Florida & Texas Pilot Program

Policy Brief — Dual-State Deployment Strategy

February 2026

Overview

This brief outlines the rationale, structure, and evaluation framework for the NHAIEF dual-state pilot program in Florida and Texas. The pilot is designed as a 12–18 month deployment targeting safety-net hospitals, rural health systems, and high Medicare-mix providers to validate AI-driven cost reduction at scale.

State Selection Rationale

Florida

- Second-largest Medicare population in the United States
- High concentration of safety-net hospitals and Medicare Advantage plans
- Significant utilization variation across urban and rural providers
- State-level policy environment supportive of healthcare innovation
- Diverse provider landscape including large health systems and independent hospitals

Florida's Medicare population of over 4.7 million beneficiaries provides a substantial baseline for measuring per-beneficiary cost impact. The state's mix of large urban systems and rural providers enables testing across different operational contexts.

Texas

- Largest uninsured population, creating acute cost-containment pressure
- Extensive rural health system network requiring scalable solutions
- Rapid population growth straining existing healthcare infrastructure
- Strong academic medical center ecosystem for research partnership
- Geographic diversity enabling rural, suburban, and urban deployment testing

Texas's healthcare landscape presents unique scaling challenges: vast geographic distances, workforce shortages in rural areas, and growing demand from population growth. These conditions make it an ideal testing ground for scalable AI infrastructure.

Deployment Timeline

Phase 1: Pilot Systems (Months 1–6)

Initial deployment to safety-net hospitals, rural health systems, and high Medicare-mix providers in both states. Activities include partner identification and onboarding, EHR integration assessment, baseline metrics collection, and initial model deployment for administrative workflows.

Phase 2: Expansion (Months 6–12)

Broader deployment across participating systems with EHR-agnostic integration kits, clinical workflow model activation, workforce optimization module rollout, and interim outcomes reporting.

Phase 3: Evaluation (Months 12–18)

Comprehensive outcomes evaluation including full cost-savings analysis per beneficiary, model retraining on outcome data, national expansion readiness assessment, and Congressional reporting.

Evaluation Framework

The pilot will be evaluated against six primary metrics, measured at baseline and at 6-month intervals:

- Cost per Medicare Beneficiary — Primary outcome measure tracking reduction in per-capita spending
- Administrative Cost Ratio — Percentage of total operating expense attributable to administrative functions
- Average Length of Stay — Inpatient LOS tracking, adjusted for acuity and case mix
- 30-Day Readmission Rate — Readmission reduction through predictive discharge planning
- Utilization Variance — Reduction in unexplained geographic and facility-level variation
- Clinician Administrative Time — Hours per week spent on documentation and non-clinical tasks

Target Participants

- Safety-net hospitals serving uninsured and Medicaid populations
- Rural health systems with limited capital for enterprise AI deployment
- Academic medical centers providing clinical validation and research infrastructure
- High Medicare-mix providers enabling direct cost-impact measurement

Federal Alignment

The pilot program directly supports federal healthcare objectives: Medicare Trust Fund sustainability, value-based care transition, and CMMI innovation goals. Outcomes data will inform federal policy on healthcare AI deployment standards and future appropriations.