the contracts issued
Year 1 (2026) Target	Planning	Planning	Planning	Planning
Year 2 (2027) Target	Implement	Implement	Implement	Implement
Year 3 (2028) Target	Improve reinvestment rate by 1%	Reduce rural Texas hospitals w/< 10 days by 1%	1% of recipient providers set up and contribute to account for sustainability.	Improve current ratio by 1%.
Year 4 (2029) Target	Improve reinvestment rate by an additional 2.5%	Reduce rural Texas hospitals w/ < 10 days an additional 2.5%	2.5% of recipient providers set up and contribute to account for sustainability.	Improve current ratio by an additional 2.5%
Year 5 (2030) Target	Improve reinvestment rate by an additional 5%	Reduce rural Texas hospitals w/ < 10 days an additional 5%.	5% of recipient providers set up and contribute to account for sustainability.	Improve current ratio by an additional 5%

Sustainability Plan: It is intentional that contractual requirements for this initiative will contain a sustainability component. It will require grantees to dedicate a savings account, not using RHTP funds, to maintain the facility or equipment using a standardized depreciation schedule so when the capital improvements or assets are fully depreciated there is an available funding source to replace the items. Grantees will be required to contribute financially on a periodic and continual basis and ensure the funds remain untouched and are dedicated to the sole purpose of facility/equipment reinvestment. Balance sheets may be used as supporting documentation to

verify compliance. The rationale for this requirement is to provide an opportunity for grantees to work towards self-sufficiency in maintaining these investments. Ideally, this cash reserve is meant to provide a bit of financial security, debt avoidance and to reduce stress when repairs or replacements are needed. However, in the case of governmental organizations who are not permitted to carry forward an unexpended balance to create a dedicated revenue account, they will be expected to identify in their strategic planning materials a publicly available depreciation schedule for these assets or materials that can be shared with state or local appropriators for consideration in future appropriation cycles.

Governance and Project Management Structure

The State of Texas wants to ensure that funding is prioritized for rural communities, and as a result will operate a lean governance structure, leveraging existing infrastructure wherever possible, and using a waterfall project management approach. HHSC, the state Medicaid agency, will serve as the lead agency and intends to engage stakeholders through the established advisory committees for their expertise. With the increase in funding awarded resulting in an increased procurement workload, HHSC will hire and dedicate 31 full-time equivalents (FTE) to executing the proposed initiatives beginning in fiscal year 2026 through 2030, with close out activities occurring before the end of the final runout period. HHSC does not intend to use consulting services, except professional services contracts for establishing financial and program control and compliance processes prior to issuing funds to sub awardees, as well as for ongoing financial and quality monitoring during the program periods. All grant or contract recipients will be held to pre-award compliance and audit activities that will be proactively created by the state. HHSC will engage an external auditor to evaluate the internal controls established by awardees and conduct

program monitoring to validate that financial and data controls have been utilized, outcomes are valid, and funds were spent in accordance with program requirements. Additional information about this evaluation plan is available in Other Supporting Materials.

Reflecting our commitment to minimizing administrative expenses and to ensuring Texas expends funds only within the state (to the greatest extent possible), the application was developed and managed entirely by HHSC staff, who reside in Texas, with the assistance of one independent contractor who joined the HHSC team for a two-month period.

The newly formed *Rural Texas Strong* team will include those outlined in the organizational chart in Other Supporting Materials. The HHSC Chief Financial Officer (CFO) will serve as the authorized organizational representative. The Program Director will work within the Provider Finance Department of the CFO division, to increase the alignment of the *Rural Texas Strong* project with existing reimbursement rate and financial program strategies. By hiring a dedicated Program Director, HHSC will ensure that the individual has sufficient time to manage and provide oversight of the program. The Program Director will be responsible for communication with CMS and will direct the work of staff skilled in financial analyses, data analyses, grant administration, and rural health policy. The Program Director will manage 14 staff devoted to initiative project management, monitoring, technical assistance, and stakeholder engagement. The CFO will also have eight dedicated contract specialists responsible for executing subrecipient agreements and vendor contracts. One dedicated contract administration manager from the Procurement and Contract Services division and three attorneys will also help execute procurements and contracts. Two information technology (IT) program managers and one IT analyst will support the development of Initiatives 2, 3, and 5.

HHSC's existing procurement and contracting processes are well-tested and ensure that contracts and subrecipient agreements are reasonable, ensure the best value for the state and federal government, and are transparent and fair. HHSC will prioritize the development and completion of contracts for most initiatives in the first year to ensure program implementation can begin, with some initiatives having procurement cycles that extend into the second year of the project. Additional information about the procurement process can be found in Other Supporting Materials.

Coordination with External Stakeholders and State Health Agencies

Strong strategic partnerships are already in place between HHSC, DSHS, the State Office of Rural Health, the Texas Association of Rural Health Clinics, and the Texas Organization for Rural and Community Hospitals, the statewide association for rural hospitals, that position Texas to amplify its ability to improve and collaborate with all rural healthcare partners.

Stakeholder Engagement

HHSC is committed to robust stakeholder engagement and public transparency, while simultaneously balancing the need to limit administrative costs.[23] HHSC began the stakeholder engagement process within one month of OBBBA being signed into law on July 4, 2025. HHSC conducted the following activities to ensure that every individual had the opportunity to provide input on the development of the application:

Table 23: Stakeholder Engagement during Application Process

Activity	Date	Description	Participants
Solicited public comments	Aug. 4 - Sept. 9, 2025	Survey tool was used with a combination of multiple choice and open-ended narrative and option to submit attachments.	Over 300 concepts, exceeding $100 billion, related to every type of rural healthcare provider including rural hospitals, clinics, FQHCs, opioid/recovery programs, behavioral health providers, academic institutions, local

[23] Letters of support from the Texas Legislature and key stakeholders can be found in the Other Supporting Materials.

Table 23: Stakeholder Engagement during Application Process			
Activity	**Date**	**Description**	**Participants**
			governments, health departments, health plans, and vendors.
Meeting with State Office of Rural Health (SORH)	Oct. 6, 2025	Provided SORH with an overview of RHT Program and an opportunity to ask questions.	SORH Staff
Meeting with Texas Tribal Liaisons	Oct. 7, 2025	Provided Tribal Liaisons with an overview of RHT Program and an opportunity to ask questions about the application process and lead agency responsible.	A list of participants can be found in Table 1 in the endnotes.[95]
Regional Stakeholder meetings hosted by philanthropic partners	Oct. 6-10, 2025	Traveling over 2,215 miles, HHSC gathered information about regional needs and obtained input about constituent needs in the following locations: Starr County/Rio Grande City, Stanton, Lufkin, Childress, Giddings, Bell County	A complete list of individuals and organizations that submitted comments or participated in stakeholder engagement meetings can be found in Table 1 in the endnotes.[96]
Public Hearing	Oct. 13, 2025	Conducted virtually and in-person to ensure members of the public and providers were able to provide additional information following the release of the NOFO.	87 people from across the state provided testimony. A list of participants can be found in Table 1 in the endnotes.[97]

Rural Texas Strong Stakeholder Engagement Plan

HHSC will use its established advisory committees and HHSC resources to facilitate stakeholder engagement for all proposed initiatives, see Other Supporting Materials for additional information about the existing engagement framework. In addition, HHSC will specifically undertake the following activities to ensure there is robust communication with stakeholders about the progress of *Rural Texas Strong.*

Table 24: Leveraging the Stakeholder Engagement Framework		
Stakeholder Activity	**Current Function**	**RHT Stakeholder Engagement Activity**
Advisory Councils (Rural Hospital Advisory Committee, DSHS Public Health Funding and Policy Committee, Health Professions Workforce Coordinating Council,	Advises State Agencies and Policymakers on various health-related topics; receives public comment	Include RHT as an annual agenda item to present progress reports and receive stakeholder input.

Table 24: Leveraging the Stakeholder Engagement Framework		
Stakeholder Activity	**Current Function**	**RHT Stakeholder Engagement Activity**
Statewide Behavioral Health Coordinating Council, etc.)		
Annual Progress Reports		Produce an annual written report describing progress, publishing outcome data, and announcing grantee recipients and amounts.
Regional Meetings		Host two regional annual meetings each year to receive direct feedback from the public on the progress and impact of RHT.
Tribal Liaisons	HHSC meets quarterly with tribal leaders and issues regular notifications related to waivers and State Plan Amendments.	HHSC will provide regular updates to tribal liaisons regarding implementation.

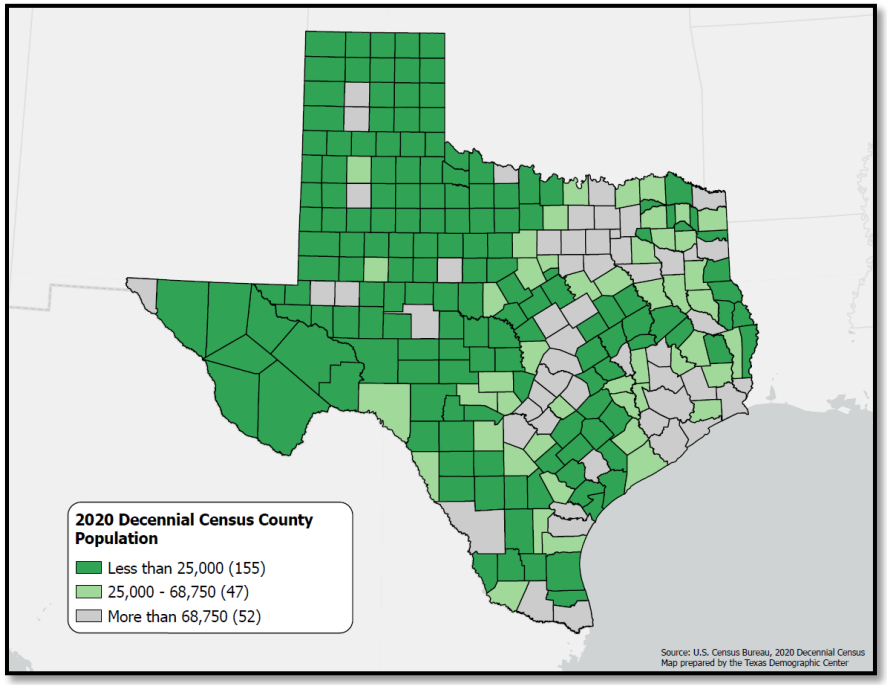
Conclusion

Texas appreciates the opportunity to submit the *Rural Texas Strong* project application for consideration by CMS. If approved, HHSC commits that every effort, decision, and dollar spent will be made with the health and wellness of rural Texans as the paramount consideration. This program belongs to rural Texas, and we look forward to working with CMS to transform the rural healthcare in the most rural state in the nation.

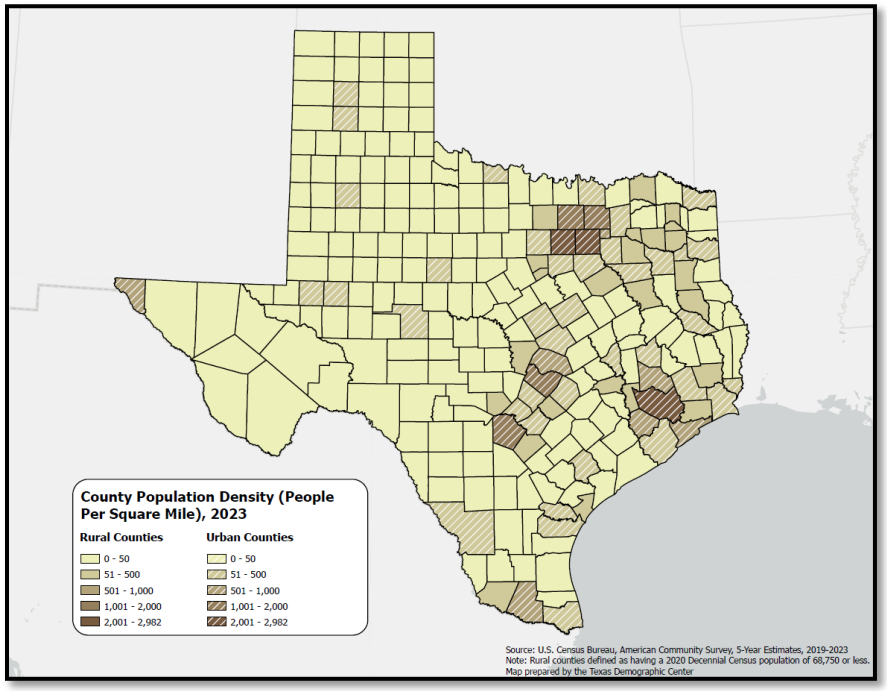
Endnotes

[1] Index for Data and Technical Scoring Factors

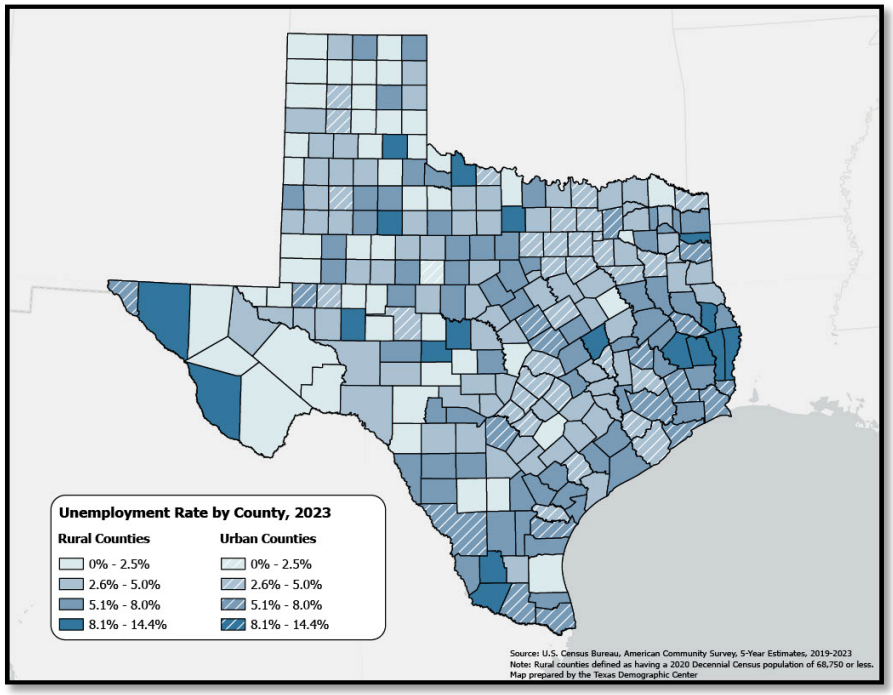
[1] See Index above.
[2] U.S. Census Bureau. Retrieved from https://data.census.gov/profile/Texas?g=040XX00US48.
[3] **Figure 1** - Rural County Population, 2020 Decennial Census, Texas Demographics Center.



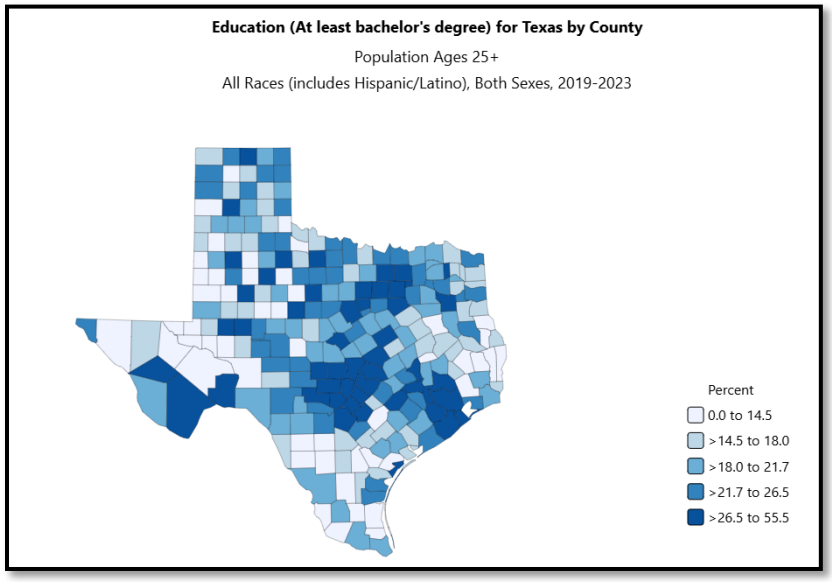
[4] **Figure 2** – County Population Density. 2023. Texas Demographic Center.



[5] **Figure 3** – Unemployment Rate by County, 2023. Texas Demographic Center



[6] **Figure 4** – Education (At least bachelor's degree) for Texas by County). An Ecosystem of Minority Health and Health Disparities Resources. National Institute on Minority Health and Health Disparities. Created 10/7/2025. Retrieved from: https://hdpulse.nimhd.nih.gov/data-portal/social/map?socialtopic=020&socialtopic_options=social_6&demo=00006&demo_options=education_3&race=00&race_options=race_7&sex=0&sex_options=sex_3&age=081&age_options=age25_1&statefips=48&statefips_options=area_states

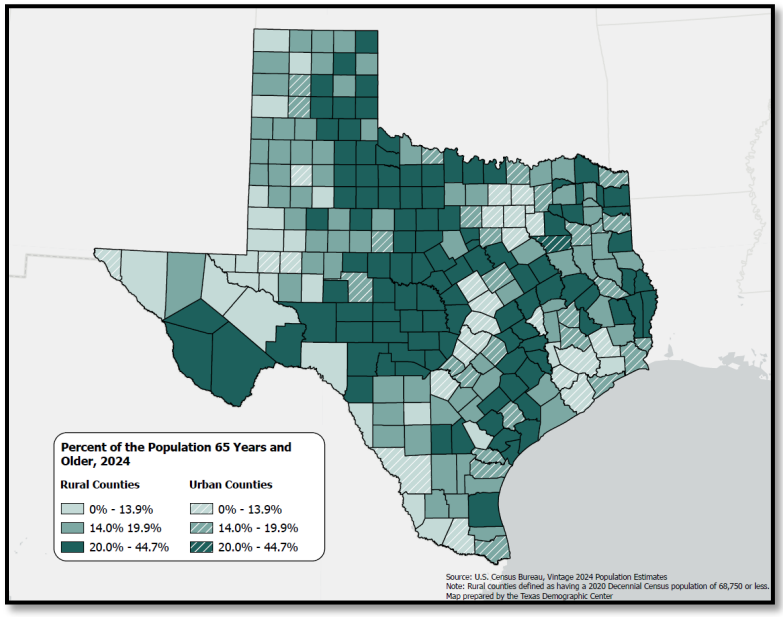


[7] U.S. Department of Agriculture, Frontier and Remote Area Codes, Retrieved from: https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes

[8] See Other Supporting Materials for a map and list of rural Texas counties, as defined for this plan.

[9] Definition aligns with Texas Government Code, Chapter 526.0321. Retrieved from: https://statutes.capitol.texas.gov/Docs/GV/htm/GV.526.htm#526.0304

[10] **Figure 5** – Percent of the Population 65 Years and Older, 2024. Texas Demographic Center.



[11] **Figure 6** – Heart Disease Crude Discharge Rates in 2022 by County. DSHS Center for Health Statistics.

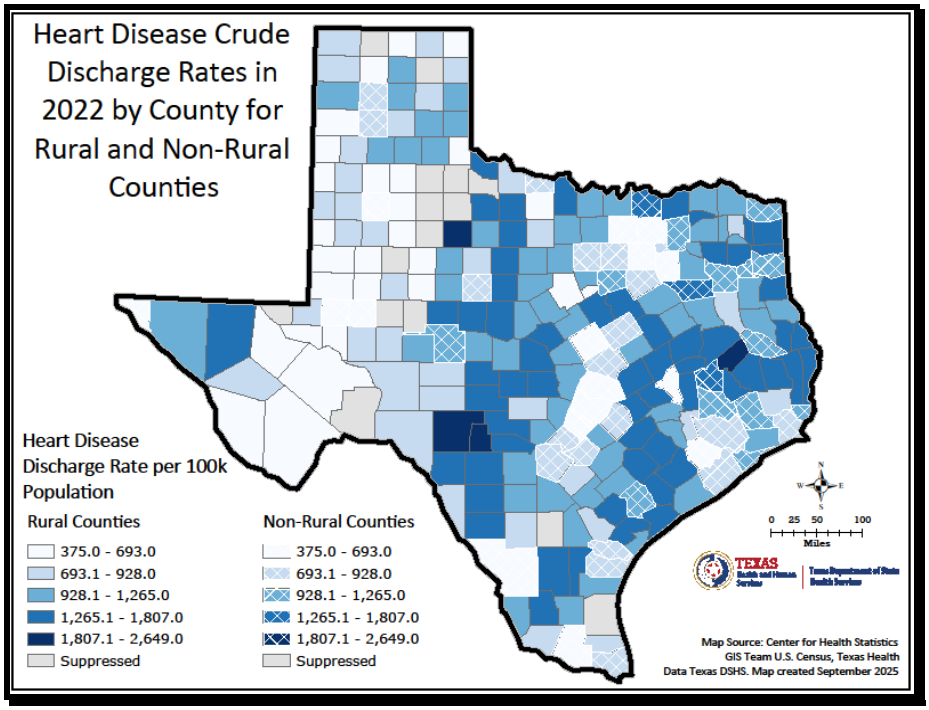


Figure 7 - Invasive Cancer Incidence Rates in 2022 by County. DSHS Center for Health Statistics.

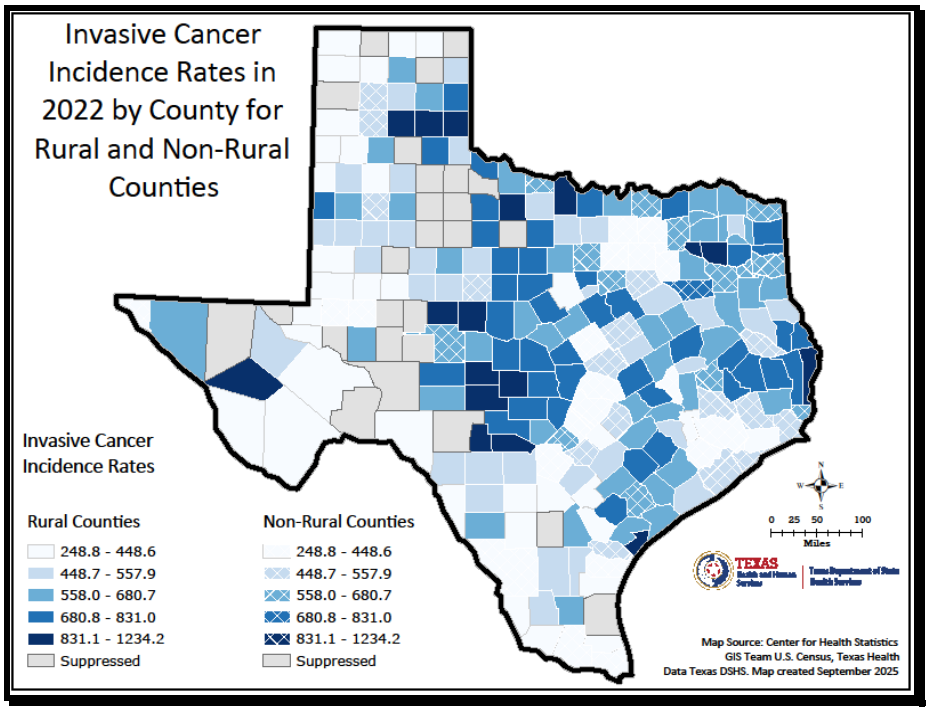
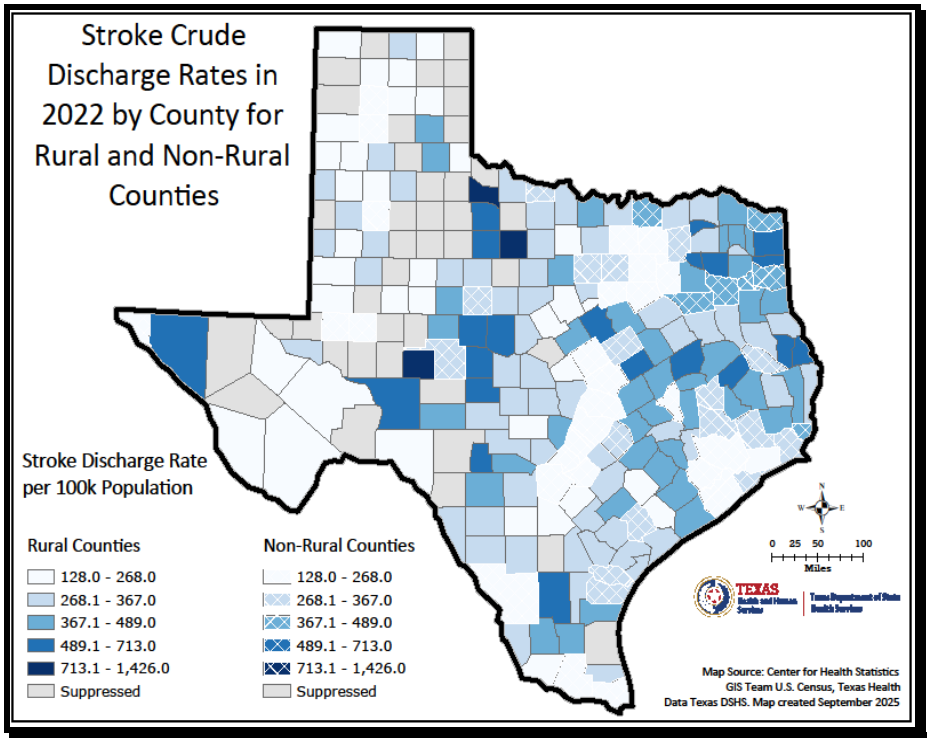


Figure 8 – Stroke Crude Discharge Rates in 202 by County. DSHS Center for Health Statistics.



[12] Nehme E, Janda K, Meier J, Wilson K, Lakey D. (2021). *The potential for a rural community health system to improve health care access and value in Texas*. Retrieved September 9, 2025 from https://www.utsystem.edu/sites/default/files/sites/texas-health-journal/THIN-RCHS-April2021.pdf.

[13] U.S. Centers for Disease and Control Prevention. New CDC Data Show Adult Obesity Prevalence Remains High. Retrieved from: https://www.cdc.gov/media/releases/2024/p0912-adult-obesity.html

[14] Department of State Health Services. Obesity Data in Texas. Retrieved from: https://www.dshs.texas.gov/obesity-texas/obesity-data#:~:text=2023%20data%20in%20Texas%20shows,vegetable%20consumption%20recommendations%20have%20obesity.

[15] Rural Health Information Hub. (2019) Low Access to Healthy Food. Retrieved from https://www.ruralhealthinfo.org/charts/69?state=TX.

[16] HHSC SNAP Cases Eligibility by County. (August 2025). Retrieved from: https://www.hhs.texas.gov/about/records-statistics/data-statistics/supplemental-nutritional-assistance-program-snap-statistics.

[17] The Rural Texas Maternal Health Assembly, 2025 Rural Texas Maternal Health Rescue Plan. Retrieved from: http://architexas.org/programs/maternal-health/rural-texas-maternal-health-plan-2025.pdf

[18] Rural Health Research & Policy Centers. (2023). Health Insurance Coverage in Rural and Urban Areas in the U.S., 2023. Retrieved from: https://www.ruralhealthresearch.org/alerts/forward?utm_source=alert&utm_medium=email&utm_campaign=20250924rupri&item=1737&url=https%3A%2F%2Frupri.public-health.uiowa.edu%2Fpublications%2Fpolicybriefs%2F2025%2FHealth_Insurance_Coverage.pdf&k=k9Ud6

[19] **Figure 9**, Percent of Population Uninsured (2019-2023 Period), HHSC.

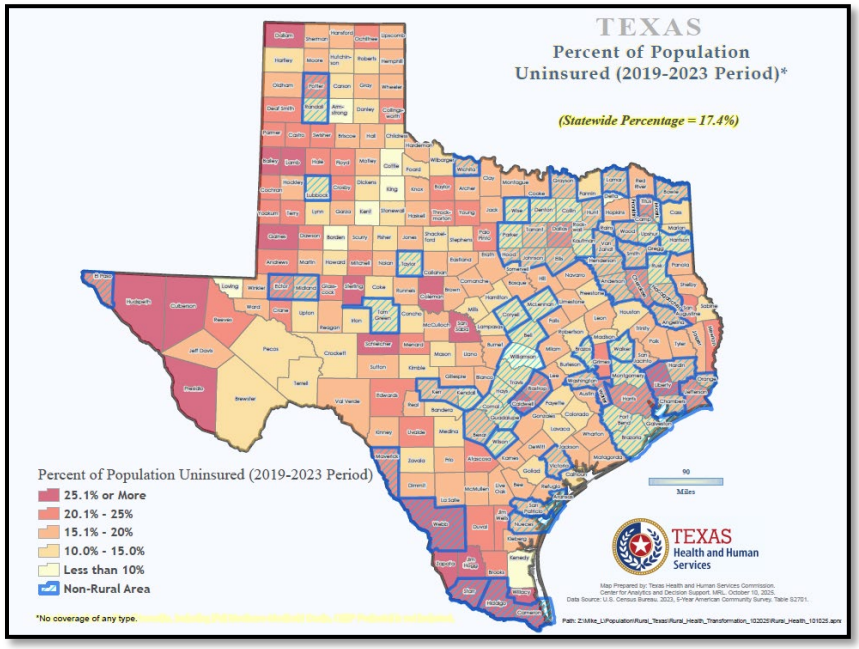


Figure 10, Percent of Population with Medicaid or CHIP Coverage (March 2025), HHSC.

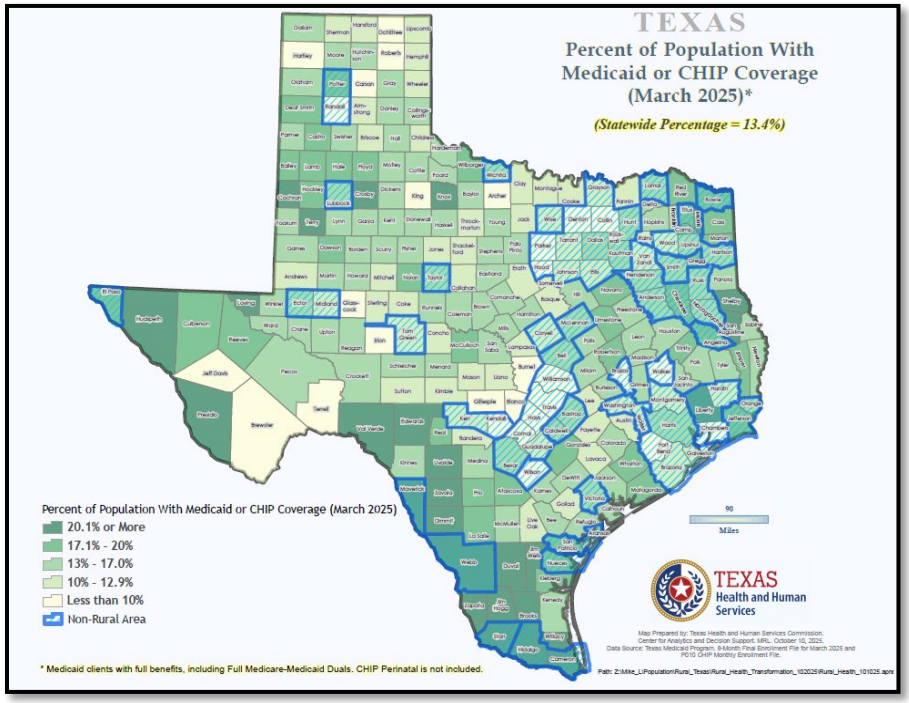
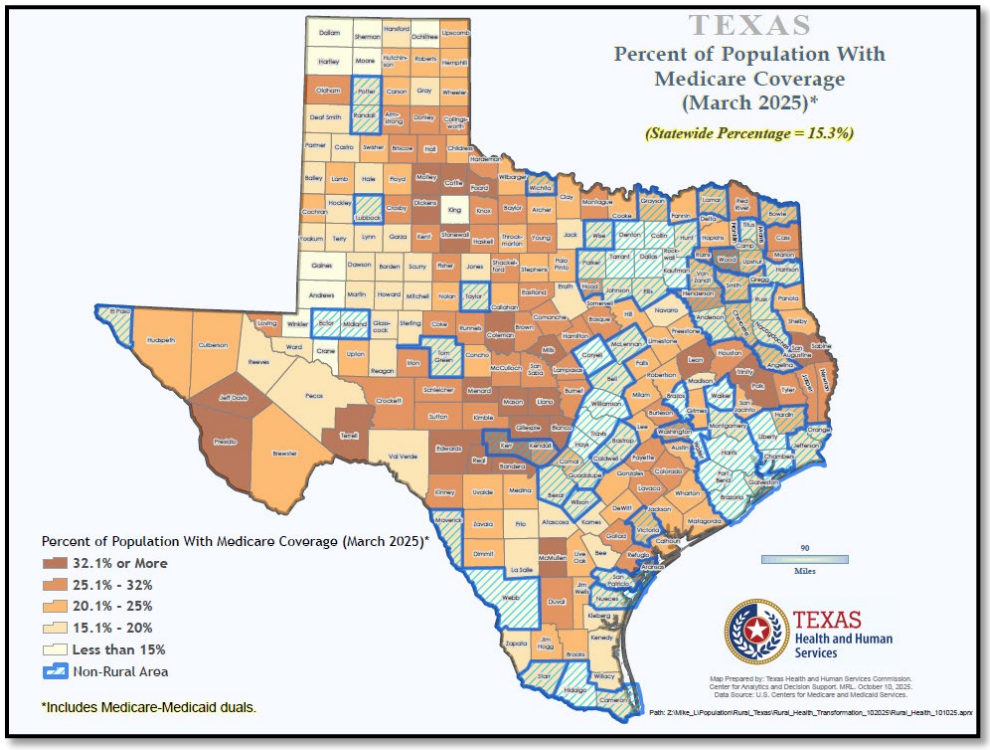


Figure 11, Percent of Population with Medicare Coverage (March 2025), HHSC.



[20] Texas Medicaid Provider Procedures Manual. (2025). 3.6 Home Telemonitoring Services, September 2025. Retrieved from: https://www.tmhp.com/sites/default/files/microsites/provider-manuals/tmppm/html/index.html#t=TMPPM%2F2_19_Telecommunication_Srvs%2F2_19_Telecommunication_Srvs.htm%231800565bc-26&rhsearch=Federally%20Qualified%20Health%20Centers%20and%20Rural%20Health%20Clinic%20Billing&rhsyns=%20&rhtocid=_30_2_5

[21] Texas Health and Human Services Commission. (2024). *Medicaid Managed Care Provider Network Adequacy Report, December 2024*. Retrieved from: https://www.hhs.texas.gov/sites/default/files/documents/medicaid-managed-care-provider-network-adequacy-dec-2024.pdf

[22] Nehme E, Janda K, Meier J, Wilson K, Lakey D. (2021). *The potential for a rural community health system to improve health care access and value in Texas*. Retrieved from: https://www.utsystem.edu/sites/default/files/sites/texas-health-journal/THIN-RCHS-April2021.pdf.

[23] Texas Organization of Rural & Community Hospitals, Hospital Referral Region Data. Provided to HHSC.

[24] **Figure 12**, Federally Qualified Health Centers and Look-Alikes. Health Resources and Services Administration Data Warehouse.

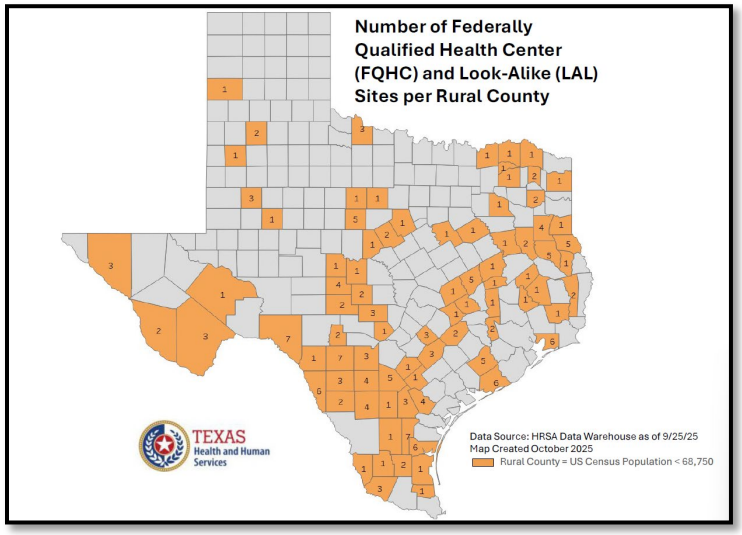
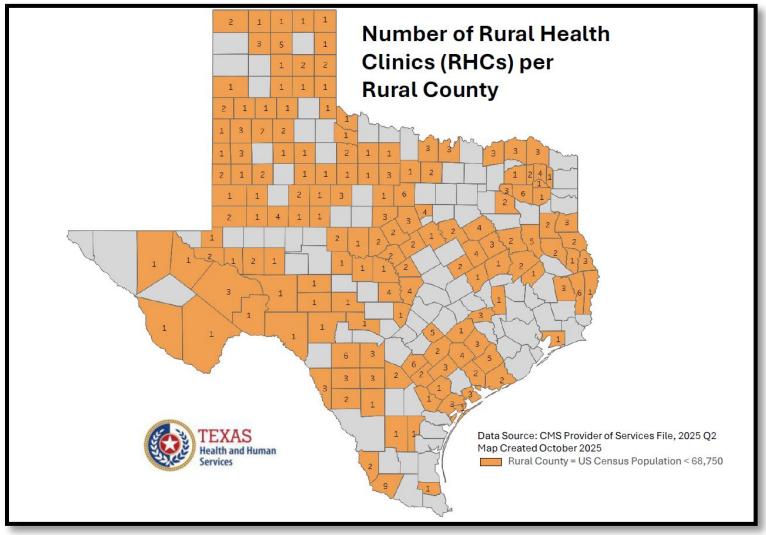


Figure 13, Rural Health Clinics per County**.** CMS Provider of Services File.

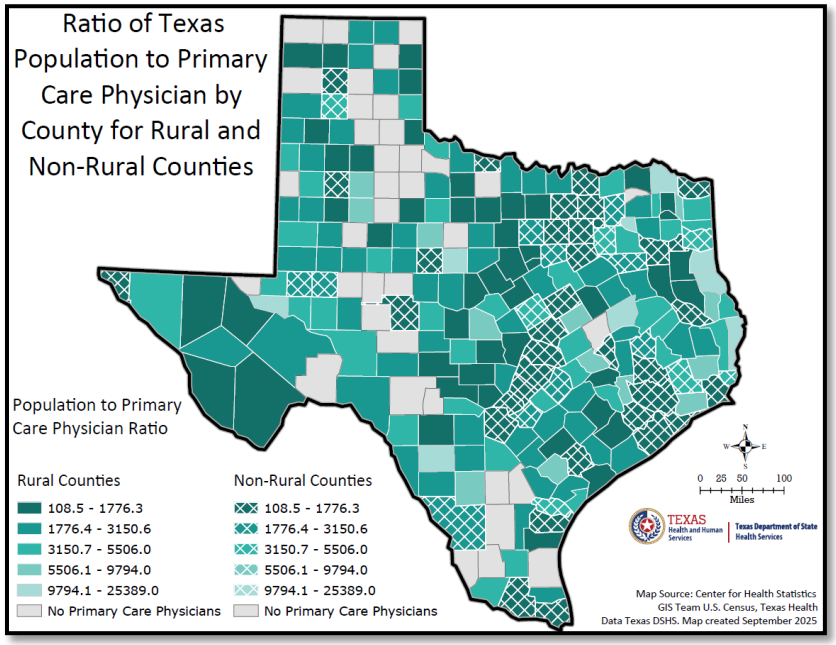


[25] The Rural Texas Maternal Health Assembly, 2025 Rural Texas Maternal Health Rescue Plan. Retrieved from: http://architexas.org/programs/maternal-health/rural-texas-maternal-health-plan-2025.pdf

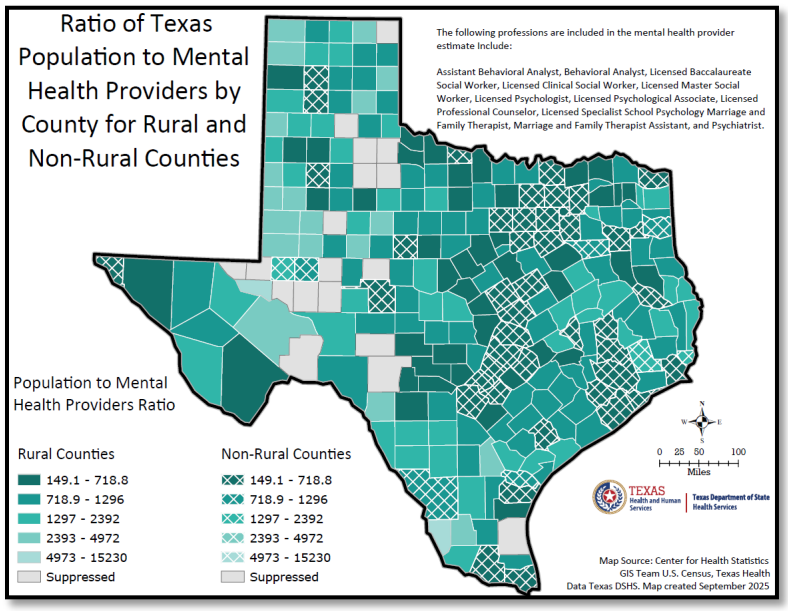
[26] Ibid.

[27] Department of State Health Services (DSHS). (2020). *Texas Physician Supply and Demand Projections, 2018-2032, May 2020*. Retrieved from: https://www.dshs.texas.gov/sites/default/files/legislative/2020-Reports/TexasPhysicianSupplyDemandProjections-2018-2032.pdf

[28] **Figure 14** – Ratio of Texas Population to Primary Care Physician by County for Rural and Non-Rural Counties.



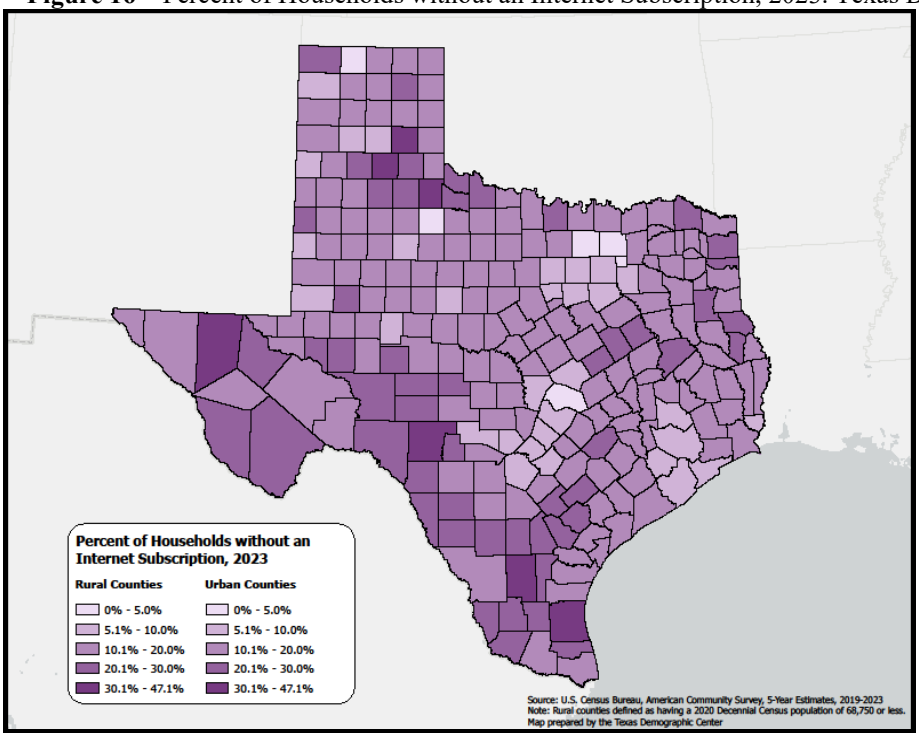
[29] **Figure 15** Ratio of Texas Population to Mental Health Providers by County for Rural and Non-Rural Counties DSHS Center for Health Statistics.



[30] Rural Health Information Hub, Transportation to Support Rural Healthcare, Retrieved from: https://www.ruralhealthinfo.org/topics/transportation

[31] Texas Department of Transportation, Rural Public Transportation Systems. Retrieved from: https://www.txdot.gov/content/dam/docs/division/ptn/rural-public-transportation-systems-districts-map.pdf.

[32] **Figure 16 –** Percent of Households without an Internet Subscription, 2023. Texas Demographics Center.



[33] Texas Broadband Development Office. (2022). Texas Broadband Plan 2022. Retrieved from https://comptroller.texas.gov/programs/broadband/about/what/docs/broadband-plan-22.pdf

[34] Statewide Health Coordinating Council, 2023-2028 Texas State Health Plan. Retrieved from: https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/Statewide-Health-Coordinating-Council-2023-2028-Texas-State-Health-Plan.pdf

[35] Ibid.

[36] Jacks, A. M., Romero, C., Rowan, C., Sterling-Lewis, J., Texas Health Institute, Blair Williams, Meghan Varghese, Jessica Cargill, Klaus Kroyer Madsen, Tanweer Kaleemullah, Briana Martin, & Shao-Chee Sim. (2024). PASSION, TRUST, PERSON-CENTERED A landscape scan of diabetes prevention programs in Texas. In Texas Health Institute. Retrieved from: https://www.episcopalhealth.org/wp-content/uploads/2025/05/Diabetes-Prevention-Programs-Final-Report.pdf

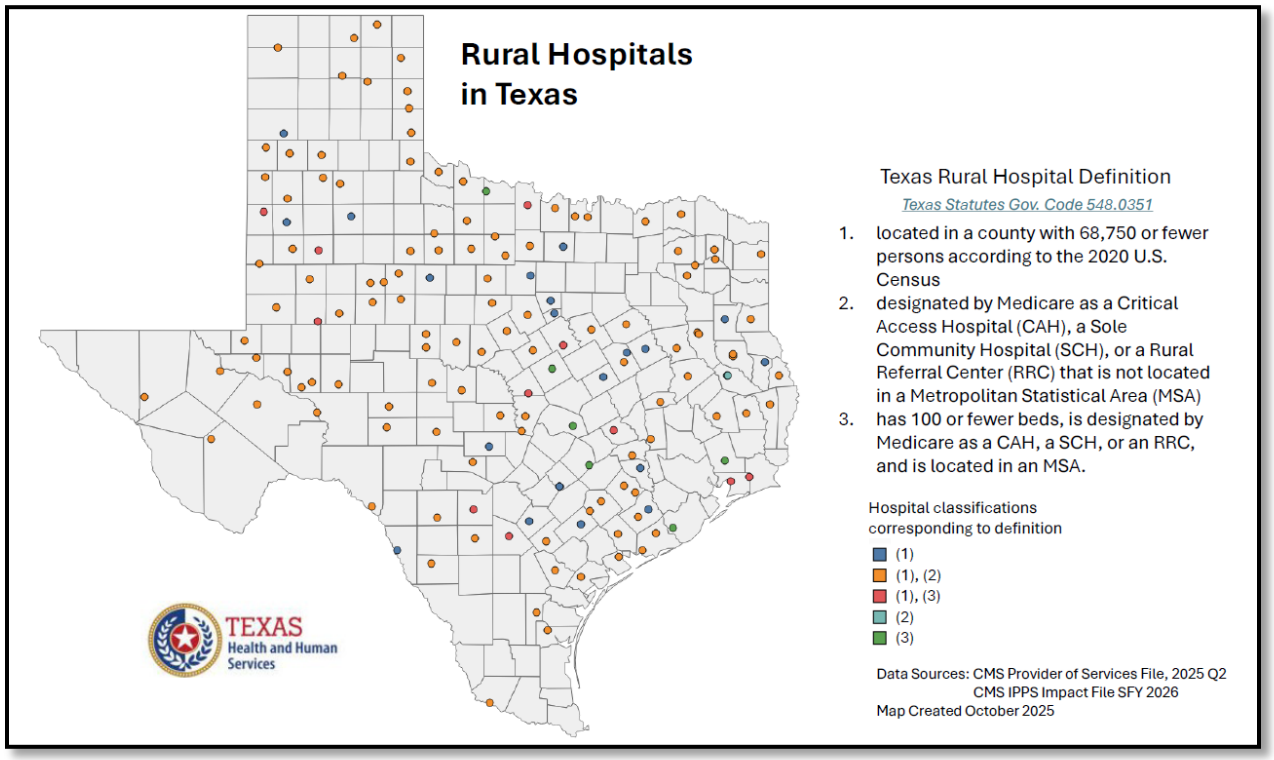
[37] Episcopal Health Foundation, Economic Impacts of Health Disparities in Texas 2020. Retrieved from: https://www.episcopalhealth.org/wp-content/uploads/2024/02/2-27-24-Health-Disparities-Full.pdf and https://www.episcopalhealth.org/enews/report-texas-economy-could-save-billions-in-losses-by-breaking-the-cycle-of-preventable-health-differences/

[38] Rural Health Info, Healthcare Access in Rural Communities. Retrieved from: https://www.ruralhealthinfo.org/topics/healthcare-access

[39] Texas Public Radio. Texas primary care doctor shortage spikes during the pandemic; rural Texans hit hardest. Retrieved from: https://www.tpr.org/public-health/2021-11-17/texas-primary

[40] DSHS, Health Professions Resources Center. Primary Care Physicians and Physicians Assistants in Texas. Retrieved from: https://www.dshs.texas.gov/sites/default/files/chs/hprc/publications/PrimaryCarePhysiciansandPAs.pdf

[41] Jafri, S.H.; Gandhi, S.; Osei, E. Physician Deserts: Navigating the Texas Terrain of Provider Supply and Demand with GIS Mapping. Healthcare 2024, 12, 2397. https:// doi.org/10.3390/healthcare12232397
[42] Health Professional Shortage Area Designations, Mental HPSAs. Retrieved from: https://www.texastribune.org/2024/07/17/texas-mental-health-workforce-explainer/
[43] DSHS Physician Supply and Demand Projections 2021-2032. Retrieved from: https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/Physician-Supply-and-Demand-Projections-2021-2032.pdf
[44] Texas Medical Association, Coming Up Short, May 2024. Retrieved from: https://www.texmed.org/Template.aspx?id=64071
[45] Texas Rural Hospital Survey Results, May 2022. (Texas State Office of Rural Health partnered with Connected Nation Texas (CN Texas) to conduct an online survey)
[46] Texas Rural Hospital Survey Results, May 2022 (Texas State Office of Rural Health partnered with Connected Nation Texas (CN Texas) to conduct an online survey that was distributed to 163 rural Texas hospitals)
[47] Southwick, R. (2022, April 7). Why smaller hospitals are targets for cyberattacks. OncLive. Retrieved from: https://www.chiefhealthcareexecutive.com/view/why-smaller-hospitals-are-targets-for-cyberattacks
[48] HHSC estimates that greater than 15 rural Texas hospitals have experienced a ransomware attack. However, it is expected that there are more clinics and other providers who have paid ransoms.
[49] Recovering from a Cybersecurity Attack and Protecting the Future in Small, Rural Health Organizations. Rural Health Information Hub. https://www.ruralhealthinfo.org/rural-monitor/cybersecurity-attacks
[50] HHSC Vulnerability Index
[51] An Analysis of Texas Rural Hospital Financial Solvency, prepared by TORCH for HHSC, February 2025.
[52] Ibid.
[53] Population counts based on July 2023 U.S. Census Bureau estimates.
[54] Definition aligns with Texas Government Code, Chapter 526.0321.
[55] **Figure 17 –** Rural Hospitals by Classification. HHSC, CMS Provider Services File.



[56] The Rural Texas Maternal Health Assembly, 2025 Rural Texas Maternal Health Rescue Plan. Retrieved from: http://architexas.org/programs/maternal-health/rural-texas-maternal-health-plan-2025.pdf

[57] Gessert C, Waring S, Bailey-Davis L, Conway P. Rural definition of health: a systematic literature review. (2015) BMC Public Health. 2015;15(378). Retrieved from: Rural definition of health: a systematic literature review - PubMed

[58] The U.S. Department of Agriculture's Food and Nutrition Service approved Texas' SNAP Food Restriction Waiver on August 4, 2025.

[59] Senate Bill 25 (89th Legislature, Regular Session, 2025). The new requirement applies only to an application for license renewal filed on or after January 1, 2027.

[60] The rules must prescribe the number of hours of the continuing medical education required and the content of the continuing medical education required based on the nutritional guidelines recommended by the Texas Nutrition Advisory Committee under Chapter 119B, Health and Safety Code. (Source: Sections 156.061(b), 204.1563(b), and 301.309(b) of the Occupation Code).

[61] Cicero Institute. (2024). A Policymaking Playbook for Certificate of Need Repeal: Ranking Certificate of Needs Laws in All 50 States. Retrieved from: https://ciceroinstitute.org/wp-content/uploads/2024/12/50-State-CON-Rankings-Report-12-5-2024.pdf.

[62] Interstate Medical Licensure Compact, Retrieved from: https://imlcc.com/; Texas Occupations Code, Chapter 171. Retrieved from: https://statutes.capitol.texas.gov/Docs/OC/htm/OC.171.htm

[63] National Council of State Boards of Nursing (NCSBN). (2025). Nurse Licensure Compact, Texas, accessed 9/26/2025; Texas Occupations Code, Chapter 304. Retrieved from: https://statutes.capitol.texas.gov/Docs/OC/htm/OC.304.htm.

[64] The United States Emergency Medical Services Compact, September 2025. Retrieved from: https://emscompact.gov/. Texas Health and Safety Code, Chapter 778A. Retrieved from: https://statutes.capitol.texas.gov/Docs/HS/htm/HS.778A.htm.

[65] PSYPACT Participation Map. Retrieved from: https://psypact.gov/page/psypactmap. Texas Occupations Code, Section 501.601. Retrieved from: https://statutes.capitol.texas.gov/Docs/OC/htm/OC.501.htm#501.601.

[66] American Academy of Physician Associations, State Practice Environment Map. Retrieved September 26,2025 from: https://www.aapa.org/advocacy-central/state-advocacy/state-maps/pa-state-practice-environment/.

[67] American Association of Nurse Practitioners, State Practice Environment. Retrieved September 26,2025 from: https://www.aanp.org/advocacy/state/state-practice-environment.

[68] Cicero Institute. (2025). 2025 Policy Strategies for Full Practice Authority. Retrieved September 26, 2025 from: https://ciceroinstitute.org/research/2025-policy-strategies-for-full-practice-authority/.

[69] Oral Health Workforce Research Center (2024). Variation in Dental Hygiene Scope of Practice by State. Retrieved September 26, 2025 from https://oralhealthworkforce.org/infographics/variation-in-dental-hygiene-scope-of-practice-by-state/.

[70] The Texas definition of "short-term limited-duration insurance" is tied directly to the federal definition of "short-term, limited-duration insurance". Consequently, the only short-term limited duration plans allowable in Texas are the same policies allowable under federal regulations. Sec. 1509.001, TX Insurance Code, provides that "short-term limited-duration insurance" has the meaning assigned by 26 CFR 54.9801-2. The definition of "short-term, limited-duration insurance" found in 26 CFR 54.9801-2 is identical to the definition of "short-term, limited-duration insurance" found at 45 CFR 144.103.

[71] Reimbursement is contingent on meeting certain conditions described in the Texas Medicaid Provider Procedures Manual (TMPPM), Telecommunications Handbook (Oct. 2025), 3.3.2 Telemedicine and Telehealth Conditions for Reimbursement (October 2025).

[72] TMPPM Telecommunication Services Handbook (Oct. 2025), 3.4.2 Telemedicine Service Delivery; 3.5.5 Telehealth Service Delivery.

[73] TMPPM Telecommunication Services Handbook (Oct. 2025), 3.4.2 Telemedicine Service Delivery; 3.5.5 Telehealth Service Delivery.

[74] The term "home telemonitoring" is synonymous with "remote patient monitoring". (Sec. 521.001(7), TX Government Code). TMPPM Telecommunication Services Handbook (Oct. 2025), 3.6 Home Telemonitoring Services.

[75] Title 22 Texas Administrative Code §175.1

[76] All physicians must hold a full Texas medical license to practice in Texas, including physicians practicing telemedicine. (Title 22 Texas Administrative Code, §161.40)
[77] Disease Management Programs: Improving health while reducing costs? Retrieved from: https://hpi.georgetown.edu/management/
[78] Rural Health Information Hub, Telehealth and Health Information Technology in Rural Healthcare. Retrieved from: Telehealth and Health Information Technology in Rural Healthcare Overview - Rural Health Information Hub
[79] American Health Information Management Association, 2016. Retrieved from: Patient Portal Toolkit
[80] Liao Y, Thompson C, Peterson S, Mandrola J, Beg MS. The Future of Wearable Technologies and Remote Monitoring in Health Care. Am Soc Clin Oncol Educ Book. 2019 Jan;39:115-121. doi: 10.1200/EDBK_238919. Epub 2019 May 17. PMID: 31099626; PMCID: PMC8325475.
[81] Michael, Ilesanmi & Bello, Usman & Ghiloubi, Imam & Idowu, Marvel & Oluwasogo, Joseph. (2021). Wearables in Remote Patient Monitoring and Telehealth. Retrieved from: https://www.researchgate.net/publication/393357631_Wearables_in_Remote_Patient_Monitoring_and_Telehealth
[82] HHSC, Health Information Technology Strategic Plan, November 2019. Retrieved from: Health IT Strategic Plan
[83] CMS Interoperability. Retrieved from https://www.cms.gov/priorities/key-initiatives/burden-reduction/interoperability/cms-interoperability
[84] CMS Health Tech Ecosystem Categories. Retrieved from https://www.cms.gov/health-technology-ecosystem/categories
[85] Perez K, Wisniewski D, Ari A, Lee K, Lieneck C, Ramamonjiarivelo Z. Investigation into Application of AI and Telemedicine in Rural Communities: A Systematic Literature Review. Healthcare (Basel). 2025 Feb 4;13(3):324. doi: 10.3390/healthcare13030324. PMID: 39942513; PMCID: PMC11816903. Retrieved from: Investigation into Application of AI and Telemedicine in Rural Communities: A Systematic Literature Review - PMC
[86] Maleki Varnosfaderani S, Forouzanfar M. The Role of AI in Hospitals and Clinics: Transforming Healthcare in the 21st Century. Bioengineering (Basel). 2024 Mar 29;11(4):337. doi: 10.3390/bioengineering11040337. PMID: 38671759; PMCID: PMC11047988. Retrieved from: https://pmc.ncbi.nlm.nih.gov/articles/PMC11047988/
[87] Ibid.
[88] Eastwood, B. (2024, August 7). Ambient listening in healthcare: dictation, documentation and AI. Technology Solutions That Drive Healthcare. Retrieved from: https://healthtechmagazine.net/article/2024/08/ambient-listening-in-healthcare-perfcon
[89] Butzner M, Cuffee Y. Telehealth Interventions and Outcomes Across Rural Communities in the United States: Narrative Review. J Med Internet Res. 2021 Aug 26;23(8):e29575. doi: 10.2196/29575. PMID: 34435965; PMCID: PMC8430850. Retrieved from: https://pmc.ncbi.nlm.nih.gov/articles/PMC8430850/
[90] Schadelbauer, Rick. (2017) Anticipating Economic Returns of Rural Telehealth. Retrieved from: https://www.ntca.org/sites/default/files/documents/2017-12/SRC_whitepaper_anticipatingeconomicreturns.pdf
[91] DSHS, Workforce Supply & Demand. Retrieved from: https://healthdata.dshs.texas.gov/dashboard/health-care-workforce/hprc/workforce-supply-and-demand-projections
[92] Hernandez, D., St, J., & John. (n.d.). 2024 Landscape of the Texas Community Health Worker CHW Workforce and Implications for Sustainability. Retrieved from: https://www.episcopalhealth.org/wp-content/uploads/2024/08/8-07-24-CHW-Full-text-edited.pdf
[93] DSHS, Health Profession Fact Sheets. Retrieved from: https://healthdata.dshs.texas.gov/dashboard/health-care-workforce/hprc/health-profession-fact-sheets
[94] Health Connect Statistical Analysis of Rural Hospital Survival. Resources provided to HHSC.
[95] Application Engagement Stakeholder Participants:

Table 1: Application Stakeholder Engagement Participants

Location	Date	Participant	Organization
Starr County - Rio Grande City	10/6/2025	Jesse Solis	RGCG ISD
Starr County - Rio Grande City	10/6/2025	Maria A. Sanchez	BRBHC
Starr County - Rio Grande City	10/6/2025	Jorge Sepulxa	BRBHC
Starr County - Rio Grande City	10/6/2025	Cesar Vasquez	BRBHC

Starr County - Rio Grande City	10/6/2025	Laura Cortez	BRBHC
Starr County - Rio Grande City	10/6/2025	Scott Lillibridge	DHR
Starr County - Rio Grande City	10/6/2025	Isidro Alaniz	District Attorney, Zapata 49th
Starr County - Rio Grande City	10/6/2025	Marisela Jacaman	1st Asst, Webb/Zapata
Starr County - Rio Grande City	10/6/2025	Jacinda Vela	County DA Office
Starr County - Rio Grande City	10/6/2025	Daniel Arriaga	Zapata Fire
Starr County - Rio Grande City	10/6/2025	Sandy Maldonado	Border Region
Starr County - Rio Grande City	10/6/2025	Camencha Lopez	BRBHC
Starr County - Rio Grande City	10/6/2025	Ana De La Cruz	BRBHC
Starr County - Rio Grande City	10/6/2025	Diana Salazar	BRBHC
Starr County - Rio Grande City	10/6/2025	Adriana Garza	BRBHC
Starr County - Rio Grande City	10/6/2025	Jessica Contreras	
Starr County - Rio Grande City	10/6/2025	Rene Montalvo	
Starr County - Rio Grande City	10/6/2025	Lupita Zapeda	Rep Don McLaughlin's Office
Starr County - Rio Grande City	10/6/2025	Reyna Guerra	Starr County Judge's Office
Starr County - Rio Grande City	10/6/2025	Yadira A. Barrera	Roma ISD Board
Starr County - Rio Grande City	10/6/2025	Alejandro Barrera	City of Roma
Starr County - Rio Grande City	10/6/2025	Antonio Falcon, MD	
Starr County - Rio Grande City	10/6/2025	James Falcon	
Starr County - Rio Grande City	10/6/2025	Mariah Montalvo	TAMU
Starr County - Rio Grande City	10/6/2025	Karen Banda-Roman	TAMU
Starr County - Rio Grande City	10/6/2025	Jayson Valerio	STE
Starr County - Rio Grande City	10/6/2025	Lance Ames	STHS
Starr County - Rio Grande City	10/6/2025	Jennifer Vasquez	Starr County Attorney
Starr County - Rio Grande City	10/6/2025	Juan Verano	
Starr County - Rio Grande City	10/6/2025	Leticia Garza-Galvan	
Starr County - Rio Grande City	10/6/2025	Arturo Montiel	
Starr County - Rio Grande City	10/6/2025	Alda Rendon	
Starr County - Rio Grande City	10/6/2025	Ediel Barrera	
Starr County - Rio Grande City	10/6/2025	Fudatio Barrera	
Starr County - Rio Grande City	10/6/2025	Gilbert Millan	
Starr County - Rio Grande City	10/6/2025	Jesus Rios, Jr.	
Starr County - Rio Grande City	10/6/2025	Mario Reyes	
Starr County - Rio Grande City	10/6/2025	Dalinda Guillen	Texas Regional Bank / RGC EDC
Starr County - Rio Grande City	10/6/2025	Elsa Moss	San Isidro ISD
Starr County - Rio Grande City	10/6/2025	Jessica Ganti	El Faro Health & Therapeutics
Starr County - Rio Grande City	10/6/2025	Nelda Elizar	SCIF
Starr County - Rio Grande City	10/6/2025	Rose Benavidez	STC/SCIF
Starr County - Rio Grande City	10/6/2025	Jaime Escobar	City of Roma
Starr County - Rio Grande City	10/6/2025	Melinda Gomez	Rio Grande City EDC
Starr County - Rio Grande City	10/6/2025	Roberto Bazur	Congressman Cuellar's Office
Starr County - Rio Grande City	10/6/2025	Cynthia Garcia Fuentes	Starr County P.R.

Starr County - Rio Grande City	10/6/2025	Joel Meya Jr.	SCMS
Starr County - Rio Grande City	10/6/2025	Valeria Delinda	City of RGC
Starr County - Rio Grande City	10/6/2025	Jennifer Vale Ortiz	Starr Camargo Bridge
Starr County - Rio Grande City	10/6/2025	Robert Vale	Starr Camargo Bridge
Starr County - Rio Grande City	10/6/2025	Sam Vale	Starr Camargo Bridge
Starr County - Rio Grande City	10/6/2025	Adrian Alfaro	Rio Grande Guardian
Starr County - Rio Grande City	10/6/2025	Nellie Gonzales	SCSO
Starr County - Rio Grande City	10/6/2025	Domingue Benavidez	SCIF
Tribal Liaison Meeting	10/7/2025	Anna Lopez	Revenue Cycle Manager, Ysleta Del Sur Pueblo
Tribal Liaison Meeting	10/7/2025	Criselda Valladarez	PRC Registration Clerk, Kickapoo Traditional Tribe of Texas
Tribal Liaison Meeting	10/7/2025	Sylvia Giron	Community Health Representative, Kickapoo Traditional Tribe of Texas
Tribal Liaison Meeting	10/7/2025	Elizabeth Palyu, LCSW	Director of Behavioral Health, Ysleta Del Sur Pueblo
Tribal Liaison Meeting	10/7/2025	Martin Lopez	Health and Human Services Director, Ysleta Del Sur Pueblo
Permian Basin - Stanton	10/7/2025	Judy Madison	South Plains Rural Health Services
Permian Basin - Stanton	10/7/2025	Dave Schmidt	Scenic Mountain Medical Center
Permian Basin - Stanton	10/7/2025	Nancy Cooke	Martin County Hospital District
Permian Basin - Stanton	10/7/2025	Jason Menefee	Marin County Hospital
Permian Basin - Stanton	10/7/2025	Jeremy Walker	Hendrick Health
Permian Basin - Stanton	10/7/2025	Kirk Canada	Hendrick Health - Abilene
Permian Basin - Stanton	10/7/2025	Brittani Bilse	Rural Health Innovators
Permian Basin - Stanton	10/7/2025	Virginia Belew	Permian Basin Regional Planning Committee
Permian Basin - Stanton	10/7/2025	Lori Wilson	State Representative Drew Darby
Permian Basin - Stanton	10/7/2025	Chris Barnhill	PermiaCare (MHMR)
Permian Basin - Stanton	10/7/2025	Alma Montes	AAA of PBRDC
Permian Basin - Stanton	10/7/2025	Craig Hunnicutt	
Permian Basin - Stanton	10/7/2025	Tim Jones	Heart of TX Healthcare System
East Texas - Lufkin	10/8/2025	Deborah Alvarenga	Texas A&M AgriLife Extension of Trinity & Polk County
East Texas - Lufkin	10/8/2025	Steve Archer	Community Healthcore
East Texas - Lufkin	10/8/2025	Amy Best	City of Longview
East Texas - Lufkin	10/8/2025	Guessippina Bonner	Sarah's Hope Charitable and Education Foundation

East Texas - Lufkin	10/8/2025	Scott Brunner	City of Longview
East Texas - Lufkin	10/8/2025	Dee Couch	Polk County Aging
East Texas - Lufkin	10/8/2025	Christy Cravey	Community Healthcore
East Texas - Lufkin	10/8/2025	Roxann Dominguez	TPA
East Texas - Lufkin	10/8/2025	Becky Eldridge	Mt Enterprise Community Health Clinic
East Texas - Lufkin	10/8/2025	Duane Galligher	TPA
East Texas - Lufkin	10/8/2025	Michael Glas	Carevide
East Texas - Lufkin	10/8/2025	Kayla Gutierrez	Vibrance Health / MEHOP
East Texas - Lufkin	10/8/2025	Sherry Harding	Shelby County Outreach Ministry Inc.
East Texas - Lufkin	10/8/2025	Ty Harmon	Matador UAS Consortium
East Texas - Lufkin	10/8/2025	Celeste Harrison	Vibrance Health
East Texas - Lufkin	10/8/2025	Martha Hernandez	Angelina County & Cities Health District
East Texas - Lufkin	10/8/2025	Angela Hobb-Spencer	City of Lufkin
East Texas - Lufkin	10/8/2025	Anita Humphreys	East Texas Community Health Services, Inc.
East Texas - Lufkin	10/8/2025	Paula Jones	Tyler County
East Texas - Lufkin	10/8/2025	Theresa Jones	Special Health Resources for Texas Inc
East Texas - Lufkin	10/8/2025	Chelsey Knowles	Community Healthcore
East Texas - Lufkin	10/8/2025	Ashley London	St. Luke's Health Memorial San Augustine
East Texas - Lufkin	10/8/2025	Jennifer Mertz	Healthpoint
East Texas - Lufkin	10/8/2025	Eric Moen	Episcopal Health Foundation
East Texas - Lufkin	10/8/2025	John Oglesbee	CHI Baylor Family Medicine
East Texas - Lufkin	10/8/2025	Lance Rather	PCCI
East Texas - Lufkin	10/8/2025	Glen Robison	East Texas Community Clinic, Inc.
East Texas - Lufkin	10/8/2025	Jessica Roldan	Special Health Resources for Texas, Inc
East Texas - Lufkin	10/8/2025	Terry Scoggin	Texas Organization of Rural & Community Hospitals
East Texas - Lufkin	10/8/2025	Angela Stewart	Pineland Activity & Nutrition Center / SCFP
East Texas - Lufkin	10/8/2025	Melanie Taylor	Burke Center
East Texas - Lufkin	10/8/2025	Todd Williams	Center for Community & Rural Health Eductions
East Texas - Lufkin	10/8/2025	Phil Yocam	Pineland Housing Authority
East Texas - Lufkin	10/8/2025	Anndrea Pickett	
East Texas - Lufkin	10/8/2025	Yesenia Cabral-Fletcher	Angelina County & Cities Health District
East Texas - Lufkin	10/8/2025	Cynthia Davis	Angelina County Senior Center

East Texas - Lufkin	10/8/2025	Kellie Harrison	Angelina County Senior Center
East Texas - Lufkin	10/8/2025	Kaylee McDaniel	Sabine County Hospital
East Texas - Lufkin	10/8/2025	Eugenio Longoria Saenz	Angelina Thrive
East Texas - Lufkin	10/8/2025	Sid Roberts	St. Luke's Health Memorial
East Texas - Lufkin	10/8/2025	Jessica Sexton	UT Tyler School of Medicine
East Texas - Lufkin	10/8/2025	Nancy Shanafelt	Trinity County
East Texas - Lufkin	10/8/2025	James Stevens	Tyler County Hospital District
East Texas - Lufkin	10/8/2025	Danielle Stevens	Tyler County Hospital District
East Texas - Lufkin	10/8/2025	Sondra Williams	Tyler County Hospital District
East Texas - Lufkin	10/8/2025	Janay Yancey	Tyler County Hospital District
East Texas - Lufkin	10/8/2025	Donna Sprouse	DETCOG
East Texas - Lufkin	10/8/2025	Karen Tiller	DETCOG
Panhandle - Childress	10/9/2025	Jonathon Gill	Pampa Regional
Panhandle - Childress	10/9/2025	Kimberly Jones	Childress Courts
Panhandle - Childress	10/9/2025	Gary Clark	
Panhandle - Childress	10/9/2025	Gayle Cannon	CRMC
Panhandle - Childress	10/9/2025	Howard Head	Reagan
Panhandle - Childress	10/9/2025	Debbie Favor	CRMC
Panhandle - Childress	10/9/2025	Paul Burke	Shamrock General Hospital
Panhandle - Childress	10/9/2025	Candy Powell	Collingsworth General Hospital
Panhandle - Childress	10/9/2025	James Driver	CRMC
Panhandle - Childress	10/9/2025	Sue Henderson	CRMC
Panhandle - Childress	10/9/2025	J.M. Henderson, MD	CRMC
Panhandle - Childress	10/9/2025	Crystal McEntire	Hyland's Pharmacy
Panhandle - Childress	10/9/2025	Marci Mills	CRMC
Panhandle - Childress	10/9/2025	Shade Miller	County
Panhandle - Childress	10/9/2025	Larry Johnson	CRMC (Retired)
Panhandle - Childress	10/9/2025	Lisa Goodwin	FRHC
Panhandle - Childress	10/9/2025	Matthew Bradley	Childress County
Panhandle - Childress	10/9/2025	Nikki Hill	CRMC
Panhandle - Childress	10/9/2025	Sarah Sprayberry	FRHC
Panhandle - Childress	10/9/2025	Kayla Meyer	CRMC
Panhandle - Childress	10/9/2025	Callie Saunders	CRMC
Panhandle - Childress	10/9/2025	Stephanie Ferguson	CRMC
Panhandle - Childress	10/9/2025	Jeremy Hill	County
Panhandle - Childress	10/9/2025	Michille Delgado	CRMC
Panhandle - Childress	10/9/2025	Nathan Taylor	Matador UAS Consortium
Panhandle - Childress	10/9/2025	Yeni Bushell	CRMC
Panhandle - Childress	10/9/2025	Griffin Fields	
Panhandle - Childress	10/9/2025	Gerardo Garcia	CRMC
Central - Giddings	10/10/2025	Andres Rosales	City of Bastrop
Central - Giddings	10/10/2025	Jo Johnson	St. Joseph Health
Central - Giddings	10/10/2025	Catherine Smider	Smithville Community Clinic

Central - Giddings	10/10/2025	Lew White	City of Lockhart
Central - Giddings	10/10/2025	Alan Casey	City of Giddings
Central - Giddings	10/10/2025	Quang Ngo	TORCH
Central - Giddings	10/10/2025	Norma Mercado	BastropCares
Central - Giddings	10/10/2025	Becki Womble	Bastrop Chamber
Central - Giddings	10/10/2025	Lindsey Tippit	Lonestar Circle of Care
Central - Giddings	10/10/2025	Preston Poole	Texas Assoc. of Community Health Center
Central - Giddings	10/10/2025	Rafael Delapaz	Community Health Centers of South Central Texas
Central - Giddings	10/10/2025	Linda Wilson	Smithville Hospital
Central - Giddings	10/10/2025	Donna Nichols	Bastop County Public Health
Central - Giddings	10/10/2025	Heather Garner	City of Giddings
Central - Giddings	10/10/2025	Jace Jones	Seton Smithville
Public Testimony - In-person	10/13/2025	Aimee Lusson	Texas Federation of Drug Stores & Walgreens
Public Testimony - In-person	10/13/2025	Charles Hinkle	Texas Ambulance Association
Public Testimony - In-person	10/13/2025	Steven Boles	Hunt Regional Healthcare
Public Testimony - In-person	10/13/2025	Paula Grahmann	
Public Testimony - In-person	10/13/2025	Sonali Weerasinghe	Texas Academy of Physician Assistants
Public Testimony - In-person	10/13/2025	Jana Eubank	TACHC
Public Testimony - In-person	10/13/2025	Burch Obenhoff	Texas EMS Alliance
Public Testimony - In-person	10/13/2025	Adam Arnwine	Mom's Meals
Public Testimony - In-person	10/13/2025	Tim Ols	
Public Testimony - In-person	10/13/2025	Lauren Ingram	Access Telecare
Public Testimony - In-person	10/13/2025	Rebecca McCain	Electra Hospital District
Public Testimony - In-person	10/13/2025	Susan Parker	TORCH / Kimble Hospital
Public Testimony - In-person	10/13/2025	Dr. Jane Wigginton	The University of Texas at Dallas
Public Testimony - In-person	10/13/2025	Terry Scoggin	TORCH
Public Testimony - In-person	10/13/2025	James Thornton	University of Houston
Public Testimony - In-person	10/13/2025	Tina Wells	Texas EMS Alliance
Public Testimony - In-person	10/13/2025	Dr. Jane Wigginton	The University of Texas at Dallas
Public Testimony - In-person	10/13/2025	Mindy Walker	OnMed
Public Testimony - In-person	10/13/2025	Bruce Tunner	Unite US
Public Testimony - In-person	10/13/2025	Douglas Dunsavage	American Diabetes Association
Public Testimony - In-person	10/13/2025	Noah Jones	Texas Counseling Association
Public Testimony - In-person	10/13/2025	John Austin Stoices	TARC - Association of Regional Councils
Public Testimony - In-person	10/13/2025	William Noll	Iraam General Hospital District
Public Testimony - In-person	10/13/2025	Brian Bessent	Hendrick Health

Public Testimony - In-person	10/13/2025	Maureen Milligan	Teaching Hospitals of Texas
Public Testimony - In-person	10/13/2025	Chris Suggs	Accent Care
Public Testimony - In-person	10/13/2025	Kara Crawford	UT Health Houston
Public Testimony - In-person	10/13/2025	Christopher Parker	PQT Health
Public Testimony - In-person	10/13/2025	David Weden	Texan Council
Public Testimony - In-person	10/13/2025	Roxann Dominguez	Texas Pharmacy Association
Public Testimony - In-person	10/13/2025	Dr. Jane Wigginton	The University of Texas at Dallas
Public Testimony - In-person	10/13/2025	Paula Grahmann	
Public Testimony - Virtual	10/13/2025	Thomas Sledge	North Texas Medical Center
Public Testimony - Virtual	10/13/2025	Jace Jones	Ascension Seton
Public Testimony - Virtual	10/13/2025	Brett Kirkham	MidCoast Health System
Public Testimony - Virtual	10/13/2025	Erin Clevenger	Memorial Medical Center
Public Testimony - Virtual	10/13/2025	Jonathan Gill	Pampa Regional Medical Center
Public Testimony - Virtual	10/13/2025	Justin Lees	Solution Shop - Armada MD
Public Testimony - Virtual	10/13/2025	Dr. Ali Ghahary	Armada MD
Public Testimony - Virtual	10/13/2025	Andres Duran	Dimmit Regional Hospital
Public Testimony - Virtual	10/13/2025	Lori DeMoss	
Public Testimony - Virtual	10/13/2025	Samantha McGee	Uniper Care, Inc
Public Testimony - Virtual	10/13/2025	Margaret Scott	Texas Academy of Physician Assistants
Public Testimony - Virtual	10/13/2025	Rubina Khan	Maternal Child health
Public Testimony - Virtual	10/13/2025	Rachel Koay	Feeding Texas
Public Testimony - Virtual	10/13/2025	Amy Fagan	Wichita Falls-Wichita County Public Health District
Public Testimony - Virtual	10/13/2025	Meera Riner	Nexion Health
Public Testimony - Virtual	10/13/2025	Jonny Hipp	Nueces County Hospital District
Public Testimony - Virtual	10/13/2025	Brandi Chane	Davis City Pharmacy, Inc
Public Testimony - Virtual	10/13/2025	Laketria Venzant	AEIC CASE MANAGEMENT
Public Testimony - Virtual	10/13/2025	Travis Richmond	CHRISTUS Health
Public Testimony - Virtual	10/13/2025	Katherine Remick	Dell Medical School, University of Texas
Public Testimony - Virtual	10/13/2025	Sarah Pletcher	Houston Methodist
Public Testimony - Virtual	10/13/2025	Anna Stelter	Texas Hospital Association
Public Testimony - Virtual	10/13/2025	Lorenzo Serrano	Winkler County Hospital District
Public Testimony - Virtual	10/13/2025	Shakirat Olanrewaju	
Public Testimony - Virtual	10/13/2025	Crystal McEntire	Hyland's Pharmacy
Public Testimony - Virtual	10/13/2025	Jessica Miller	Flatland Psychiatry
Public Testimony - Virtual	10/13/2025	Lynn Falcone	Cuero Regional Hospital
Public Testimony - Virtual	10/13/2025	Kurt Sunderman	Rice Medical Center
Public Testimony - Virtual	10/13/2025	Dr Matthew B. Roberts	Texas Dental Association
Public Testimony - Virtual	10/13/2025	Sondra Williams	Tyler County Hospital District
Public Testimony - Virtual	10/13/2025	Merrick Morgan	UHS

Public Testimony - Virtual	10/13/2025	Adam Ratner	University of the Incarnate Word School of Osteopathic Medicine
Public Testimony - Virtual	10/13/2025	James (Sarosha Momin) Dieter	
Public Testimony - Virtual	10/13/2025	Aimee Lusson	Walgreens and Texas Federation of Drug Stores
Public Testimony - Virtual	10/13/2025	Jessica Gomez	
Public Testimony - Virtual	10/13/2025	Benjamin McNabb	Texas Pharmacy Association
Public Testimony - Virtual	10/13/2025	James (Josh Miller) Mault	BioIntelliSense
Public Testimony - Virtual	10/13/2025	Phil Beckett	thsa.org
Public Testimony - Virtual	10/13/2025	Catherine Morrison	Maxim Healthcare Services
Public Testimony - Virtual	10/13/2025	Nora Cox	Texas e-Health Alliance
Public Testimony - Virtual	10/13/2025	Christopher Hall	PHI Health, LLC
Public Testimony - Virtual	10/13/2025	Jorge Cruz (Private Citizen) Saenz	Veteran-Owned Business
Public Testimony - Virtual	10/13/2025	Marc Strode	Methodist
Public Testimony - Virtual	10/13/2025	Timothy Ols	Baylor Scott & White
Public Testimony - Virtual	10/13/2025	Venus Gines	Dia de la Mujer Latina Inc
Public Testimony - Virtual	10/13/2025	Michelle Gafford	Mitchell County Hospital District
Public Testimony - Virtual	10/13/2025	Titilope Fasipe	
Public Testimony - Virtual	10/13/2025	Linda Chandler	
Public Testimony - Virtual	10/13/2025	Jessica Boston	
Public Testimony - Virtual	10/13/2025	Titilope Fasipe	
Public Testimony - Virtual	10/13/2025	Kara Hartl	Troy Medical
Public Testimony - Virtual	10/13/2025	Melissa Wilson	
Public Testimony - Virtual	10/13/2025	Duncan Van Dusen	
Public Testimony - Virtual	10/13/2025	Amy Best	
Public Testimony - Virtual	10/13/2025	Billie Bell	