Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

Winter Conference
Wednesday, February 18, 2026
3:30pm-4:30pm

4d. The Strategic Executive's Guide to Managed Care: From Cost Pressures to Value Based Growth-What Leaders Need Now

Presented by:

Joe Russell, Vice President of Network Management & Contracting, Strategic Health Care

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Strategic Executive's Guide to Managed Care

Navigating Cost Pressures to Value-Based Growth: A Data-Driven Roadmap for Home Health & Hospice Leaders

Presented by Joe Russell

Texas Association for Home Care & Hospice (TAHC) - Winter Conference 2026

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Roadmap

01. The Healthcare Market
Examining what's driving the growth in healthcare spending

02. Government Policy to Cost Contain
Examining the government's approach toward driving down healthcare spending

03. Managed Care & MCOs
Exploring how managed care and MCOs became so important for cost containment

04. Value-Based Care & CINs
Exploring what's next in this hyper cost containment era

05. Strategic Roadmap
Actionable implementation strategies for managed care success.

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The Healthcare Market

Examining what's driving the growth in healthcare spending

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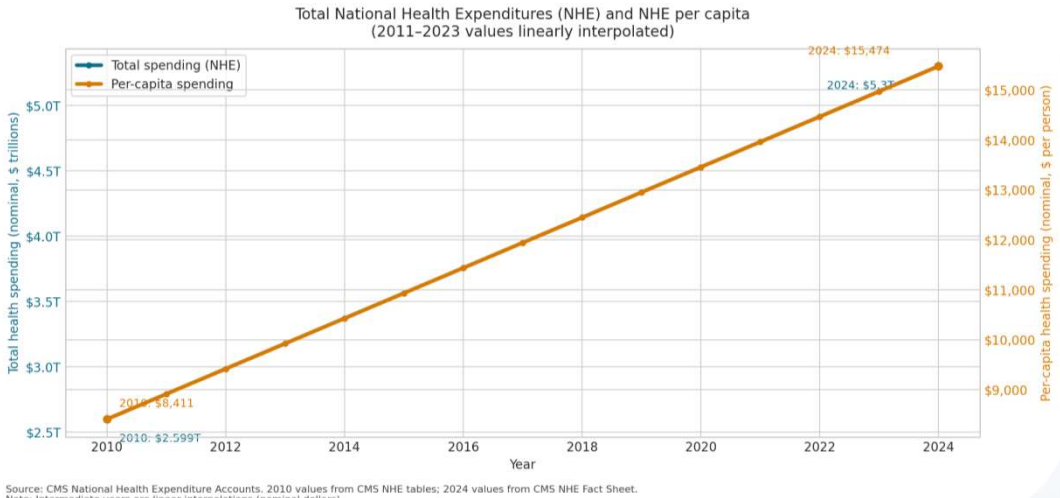
Healthcare Costs Are Reaching Crisis Levels

U.S. Health Care Spending Growth (Nominal), 2010-2024



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Post-Acute Care Inefficiencies Highlight Systemic Spending Challenges

Supply-Demand Imbalance

Demand for home-based care significantly outpaces available supply, creating access barriers and limiting growth opportunities for agencies across the market.

Prior Authorization Delays

Texas agencies experience an average 9-day delay in prior authorizations, resulting in substantial revenue loss, delayed patient care, and administrative inefficiencies.

Severe Understaffing Crisis

1 in 4 Texas home health and hospice agencies report being critically understaffed, with workforce turnover rates reaching unsustainable levels of 31%.

Deteriorating Staffing Ratios

Staffing ratios have declined dramatically from pre-pandemic levels, forcing agencies to operate with reduced capacity while demand continues increasing.

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Healthcare's Price Problem Underpins a Cost Problem

Labor: 56% of Operating Costs

Wage increases and persistent workforce shortages drive labor to represent the majority of post-acute agency operating expenses, creating unprecedented financial pressure.

Drug Costs: $115B Nationally

Pharmaceutical expenses surged 17% since 2022, reaching $115 billion nationally and significantly impacting agency margins and care delivery budgets.

Medicare Underpays $130B/Year

Annual Medicare underpayments total $130 billion nationwide, with Texas experiencing particularly severe 12% cuts for home health services since 2023.

There many other factors impacting the cost of delivering care too

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Government Policy to Cost Contain

Examining the government's approach toward driving down healthcare spending

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The Government's Policy Solution is Cost Containment Achieved by Shifting Toward More Integrated, Value-Based Care

2024

ACO TEAMs Launch

CMS launches ACO TEAMs program, significantly expanding managed care contracting opportunities for home health and hospice providers nationwide.

2025

Age-Friendly Health System Initiative

CMS implements Age-Friendly Health System Initiative, requiring interoperable patient data and pushing integrated, patient-centered care for seniors.

2025-2026

Texas $1.4B CIN Investment

Texas state government invests $1.4 billion through Medicaid waivers specifically for Clinical Integration Network development and rural healthcare transformation.

ACO LEADs is coming soon…

Understanding the policy environment and the goals of the government, and their health plan partners, can help agencies plot a course toward a bright future!

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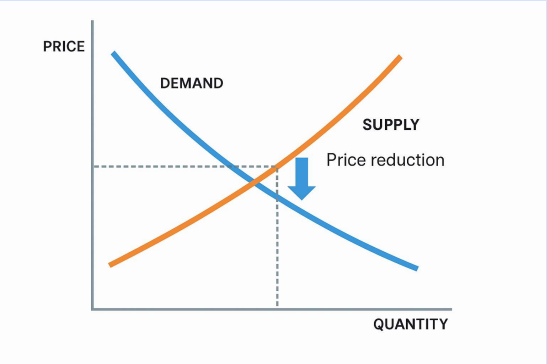
Cost Containment Options Are Limited



Healthcare Market Realities

- **Demand will continue to increase**
- **Service delivery costs are tied to other markets**
- **Government policy seeks to reduce utilization of supply**
- **Costs can be managed through efficient care that increases supply**

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CMS Age-Friendly Initiative Directly Links Compliance to Higher Payments

Initiative Requirements

- *New mandatory reporting elements for home health and hospice agencies*
- *Focus on integrated, patient-centered care specifically designed for senior populations*
- *Required data sharing protocols across all provider networks*
- *Emphasis on care coordination and seamless transitions*

Financial Impact

- *Agencies demonstrating full compliance receive 8% higher value-based payments*
- *Enhanced reimbursement opportunities through quality metric achievement*
- *Improved payer contract negotiations based on Age-Friendly designation*
- *Long-term competitive advantage in senior care market positioning*

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Managed Care & MCOs

Exploring how managed care and MCOs became so important for cost containment

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History of Managed Care

1910 — First prepaid group medical practice - The Western Clinic in Tacoma, Washington begins offering broad medical services for a fixed monthly prepaid fee, forming one of the earliest prototypes of a health maintenance organization (HMO).

1929 — Prepaid health plans expand (Blue Cross origins & cooperative models) - Multiple prepaid health arrangements emerge—including the Baylor Hospital prepaid teachers' plan (precursor to Blue Cross) and a farmers' cooperative plan created by Dr. Michael Shadid in Oklahoma—further establishing early managed-care concepts linking prepayment, cost control, and organized provider networks.

1970s — Federal encouragement of prepaid group health plans - The federal government, along with large private employers, begins actively encouraging workers to join prepaid health groups as a strategy to contain rising healthcare costs and broaden access to care.

1973 — Passage of the Health Maintenance Organization (HMO) Act - President Richard Nixon signs the HMO Act of 1973, which provides federal assistance and regulatory support to develop and expand HMOs, formally embedding managed care into U.S. national health policy as a cost-containment mechanism.

Late 1970s –1980s — Amendments and national expansion - Federal amendments in 1976 and 1978, along with subsequent regulatory changes, accelerate HMO development and embed managed care into employer-sponsored benefits and government health program strategies, reinforcing it as a dominant policy tool for controlling healthcare inflation.

2000s - Present— Government partners with private insurance companies – As a result of inefficiency and cost in Medicaid and Medicare, the federal and state governments collaborate with private market health plans to improve cost containment. Notably MA in 2003 and ACA in 2010.

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Cost Containment Strategies Used By Managed Care Organizations (MCOs)

Coordinated and Preventive Care

MCOs emphasize early risk identification and chronic disease management to reduce emergency service reliance and costs.

Integrated Provider Networks

Streamlined clinical workflows and high-value care settings reduce redundancies and promote efficient patient care.

Financial Controls and Utilization Management

Use of prior authorization, case management, and payment models align provider behavior with cost-efficiency goals.

Oversight and Accountability

Regulatory frameworks and transparency measures ensure responsible stewardship of healthcare funds and quality care.

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Why The Government Works With MCOs

Control and Predict Health Care Spending

Capitated payments enable more predictable cost management and reduce financial risk

Provide Administrative Capacity

MCOs assume major operational functions at scale

Manage Utilization and Reduce Inefficiencies

Utilization management strategies curb unnecessary or duplicative services

Expand Benefits and Innovation

Private plans can offer additional services beyond traditional coverage

Improve Care Quality and Outcomes

Coordination and integration initiatives lead to enhanced care

Promote Accountability

Contracts enforce performance and quality standards

HINT: The government is HIGHLY inefficient.

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Value-Based Care & CINs

Exploring what's next in this hyper cost containment era

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Defining Value-Based Care (VBC)

Pays for outcomes, not volume

Ties payment to the quality, equity, and ccost-effectiveness of care.

Improves patient health and experience

Focuses on prevention, coordinated care, and whole-perrson management.

Aligns incentives across providers

Accountable for population health and performance measures.

Reduces costs by focusing on efficiency

Eliminates low-value care and manages chronic conditions.

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By 2030, all MCOs will be offering providers some sort of value-based contract

Agencies participating in value-based care models demonstrate superior performance across all key financial and clinical metrics compared to traditional fee-for-service operations. Evidence from real-world implementations shows significant improvements in both cost management and patient outcomes.

17%	28%	1.5x
Total Spending Reduction	Readmission Decrease	Payer Contract Growth

What does this tell us? **The government is fully committed to VBC as the next phase of cost containment.**

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How can VBCs for EVERY provider be manageable or even be possible?

CINs will allow PAC HCBS provider to win BIG in managed care.

The market is fundamentally transitioning from isolated, individual agency contracts to regional collaborative networks. This transformation brings together home health, hospice, skilled nursing facilities, and physicians into unified Clinically Integrated Networks (CINs). Early adopters are already successfully negotiating advantageous upside-risk contracts, demonstrating the strategic value of integrated care delivery models.

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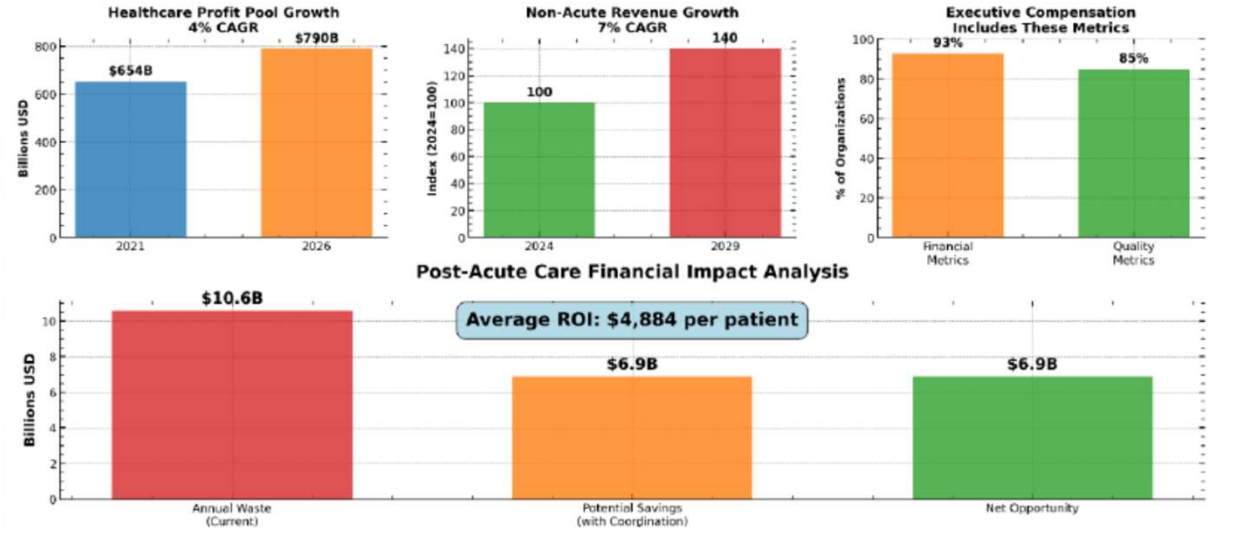
VBC Shared Savings Opportunities in PAC



Data Sources

- AHRQ National Readmissions Database
- MedPAC, CMS, and peer-reviewed healthcare economics studies
- Published case studies and program evaluations (see research reports above)
- Executive compensation survey data

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CINs Deliver Five Strategic Benefits While Preserving Agency Independence

Enhanced Reimbursement

Access to better reimbursement rates, shared savings programs, and value-based payment incentives that improve bottom-line performance.

Administrative Burden Relief

Centralized contracting processes, EHR support, data infrastructure, and quality reporting systems reduce operational overhead significantly.

Quality Improvement

Standardized clinical pathways, data-driven performance feedback, and comprehensive care management tools elevate patient outcomes consistently.

Independence with Scale

Retain local autonomy and agency identity while leveraging network resources, expertise, and collective negotiating power.

Value-Based Contracting Platform

Foundation for both upside and downside risk contracts, enabling participation in population health management programs.

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Strategic Roadmap

Actionable implementation strategies for managed care success.

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Fundamentals to WINNING in the Business of Managed Care

Have a Payer Strategy

Know where the opportunities to drive revenue exist, create a strategy that diversifies those opportunities, and execute the strategy.

Know *Your* Data

Learn what your organization looks like from the data, compare yourself to market peers, and drive toward data marks that scream value.

Build Partnerships

Create partnerships that are relationships, listen to their biggest pain points, solve for those problems, and do NOT do business with everyone.

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Strategic Actions: Four Steps To Maximize VALUE

Streamline and standardize clinical workflows

Reduce variation and improve care consistency.

Adopt technology that reduces administrative burden

Automate tasks and integrate EHR systems.

Implement continuous quality-improvement processes

Engage frontline staff in problem solving.

Leverage data analytics to inform decisions

Monitor performance and identify waste.

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Strategic Recommendations: Five Critical Actions for Leadership Teams

1 Engage with CINs

Actively pursue CIN partnerships to access value-based contracting opportunities, shared savings programs, and enhanced reimbursement models.

2 Invest in Data Infrastructure

Prioritize EHR integration, advanced analytics capabilities, and interoperable data systems to ensure regulatory compliance and enable data-driven decision making.

3 Prepare for Downside Risk

Build robust care management programs and financial modeling capabilities to successfully participate in shared risk arrangements and population health contracts.

4 Prioritize Clinical Quality

Develop and strengthen quality initiatives like transition-of-care programs to improve patient outcomes, reduce hospital readmissions, and demonstrate value to payers.

5 Leverage Your Community Partners & TAHC

Capitalize on and collaborate with your community relationships and work together to improve value to be positioned for long-term sustainable growth.

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Thank You – Q&A

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