GOVERNOR GREG ABBOTT

March 26, 2024

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: 11-W-00326/6 Healthy Texas Women Demonstration

Dear Secretary Becerra:

The Texas Health and Human Services Commission (HHSC) submits the attached application to extend the Healthy Texas Women (HTW 11-W-00326/6) demonstration under section 1115(a) of the Social Security Act.

The Healthy Texas Women demonstration is dedicated to offering women's health and family planning services at no cost to eligible women in Texas. The care provided by the demonstration will continue to help women plan their families, whether they seek to achieve, postpone, or prevent pregnancy.

Through the HTW demonstration, HHSC seeks to continue to enhance women's health care services by increasing access to and participation in the HTW program. HTW demonstration services are available statewide to eligible women.

The goals and objectives of the HTW Demonstration are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes, and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.

- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective services across a woman's lifecycle.
- Increase the use of value-based payment arrangements among managed care organizations (MCOs) and their provider networks.

This extension request will allow HHSC additional flexibility to use a managed care delivery model and increase the use of value-based payment arrangements among MCOs and their provider networks.

Additionally, the extension request will reflect an increase to the state's comparable income limit to convert the existing state income threshold standards from 200% of the Federal Poverty Level (FPL)to 204.2% of the FPL, the equivalent of the Modified Adjusted Gross Income (MAGI) standard.

The proposed effective date for the extension is January 1, 2025, for a five-year period ending December 31, 2029.

Thank you for the opportunity to submit this demonstration extension request. If you have any questions, please contact Cecile Erwin Young, the HHSC Executive Commissioner, at (512) 424-6502 or Cecile.Young@hhs.texas.gov. Thank you for your consideration and prompt action to approve this extension.

Sincerely,

Greg Abbott
Governor

GA:tgd

Healthy Texas Women Section 1115 Demonstration Extension Application

As Required by
Centers for Medicare & Medicaid Services

Texas Health and Human Services
March 2024

TEXAS
Health and Human Services

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Executive Summary

Healthy Texas Women Demonstration

The Healthy Texas Women (HTW) Demonstration has a history that began with a predecessor program called the Texas Women's Health Program. In December 2006, the Centers for Medicare and Medicaid Services (CMS) approved the Texas Women's Health Program demonstration under section 1115(a) of the Social Security Act (the Act) that provided a limited Medicaid benefit package of family planning and services to women ages 18 to 44. The goal of the Texas Women's Health Program was to improve health outcomes for low-income Texas women and babies, and to reduce expenditures for Medicaid-paid births by increasing access to family planning services. The Texas Women's Health Program demonstration expired in December 2012 and the program continues using general revenue (GR) funds.

On July 1, 2016, the Health and Human Services Commission (HHSC) launched the state funded Healthy Texas Women (HTW) program to provide women's health and family planning services at no cost to eligible, low-income Texas women.

On January 22, 2020, CMS approved the HTW demonstration under section 1115(a) of the Act for five years, from January 22, 2020, to December 31, 2024. The HTW demonstration is designed to further the goals of Title XIX of the Social Security Act (Medicaid) by increasing and strengthening coverage for low-income women in Texas through the provision of a unique benefit package for women who would not otherwise be eligible for family planning and preventive services under Texas Medicaid. Additionally, the HTW demonstration is designed to improve health outcomes for the Medicaid population by providing preconception and interconception care to women eligible for Medicaid coverage if they become pregnant, aiming to improve birth outcomes and support optimal birth spacing. The HTW demonstration provides family planning services as well as other women's health services that contribute to preconception care, better birth outcomes and improved maternal health in Texas.

HHSC now seeks to extend the HTW demonstration from January 1, 2025 through December 31, 2029, and submits this request to CMS as required by federal regulations at 42 CFR §431.412(c)(2).The following information will demonstrate compliance with demonstration extension requests and transparency requirements per the CFR.

CFR Requirements

42 CFR 431.412(c)(2)(i) A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

Through the HTW demonstration, HHSC sought to enhance women's health care services by increasing access to and participation in the HTW program. HTW demonstration services are available statewide to eligible women.

The goals and objectives of the HTW demonstration were to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
    - HHSC provided women's health and family planning services to all women eligible for HTW. For example, in State Fiscal Year (SFY) 2022, the number of HTW women receiving a long-acting reversible contraceptive was 7,467. HHSC will continue to provide and promote the use of an array of women's health and family planning services in the HTW demonstration extension request if extended.
- Increase access to preventive health care, including screening and treatment for hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
    - HHSC provided screenings and treatment for early detection and prevention of chronic health conditions and some immunizations. HHSC will continue to provide preventive health care in the HTW Demonstration extension request if extended.

- Increase access to women's breast and cervical cancer services to promote early cancer detection.
    - HHSC provided breast and cervical cancer services such as radiological procedures, including mammograms. In 2021, the breast and cervical cancer services rate was 60%, (which was the only year for which complete data was available for the interim report), is 2.8 percentage points higher than the corresponding rate among all Texas Medicaid recipients. HHSC will continue to provide these services in the HTW demonstration extension request, if extended.
- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.
    - HHSC required criteria for HTW provider enrollment to align with state policy. HHSC will continue to require the same provider enrollment criteria in the HTW demonstration extension request if extended.
- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective services consistent with these goals.
    - HHSC continued to provide safe, effective services to low-income Texans. Per the Interim Report, Per Member Per Month (PMPM) costs for the HTW Demonstration remained considerably below the CMS pre-established expenditure limits. HHSC will continue to make efforts to reduce the overall cost of publicly funded health care by providing a safe and effective service package in the HTW demonstration extension request and monitor HTW client enrollment.

42 CFR 431.412(c)(2)(ii) If changes are requested, a narrative of the changes being requested along with the objective of the change and the desired outcomes.

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under the managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of SFY 2026.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the HTW demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW demonstration by incorporating core features of Medicaid managed care programs into the HTW demonstration, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
- Increase access to women's health and family planning services by enhancing continuity of care for women transitioning among Texas' managed care programs – STAR, the Children's Health Insurance Program (CHIP), and HTW throughout a woman's lifecycle. This includes young women transitioning from adolescent to well woman care, pregnant women transitioning from well woman to obstetric care, and postpartum women transitioning back to well woman care.
- Further HHSC's goal of advancing value-based payment arrangements across Medicaid managed care programs and providers by aligning incentives for more holistic, integrated, and accountable care models.

Additionally, the state's comparable income limit was increased to convert existing state income threshold standards from 200% of the Federal Poverty

Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

42 CFR 431.412(c)(2)(iii) A list and programmatic description of the waivers and expenditure authorities that are being requested for the extension period, or a statement that the State is requesting the same waiver and expenditure authorities as those approved in the current Demonstration.

HHSC is requesting the same waivers as those approved in the current Demonstration, including the approved waiver of Section 1902(a)(23)(A) of the Social Security Act that will enable the State to limit freedom of choice of provider through the use of mandatory enrollment in managed care organizations.

HHSC is requesting the same expenditure authorities as those approved in the current demonstration. Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

Expenditures Related Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) providing HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for HTW services for less than six (6) months.

42 CFR 431.412(c)(2)(iv) Summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO)

and State quality assurance monitoring, and any other documentation of the quality of and access to care provided under the Demonstration, such as the CMS Form 416 EPSDT/CHIP report.

Because the HTW demonstration has operated under a FFS model, the EQRO reports, quality assurance monitoring and documentation required under this CFR requirement are not applicable. However, the quarterly and annual HTW monitoring reports HHSC currently submits to CMS captures data measurements for Utilization Monitoring (Tables 2 through 6), and Primary Care Physicians and Pharmacy Network Adequacy (Tables 8 and 8.1). Upon CMS approval of the extension and the change to a managed care delivery model, the HTW demonstration will be monitored in accordance with the above CFR requirements for EQRO reports, MCO, state quality assurance monitoring, and documentation of the quality and access to care.

42 CFR 431.412(c)(2)(v) Financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration. This includes a financial analysis of changes to the demonstration requested by the State.

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year (CY) 2025 - which includes seven months of impact –- is approximately $17.5M with a General Revenue (GR) cost of approximately $4.8M (27.6 percent of AF). The first full year impact in CY 2026 is estimated to cost approximately $31.9M AF and $8.8M GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Texas is assuming the latest CMS budget neutrality policies, including the re-basing methodology, would apply to the HTW demonstration. Below is a summary of the methodology applied and a description of the State's overall methodology in projecting that Demonstration Year (DY) 6-DY10 will remain budget neutral.

- Rebased Without Waiver (WOW) Per Member Per Month (PMPM) costs are set at 80% to actual state costs and 20% of the prior established WOW PMPMs.
- For the actual state costs portion of the rebase, HHSC is submitting an adjusted estimate of costs related to public health emergency (PHE) maintenance of effort (MOE) policies, as they have significantly impacted PMPMs under the HTW demonstration, resulting in a significant reduction due to the current case-mix of clients. This altered case-mix excludes clients that would have entered HTW after leaving Medicaid pregnant women postpartum coverage but instead remain in Medicaid with full benefits and includes lower utilizing clients that are remaining in HTW through the duration of the PHE who otherwise would have exited without the MOE policy.
    - Pre-PHE MOE, the calendar year (CY) 2019 HTW PMPM was $21.77. But as of CY 2023, the PMPM is estimated to be $10.48 based on incomplete data through May 2023 and projections for June 23 – December 23. If the State were to use the PHE impacted CY 2023 PMPM of $10.48 as the base year for the CY 2025 extension/rebase, budget neutrality would not be achieved as normal case-mix returns post-PHE MOE policy.
    - The proposed adjusted CY 2023 base year of $23.52 is an average annual increase of approximately 1.9% from the pre-PHE CY 2019 PMPM – below the allowable President's Trend of 4.6% used to trend the rebased CY 2025 WOW PMPM forward.
    - The proposed CY 2023 base year of $23.52 was estimated by assuming the Pre-PHE utilization rate among the enrolled would have remained stable through CY 2023 to maintain expected PMPM levels absent PHE MOE impact; however, actual cost per utilizer data is still used. In addition, an adjustment is made to vendor drug cost per client served to stay flat at CY 2019 Pre-PHE levels as the MOE case-mix did have a negative impact on

vendor drug cost per utilizer that is inconsistent with overall drug cost trends.

  - The work for the proposed adjusted CY 2023 WOW PMPM is included as part of the submitted budget neutrality workbook. The $23.52 PMPM can be found on the "Historical CY 2019-23" tab, cell F19 and the work leading to this calculation can be followed back to the "WOW PHE MOE Adjust" tab.

- Caseload forecasts for both With Waiver (WW) and WOW sides are a continuation of the caseload forecast for years 4 and 5, based on time series models using data through August 2023. All populations currently excluded from the waiver are assumed to be excluded in years 6-10.
- Cost forecasts on the WOW side of the budget neutrality exhibit utilize the estimated re-based DY06 PMPM as described above, trended forward through DY10 with an annual 4.6% Presidential Cost Trend as shown on the "WOW PMPMs tab" and according to latest CMS BN policy that continues use of the President's Trend (prior trend is currently assumed as any updates to this trend are not known at this time by Texas).
- The cost forecasts on the WW side of budget neutrality are a continuation of the cost forecast for years 4 and 5, based on time series models using data through May 2023 and internal assumptions regarding a return to pre-PHE Case-Mix levels. All costs (costs for clients aged 15-17 and HTW+ Costs) that are currently excluded from the waiver are assumed to be excluded in years 6-10.
- In addition, as part of the extension, the delivery of HTW services will change to include a managed care model.
  - The managed care impact only impacts the WW or state costs and adds capitation related expenses to the existing forecast. No savings assumption has been included at this time. As this is a limited benefit program, the capitation costs only include a $5 fixed admin cost, premium tax and risk margin as required for capitated rates.
  - The managed care impact can be found on the "WW PMPMs" tab – rows 12-14 of the budget neutrality workbook and the work for the capitation costs can be followed back to the "Capitation" tab.

- The "BN Summary PHE Adj & Carve-in" tab shows all work described above leading to the state's estimates for the extension including the managed care carve-in, budget neutrality continues to be maintained (rows 32-34).
- The BN workbook is included as an attachment to the extension application packet.

42 CFR 431.412(c)(2)(vi) An evaluation report of the demonstration, inclusive of evaluation activities and findings to date, plans for evaluation activities during the extension period, and if changes are requested, identification of research hypotheses related to the changes and an evaluation design for addressing the proposed revisions.

Overview of the HTW 1115 Demonstration Evaluation

The focus of the HTW evaluation is to determine if the HTW demonstration waiver achieved its intended objectives. The current CMS-approved HTW evaluation design, covering Demonstration Years (DYs) 1 to 5 (January 2020 - December 2024), is guided by five evaluation questions focused on access to services, utilization of services, women's health and pregnancy outcomes, effective use of public funds, and implementation of the provider eligibility criteria. Each evaluation question is addressed through a minimum of one corresponding hypothesis and measure.[a] Altogether, the current CMS-approved HTW evaluation design includes five evaluation questions, eight hypotheses, and 29 evaluation measures.[b]

Evaluation Activities to Date

During the past four years, HHSC developed the CMS-approved evaluation design; procured an external evaluator; provided the external evaluator with data sources outlined in the evaluation plan; provided data-related technical

[a] The current CMS-approved evaluation design plan can be found at https://www.hhs.texas.gov/sites/default/files/documents/htw-1115-waiver-evaluation-design.pdf.

[b] One hypothesis and four corresponding evaluation measures are excluded from these tallies as they pertain to HTW Plus services. Based on CMS direction, HHSC incorporated the HTW Plus services into the CMS-approved evaluation plan covering DYs 1 to 5. However, at the time of writing, the HTW Plus amendment was still awaiting CMS determination and is therefore excluded from the interim report.

assistance as requested by the external evaluator; and participated in planned and ad hoc meetings with the external evaluator. Additionally, HHSC received the draft interim report from the external evaluator on September 1, 2023. The interim report was submitted to CMS on December 21, 2023.

Preliminary Evaluation Findings to Date

The draft interim report was submitted to CMS on December 21, 2023. The interim report evaluated measures related to access, utilization, health outcomes, costs, and the provider eligibility criteria from the first two years of the demonstration (2020-2021) compared to the predecessor program. Key findings from the interim report are summarized below.

Importantly, findings from the interim report should be interpreted with caution given that the HTW demonstration coincided with the federal COVID-19 Public Health Emergency (PHE). The PHE impacted individuals' engagement with the healthcare services, which influenced measures examining access to and utilization of HTW services. Additionally, PHE-related maintenance of eligibility policies changed the overall composition of the HTW population, which also influenced observed effects of the HTW demonstration. Because the interim report primarily relies on data through 2021, findings are only reflective of the HTW demonstration during the PHE. The summative report will include data after the PHE, providing greater insight into the HTW demonstration. Key findings most directly impacted by the PHE, or PHE-related policies, are noted below to support interpretation.

Planned Evaluation Activities During the HTW 1115 Demonstration Extension

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from fee-for-service (FFS) to managed care during Quarter 1 of SFY 2026 (approximately nine to twelve months after the extension period begins). This transition may influence measures related to access, quality, and cost. As a result, the evaluation for the HTW demonstration extension

will focus on the impacts of this service delivery change. Whenever possible, HHSC will retain data sources, statistical methods, and/or outcome measures in the current evaluation design to support continuity across demonstration approval periods, but hypotheses will shift from testing differences before and after the HTW demonstration to testing differences before and after the transition to managed care under the HTW demonstration. HHSC will also add new evaluation components, where necessary, to ensure the evaluation provides a comprehensive assessment of HTW services delivered under managed care.

HHSC will submit a draft evaluation design to CMS no later than 120 calendar days after the HTW demonstration extension is approved. Tentative plans for the evaluation during HTW demonstration extension period are outlined in Table 1; final components of the evaluation design will be refined based on applicability of measures, data availability, and feasibility.

The HTW Interim Report from the external evaluator the University of Texas Health School of Public Health Center for Health Care Data, is provided as an attachment to the extension application packet.

Table 1. Proposed Revisions to the HTW Demonstration Evaluation

Current CMS-Approved Evaluation Design	Tentative Plans for HTW Demonstration Extension Evaluation	Summary of Proposed Updates
Evaluation Question 1. Did the HTW Demonstration increase access to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas? • Hypothesis 1.1. The HTW Demonstration will maintain or increase access to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas. • Hypothesis 1.2. The state's outreach and engagement activities support understanding of the HTW Demonstration.	**Evaluation Question 1.** Did the transition of HTW services to managed care improve access to family planning, family planning-related, and preconception care, services for low-income women in Texas? • Hypothesis 1.1. The transition of HTW services to managed care will maintain or increase access to family planning, family planning-related, and preconception care for low-income women in Texas. • Hypothesis 1.2. The state's outreach and engagement activities will continue to support understanding of HTW *(during and after the transition to managed care)*.	The evaluation question and hypotheses will remain similar, but the focus will shift from pre/post Demonstration, to pre/post managed care transition under the Demonstration. HHSC will review and modify current measures, where necessary, to ensure they are applicable within the managed care environment, especially the network adequacy measure as the provider network may be impacted by the transition to managed care. HHSC may also add new measures specific to managed care service delivery.
Evaluation Question 2. Did the HTW Demonstration increase utilization of family planning, preconception care, and postpartum services? • Hypothesis 2.1. The HTW Demonstration will maintain or increase utilization of family planning services among HTW clients. • Hypothesis 2.2. The HTW Demonstration will maintain or increase utilization of	**Evaluation Question 2.** Did the transition of HTW services to managed care improve utilization of family planning, and preconception care, services? • Hypothesis 2.1. The transition of HTW services to managed care will maintain or increase utilization of family planning services among HTW clients. • Hypothesis 2.2. The transition of HTW services to managed care will maintain or increase utilization of	Hypothesis 2.3, which is specific to HTW Plus services, will be removed.[c] Evaluation Question 2 and Hypotheses 2.1 and 2.2 will remain similar. However, the focus of the evaluation question will shift from pre/post Demonstration, to pre/post managed care transition under the Demonstration. HHSC will review and modify current measures, where necessary, to ensure they are applicable within the managed care environment. HHSC may also add new measures specific to managed care service delivery.

[c] At the time of writing, the HTW Plus amendment was still awaiting CMS determination and is therefore excluded from HTW Demonstration extension evaluation.

preconception care services among HTW clients. • Hypothesis 2.3. The HTW Demonstration will increase utilization of HTW Plus postpartum care services among HTW clients.	preconception care services among HTW clients.	
Evaluation Question 3. Did the HTW Demonstration improve women's health and pregnancy outcomes? • Hypothesis 3.1. The HTW Demonstration will maintain or improve women's health among HTW clients. • Hypothesis 3.2. The HTW Demonstration will maintain or improve pregnancy outcomes and maternal health among HTW clients.	**Evaluation Question 3.** Did the transition of HTW services to managed care improve women's health and pregnancy outcomes? • Hypothesis 3.1. The transition of HTW services to managed care will maintain or improve women's health among HTW clients. • Hypothesis 3.2. The transition of HTW services to managed care will maintain or improve pregnancy outcomes and maternal health among HTW clients.	The evaluation question and hypotheses will remain similar, but the focus will shift from pre/post Demonstration, to pre/post managed care transition under the Demonstration. HHSC will review and modify current measures, where necessary, to ensure they are applicable within the managed care environment. HHSC may also add new measures specific to managed care service delivery.
Evaluation Question 4. Did the HTW Demonstration effectively use public funds to provide women's health care in Texas? • Hypothesis 4.1. The HTW Demonstration will remain at or below the CMS-specified annual expenditures limits.	**Evaluation Question 4.** Did the HTW Demonstration effectively use public funds to provide women's health care in Texas? • Hypothesis 4.1. The HTW Demonstration will remain at or below the CMS-specified annual expenditures limits.	The evaluation question and hypothesis will remain the same, but HHSC will direct the external evaluators to interpret findings within the context of the transition to managed care, as with-waiver and without-waiver costs may be significantly different under managed care compared to prior FFS estimates.
Evaluation Question 5. How does implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services? • Hypothesis 5.1. The implementation of HTW provider eligibility criteria does not adversely affect access to and utilization of women's health and family planning services.	**Evaluation Question 5.** How does implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services? • Hypothesis 5.1. The implementation of HTW provider eligibility criteria does not adversely affect access to and utilization of women's health and family planning services.	The intent of the evaluation question and hypothesis will remain the same as the provider eligibility criteria will continue under managed care. However, the provider network may be impacted by the transition to managed care. HHSC will review and modify current measures, where necessary, to ensure they are applicable within the managed care environment. HHSC may also add new measures specific to managed care service delivery.

N/A	**Evaluation Question 6.** How did the transition of HTW services to managed care impact member, provider, and MCO experiences with HTW? • Hypothesis 6.1. The transition of HTW services to managed care will support overall experiences with the HTW Demonstration. **Evaluation Question 7.** Did the transition of HTW services to managed care increase the use of value-based payment arrangements? • Hypothesis 7.1. The implementation of value-based payment arrangements will increase over time.	These evaluation questions and hypotheses have been added for the HTW Demonstration extension period. Evaluation Question 6 will assess perceptions of and overall satisfaction with the HTW demonstration after transitioning to managed care among MCOs, providers, and women enrolled in HTW. Evaluation Question 7 will assess whether transitioning HTW to managed care supported the use of value-based payment arrangements.

42 CFR 431.412(c)(2)(vii) Documentation of the State's compliance with the public notice process set forth in § 431.408 of this subpart, including the post-award public input process described in § 431.420(c) of this subpart, with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

Pursuant to the special terms and conditions (STCs) for the HTW demonstration, the public notice for public comment about the changes requested in the extension was published in the Texas Register on February 9, 2024 (see attachment named TX Reg Public Notice). The Texas Register is published weekly and is the journal of state agency rulemaking for Texas. In addition to activities related to rules, the Texas Register publishes various public notices including attorney general opinions, gubernatorial appointments, state agency requests for proposals and other documents, and it is used regularly by stakeholders. HHSC publishes all Medicaid waiver submissions in the Texas Register in addition to many other notices. The publication is available online and in hard copy at the Texas State Library and Archives Commission, the State Law Library, the Legislative Reference Library located in the State Capitol building, and the University of North Texas libraries. All of these sites are located in Austin, except for the University of North Texas, which is located in Denton. Printed copies of the Texas Register are also available through paid subscription; subscribers include cities, counties and public libraries throughout the state.

HHSC hosted two public hearings to provide information about the demonstration extension as well as an opportunity for the public to provide comments. Locations, dates and times were as follows:

On February 22, 2024 at 1 p.m., HHSC held a hybrid public hearing with both virtual and in-person options. The public hearing was held in conjunction with the quarterly State Medicaid Managed Care Advisory Committee (SMMCAC) meeting and was located at the Texas Department of State Health Services, Moreton Building, Room M100, First Floor, 1100 West 49th Street, Austin, Texas 78756. Members of the public pre-registered to provide oral comments virtually during the meeting and written comments by completing a Public Comment Registration form.

On March 5, 2024 at 10:30 a.m., HHSC held a public hearing at 801 S. State Highway 161, 2nd Floor, Lone Star Conference Room #200, Grand Prairie, TX 75051. This was an in-person hearing. Public comments were accepted at this hearing. Members of the public were able to provide oral comments during the hearing in-person at the hearing location either by pre-registering using a Public Comment Registration form or without pre-registering by completing a form at the entrance to the hearing room.

Tribal Consultation

In accordance with 42 CFR § 431.408(b) and the requirements included in STC 12, letters were sent on February 9, 2024, to tribal organizations (included Federally-recognized Indian tribes) requesting comments, questions, or feedback on the demonstration extension application by March 11, 2024, (see attached copies of all letters sent to the tribes). Texas also conducted consultation activities with the tribes and sought advice from Indian health programs, and urban Indian health organizations prior to submission of the demonstration extension application. HHSC provided the letters to the State's tribal organizations (Alabama-Coushatta Tribe, Kickapoo Traditional Tribe, Texas Native Health, and Yselta Del Sur Pueblo).

The notification included detailed information about the public hearings as well as information on where the tribal representatives could find online postings of the abbreviated and detailed public notices and a copy of the demonstration extension application.

In addition to the letters sent on February 9, 2024, staff informed the tribal representatives of the demonstration extension application and provided an overview of the application during a quarterly call with tribal representatives held on March 4, 2024.

No comments, or feedback on the demonstration extension application were received from tribal organizations (including Federally-recognized Indian tribes) during the initial Tribal Consultation period.

Additional Public Notice Activities

On February 8, 2024, HHSC directed their network of Access and Eligibility Services local benefit offices to physically post the detailed Public Notice of Intent (PNI) from February 9, 2024 through March 11, 2024. Local Access and Eligibility offices are accessible to the public and are predominantly used by persons seeking or receiving Medicaid and other public health services benefits.

In accordance with 42 CFR § 431.408(a)(2)(iii), HHSC utilized electronic mailing lists to send notices and notify interested parties of the demonstration extension application and provide the opportunity to submit comments and attend public hearings. The electronic notices were generated through the HHSC Gov Delivery system. The system allows members of the public to sign up for HHSC email notifications. The electronic notice was sent to Healthy Texas Women contractors, Texas Medicaid providers, HHSC stakeholders, including those signed up to receive notifications regarding Public Meetings and Events, Medicaid Transformation Waiver Gov Delivery list, and the Women's Health and Education Services Listserv.

In accordance with 42 CFR § 431.408(a)(1), HHSC posted the full public notice and accessible extension application on HHSC's public facing webpage on February 9, 2024 and the demonstration extension application continues to be available at the following link: Healthy Texas Women 1115 Demonstration | Texas Health and Human Services.

Post Award Public Forums

In compliance with STC 29, and as part of the Medical Care Advisory Committee (MCAC) meeting, HHSC hosted a public post-award forum in-person with a virtual attendance option on June 8, 2023, to provide the public with an annual update on progress of the HTW demonstration. The public forum was held at the Winters Building Public Hearing Room, 701 W. 51st Street Austin, TX 78751. The date, time, and location of the public forum were published on HHSC's public facing website 30 days in advance of the meeting. A link to the demonstration year 3 2022 annual report was also provided to the public. The presentation and agenda were posted to the HHSC pubic facing website.

On May 14, 2024, as part of the MCAC meeting, HHSC will host the HTW

demonstration annual post-award forum in-person with a virtual attendance option, to provide the public with an annual update on the progress of the HTW demonstration, including the HTW extension request. The public forum will be held at the Winters Building Public Hearing Room, 701 W. 51st Street Austin, TX 78751. The date, time, and location of the public forum will be published on HHSC's public facing website 30 days in advance of the meeting.

Summary of Comments Received

HHSC received several written comments during the public comment period that were documented, reviewed, and carefully considered by HHSC staff. Based on public comment, HHSC may consider program updates in the future through a waiver amendment.

The following is a summary of the comments received, as well as HHSC's responses. Comments focused on the use of the modified adjusted gross income (MAGI) compliant form for enrollment in HTW, adding evaluation metrics around the quality of HIV care, program benefits, provider qualifications, program eligibility criteria, enrollment, renewal process, managed care organization and provider credentialing oversight, network adequacy, the transition to managed care and waiver authority.

Comments in Support

Public Comment

Individuals representing Every Body Texas, ViiV Healthcare, Vivent Health, Texas Women's Healthcare Coalition and The American College of Obstetricians & Gynecologists expressed support for the HTW program and demonstration extension.

State Response

HHSC appreciates the support. HHSC is committed to continuing to collaborate with women's health and family planning providers in the state to ensure the Healthy Texas Women (HTW) program continues and expands upon efforts to improve service and efficiency for HTW clients and providers.

Public Comment

A commenter expressed support for the waiver goal of increasing access to preventative care, including screening and treatment for sexually transmitted infections, and recommended the inclusion of Pre-exposure Prophylaxis (PrEP) as a covered preventive service.

State Response

HHSC appreciates the support for the HTW benefits package. HHSC reviews every request to include a new program benefit to determine if it is cost effective, is evidence-based, does not carry additional risk, and is within the scope of the HTW program.

Public Comment

A commenter supports moving the HTW program to managed care and urges the state to ensure a smooth transition process with limited impact on enrollees and providers.

State Response

HHSC is legislatively required to transition the HTW program to managed care. It is HHSC's goal to ensure a smooth transition process for enrollees and providers.

Comments on the HTW Client Application

Public Comment

Several commenters requested the shift from the long form client application to the use of a streamlined, short form Medicaid Family Planning Application for women who wish to enroll in HTW.

State Response

HHSC acknowledges the comment regarding the client application form for the HTW program. The Implementation Plan for Texas' current HTW 1115 waiver as approved by CMS on January 4, 2021, requires HHSC to use Medicaid Modified Adjusted Gross Income (MAGI) methodologies to determine household composition and financial eligibility, including the requirement that HTW applicants use one of Texas' approved applications for MAGI. HHSC will continue discussions with the Centers for Medicare and Medicaid Services (CMS) to determine if it is permissible to implement a different, non-MAGI application for the HTW 1115 Demonstration even though it is not a traditional family planning and related services program.

Comments on Services Provided

Public Comment

A commentor stated the HTW program provides a limited set of Medicaid benefits to women and believes many individuals may not receive all the recommended preventive services. The commentor urged HHSC to consider a more robust HTW benefit package.

State Response

HHSC acknowledges the comment regarding the HTW 1115 Demonstration benefits package and is committed to continuing to provide women's health and family planning services that contribute to maternal health and better birth outcomes in the HTW program.

Comments on Provider Network and Client Access

Public Comment

A commenter opposed HHSC's request to waive the Freedom of Choice requirement in the Social Security Act for the HTW demonstration and would not support any freedom of choice waiver if the state uses its managed care contracts to limit or impede access to providers that offer the full range of reproductive services.
State Response

HHSC acknowledges the commenter's concern regarding access to providers that offer the full range of reproductive services. HHSC clarifies that the HTW Demonstration extension is not proposing any program changes other than a change in the program delivery of services from a fee-for-service (FFS) delivery model to a managed care delivery model, as required by Texas Government Code §533.002555. A goal of the HTW demonstration is to increase access to women's health, family planning, and preventive services for women in Texas. In addition, as a state agency, HHSC is required to comply with state law regarding women's health provider qualifications. Consequently, provider eligibility requirements for the HTW 1115 Demonstration must remain compliant with Texas Human Resources Code §32.024(c-1). For these reasons, HHSC seeks in the HTW Demonstration extension application to continue to waive Section 1902(a)(23)(A) of the Social Security Act.

Comments on Eligibility & Enrollment

Public Comment

A commenter requested HHSC reconsider automatic enrollment for women transitioning from pregnant women's Medicaid and adjunctive eligibility.

State Response

HHSC acknowledges the comment regarding reconsideration of automatic enrollment. The Implementation Plan required by Special Term and Condition (STC) 17 of the HTW 1115 Demonstration requires HHSC to review financial eligibility before enrollment into the HTW program. However, women are automatically evaluated for HTW eligibility. Before a woman is automatically evaluated for the HTW program at the end of her Medicaid for Pregnant Women coverage period, HHSC will determine whether the woman is eligible for full coverage Medicaid or CHIP. If the woman is determined ineligible for full coverage Medicaid or CHIP, and she does not have Medicare or, any other creditable health coverage, she will be certified for the HTW program in addition to being referred to the federal Health Insurance Marketplace.

Public Comment

A commenter urged the state to ensure that eligibility determinations are updated in alignment with the 12 months postpartum coverage extension and that no new mother is accidentally disenrolled from Medicaid and transitioned to the HTW program during the postpartum period.

State Response

HHSC acknowledges the comment and has updated processes regarding eligibility determinations to be in alignment with the Medicaid 12 month postpartum coverage extension.

Public Comment

One comment focused on minor eligibility. The commenter expressed concern that HTW demonstration creates barriers to care for 15 through 17-year-olds by requiring a parent or legal guardian apply for or renew HTW services on behalf of minors 15-17 years of age and expressed general concerns for minor access to the program. Additionally, the commenter expressed concern over the eligibility requirements for minors in the HTW program differing from other Medicaid programs. The commenter recommends the state remove the requirement that parents, or legal guardians must apply and reapply and give permission for services for HTW on behalf of minors 15 – 17 years of age to access effective contraception and services.

State Response

HHSC acknowledges the comment regarding the eligibility requirements for minors ages 15-17 and is committed to continuing to provide women's health and family planning services to this population. Minors ages 15-17 are not included in the HTW 1115 Demonstration, and services for this population are non-Medicaid and fully funded through state general revenue.

Public Comment

Commenters recommended HHSC opt-in to presumptive eligibility for the HTW population.

State Response

At this time, HHSC does not have the authority to implement Medicaid presumptive eligibility for the HTW 1115 Demonstration extension without legislative direction.

Public Comment

One commenter suggested using the woman's income only, rather than extending the requirement to everyone in the household, stating this poses a barrier to birth control access for college aged women.

State Response

HHSC acknowledges the comment regarding household income. At this time, HHSC must continue to use MAGI methodologies as required in the CMS approved Implementation Plan approved on January 4, 2021, to determine household composition and financial eligibility as required by the HTW 1115 Demonstration. A woman's household size, and whose income is included when determining eligibility, is based on her tax filing status and tax relationships. HHSC only considers income that must be reported when filing a federal income tax return (taxable income). HHSC will continue discussions with the CMS to determine if it is permissible to implement a different, non-MAGI application process for the HTW 1115 Demonstration even though it is not a traditional family planning and related services program.

Comments Regarding Transitioning to Managed Care

Public Comment

One commenter requested HHSC evaluate how current policies and procedures may negatively impact access to care and recommends that HHSC increase oversight of provider credentialing with the transition from FFS to managed care.

State Response

The evaluation for the HTW 1115 Demonstration extension will focus on the impacts of the transition from FFS to managed care, including access to care. Additionally, MCOs have contractual obligations regarding provider credentialing turnaround times. HHSC will follow established policies and processes to monitor provider complaints related to credentialing.

Public Comment

One commenter stated HHSC should take steps to ensure network adequacy and expedited provider credentialing when moving to managed care, citing concerns about the availability of providers impacting the ability of women to obtain HTW care.

State Response

HHSC agrees maintaining an adequate provider network is critical for the HTW program. HHSC currently monitors and will continue to monitor the HTW provider network to ensure adequacy. HHSC also reports to CMS on network adequacy measures in the HTW quarterly monitoring reports and will continue to do so as the program shifts to managed care. HHSC will expand upon ongoing outreach efforts to help increase qualified provider enrollment in the HTW 1115 Demonstration.

Comments Regarding Evaluation Metrics

Public Comment

One commenter recommends adding HIV treatment adherence/viral load suppression as an additional evaluation metric to ensure the transition from FFS to managed care doesn't negatively impact screening and treatment for HTW beneficiaries with HIV.

State Response

HHSC appreciates the commenter's support for the ongoing evaluation of the HTW 1115 Demonstration. The evaluation for the HTW 1115 Demonstration extension will focus on the impacts of the transition from FFS to managed care, including changes in testing for sexually transmitted infections or diseases. Because HIV treatment is not currently an HTW covered benefit, evaluation metrics on treatment adherence and viral load suppression are not possible at this time. HHSC reviews every request to include a new program benefit to determine if it is cost effective, is evidence-based, does not carry additional risk, and is within the scope of the HTW program.

Additional Comment

Public Comment

A commenter recommends the following regarding the STAR/CHIP procurement that is currently in progress:

- Recommends that HHSC take steps during this interim to ensure that MCOs who are awarded contracts for HTW can assure stability and growth in the statewide provider network.
- Recommends that MCO contracts include a provision that requires them to have a consistent point of contact for HTW providers, and that this person be available for troubleshooting issues and billing questions.
- As a part of MCO readiness and education activities, HHSC should offer every available opportunity to learn about state and federal family planning requirements including choice of provider and prior authorization policies before implementation of HTW into Managed Care.

- As part of the transition calls with MCOs, the commenter recommends the agency bring in women's health stakeholders and women's health providers.
- Recommends considering the non-postpartum clients who will apply and enroll in the program without transitioning from Medicaid or CHIP. Clients who have no previous experience with managed care will need assistance with navigating the managed care system, which could include application assistance and supportive service coordination.

State Response

HHSC acknowledges the recommendations and will take them under consideration related to implementing the new STAR/CHIP contracts currently undergoing a procurement process.

Enrollment, Cost Sharing and Service Delivery

There were no changes to the eligibility in the HTW demonstration, however HHSC has updated the waiver documents to reflect the operational changes that were made to comply with the MAGI requirements. There is no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to include a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

CHIP Allotment Worksheet

The CHIP allotment worksheet is not applicable to the HTW extension request.

Healthy Texas Women 1115 Demonstration Renewal - Includes Carve-in Amendment

Includes PHE MOE adjustment for Rebasing of WOW PMPMs

Budget Neutrality Calculation (Hypothetical Budget Model - Without Waiver = With Waiver)

Current Projected Cost of Hypothetical Per Capita (WOW)								
	Trend Rate		**DY01 (CY20)**	**DY02 (CY21)**	**DY03 (CY22)**	**DY04 (CY23)**	**DY05 (CY24)**	**DY06 (CY25)**
Enrollee Member Months			3,951,328	4,622,588	5,047,109	5,553,914	5,498,010	4,859,124
Per Member Per Month Cost	4.6%		$ 27.13	$ 28.38	$ 29.68	$ 31.05	$ 32.48	$ 27.38
Projected Total Costs			**$ 107,200,192**	**$ 131,180,522**	**$ 149,816,117**	**$ 172,443,444**	**$ 178,560,222**	**$ 133,039,590**

WOW Projected 5-Year Renewal				
DY07 (CY26)	DY08 (CY27)	DY09 (CY28)	DY10 (CY29)	5-Yr Total
5,402,528	5,500,058	5,615,612	5,734,095	27,111,418
$ 28.64	$ 29.96	$ 31.33	$ 32.78	**$ 30.11**
$ 154,721,837	**$ 164,760,658**	**$ 175,960,444**	**$ 187,937,963**	**$ 816,420,492**

SPECIAL TERMS AND CONDITIONS

NUMBER: 11 -W-00326/6

TITLE: Healthy Texas Women

AWARDEE: Texas Health and Human Services Commission

I. PREFACE

The following are the Special Terms and Conditions (STC) for the "Healthy Texas Women" section 1115(a) Medicaid demonstration (hereinafter "demonstration") to enable the Texas Health and Human Services Commission (state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted the state expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, and which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The Healthy Texas Women demonstration will be statewide and is approved for a five year period, from January 1, 2025 through December 31, 2029.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Benefits
VI. General Reporting Requirements
VII. General Financial Requirements
VIII. Monitoring Budget Neutrality
IX. Evaluation of the Demonstration

Additional attachments have been included to provide supplementary information and guidance for specific STCs:

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Evaluation Report
Attachment C: Annual Monitoring Report Template
Attachment D: Evaluation Design (reserved)

II. PROGRAM DESCRIPTION AND OBJECTIVES

. The demonstration was originally approved on January 22, 2020 for a five year period through December 31, 2024. As originally approved, the demonstration provided federal authority to expand the provision of family planning services, family planning-related services and other preconception women's health services to women ages 18 through 44 with family income at or below 204.2 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid or CHIP, or enrolled in other creditable health insurance coverage that provides family planning services.

HHSC seeks to enhance women's health care services by increasing access to and participation in the HTW program. HTW demonstration services are available statewide to eligible women.

The goals and objectives of the HTW demonstration are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health outcomes; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.
- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective services across a woman's lifecycle .
-

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, to ensure they understand program rules and notices, as well as meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program, expressed in federal law, regulation, and written policy, not

expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon the issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, as well as a modified allotment neutrality worksheet as necessary, to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
   b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under federal law, whichever is sooner.
5. **State Plan Amendments.** The state will not be required to submit title XIX state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid state plan governs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
    a. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanations must include a summary of any public feedback received and identification of how this feedback was addressed by the state in final amendment request submitted to CMS;
    b. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;
    c. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment; and
    d. The state must provide updates to existing demonstration reporting, quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs, must submit a transition and phase-out plan consistent with the requirements of STC 9.
9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:
    a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised transition and phase-out plan.

    b. Transition and Phase-out Plan Requirements. The state must include, at a minimum,

in its transition and phase-out plan, the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities , including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.
d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration beneficiaries as outlined in 42 CFR 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category.
e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.
g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Withdrawal of Expenditure Authority. CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid state plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation.** No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY AND ENROLLMENT

16. Eligibility Requirements. Family planning, family planning-related, and other preconception women's health services are provided to eligible individuals with income at or below 204.2 percent of the FPL.

Eligibility in the demonstration is limited to the following individuals who are not currently receiving benefits through or otherwise eligible for Medicaid, CHIP, Medicare Part A or B, and do not have other creditable health insurance coverage: Women ages 18 through 44 who are United States citizens or qualified immigrants, reside in Texas, and who are not currently pregnant. Individuals found income eligible upon application or annual redetermination are not required to report changes for income or household size for 12 months.

17. Eligibility Determination Process. The state integrated its eligibility, application, verification and redetermination processes into the state's Medicaid state plan eligibility system in compliance with applicable federal policies and procedures. The state conducts a targeted application and eligibility determination process that meets the intent of section 1943 of the Act in accordance with the following processes:

a. Application. Women apply for Healthy Texas Women using the Form H1010 -*Texas Works Integrated Application for Assistance* or Form H1205 – *Texas Streamlined Application for Healthcare Coverage*. The applications are available online for download and fax submission, by mail submission, and available at the local county health department for application and submission in person. The state maintains a prominent location on its Medicaid/Healthy Texas Women website where the state offices are located for in person application, as well as a list of the Healthy Texas Women provider locations where application and receipt of family planning services can be completed onsite and by phone.

b. Reasonable Opportunity Period. The state provides a process for verification of non-financial information (e.g., citizenship and immigration status) at initial application for coverage under the Healthy Texas Women demonstration in alignment with 42 CFR 435.956.

c. Notices. The beneficiary eligibility determination notices provide advance notification that eligibility will be for a 12-month period without a requirement to report a change in income or household size.

d. Verifications. The state uses electronic data sources to which it has system capability to verify factors of eligibility. To the extent the state is not able to verify factors of eligibility electronically, the state accepts self-attestation, except for income and citizenship/immigration status. To verify income and citizenship/ immigration status, the state may request applicants provide this information as part of the eligibility determination. However, the state may not make a final determination of ineligibility based on lack of documentation of income and citizenship/qualified immigration status provided by the applicant until the state first utilizes an alternative process to verify this information through the electronic data sources utilized for Medicaid state plan eligibility.

e. Notification to Applicants of Other Coverage Options.

i. Women applying through the Healthy Texas Women family planning only application are provided information about potential eligibility for full-scope Medicaid or CHIP coverage. If individuals indicate they have not applied, but wish to apply for more comprehensive coverage, individuals are provided facilitated access to or assistance with applying for full-scope Medicaid or CHIP coverage through the single streamlined application process. Women apply for HTW using the Form H1010 - *Texas Works Integrated Application for Assistance* or Form H1205 – *Texas Streamlined Application for Healthcare Coverage* or can continue to apply using the online YourTexasBenefits.com application. Women are first be determined ineligible for Medicaid and CHIP before being determined eligible for HTW.

ii. To provide continuity of care, women 18 through 44 years of age whose Medicaid eligibility as a pregnant woman coverage period is ending are tested for the demonstration if they are not otherwise eligible for full Medicaid benefits and they do not have other creditable health coverage.

iii. Pregnant women are automatically tested for coverage under Medicaid or CHIP.

f. Individuals that apply for full-scope Medicaid or CHIP coverage through Texas' streamlined eligibility application and are determined ineligible for full-scope coverage are tested for eligibility under the Healthy Texas Women family planning only coverage and certified, if eligible. Certified individuals are provided with information on how to opt out of the program on their certification notice

g. Renewals. The state conducts redeterminations of eligibility once every 12 months.

h. Demonstration Disenrollment. If a beneficiary becomes pregnant while enrolled in the demonstration, she must be determined eligible for Medicaid under the state plan or CHIP. The state must not submit claims under the demonstration for any woman who is found to be eligible under the Medicaid state plan or CHIP.

18. Managed Care Organization (MCO) Enrollment and Disenrollment Process.

a. Time to Choose a Plan. All beneficiaries who obtain Medicaid eligibility will have at least 15 days to choose a managed care organization (MCO).

b. Auto-Assignment. If a potential beneficiary does not choose an MCO within the time frames defined in (a), she may be auto-assigned to an MCO. When possible, the auto-assignment algorithm shall take into consideration the beneficiary's history with a primary care provider, and when applicable, the beneficiary's history with an MCO. If this is not

possible the state will equitably distribute beneficiaries among qualified MCOs.

c. Re-Enrollment. The State may automatically re-enroll a beneficiary in the same MCO if there is a loss of Medicaid eligibility for six months or less.

d. Disenrollment or Transfer. Individuals should be informed of opportunities no less than annually for disenrollment and ongoing plan choice opportunities, regularly and in a manner consistent with 42 CFR Part 438 and other requirements set forth in the demonstration Special Terms and Conditions.

i. *MCO Transfer at Request of Beneficiary.* Beneficiaries may request transfer to another MCO in the service area through the enrollment broker at any time.

ii. *Disenrollment at Request of Beneficiary*. Recipients that are voluntarily enrolled in a MCO may request disenrollment and return to traditional Medicaid. Mandatory recipients must request disenrollment from managed care in writing to HHSC; however, HHSC considers disenrollment from managed care only in rare situations, when sufficient medical documentation establishes that the MCO cannot provide the needed services, or in any of the circumstances described in 42 CFR 438.56(c). An authorized HHSC representative reviews all disenrollment requests, and processes approved requests for disenrollment from an MCO. HHSC's enrollment broker provides disenrollment education and offers other options as appropriate.

iii. *Disenrollment at Request of MCO*. An MCO has a limited right to request a beneficiary be disenrolled from the MCO without the beneficiary's consent pursuant to 42 CFR 438.56(b).

V. BENEFITS

19. Family Planning Benefits. Beneficiaries eligible under this demonstration receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act, which are reimbursable at the 90 percent Federal matching rate. The specific family planning services provided under this demonstration are as follows:

a. FDA-approved methods of contraception;
b. Contraceptive management, patient education, and counseling;
c. Pelvic examinations with a family planning diagnosis;
d. Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing and treatment services; and
e. Drugs, supplies, or devices related to women's health services described above.

20. Family Planning-Related Benefits. Beneficiaries eligible under this demonstration also receive family planning-related services and supplies defined as those services provided as part of or as follow-up to a family planning visit and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. Examples of family planning-related services and supplies that would be provided under this demonstration include:

a. Drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections.
b. Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting.
c. Treatment of major complications arising from a family planning procedure such as:
    i. Treatment of a perforated uterus due to an intrauterine device insertion;
    ii. Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
    iii. Treatment of surgical or anesthesia-related complications during a sterilization procedure.

21. Preconception Care Services. Individuals eligible under this demonstration also receive certain women's health services related to better preconception care and birth outcomes. The preconception care services provided under this demonstration are reimbursable at the state's regular FMAP rate and are as follows:

a. Screening and treatment for cholesterol, diabetes, and high blood pressure;
b. Breast and cervical cancer screening and diagnostic services;
c. Screening and treatment for postpartum depression;
d. Immunizations; and
e. Mosquito repellant prescribed by an authorized health professional.

22. **Minimum Essential Coverage (MEC).** The Healthy Texas Women family planning demonstration is limited to the provision of services as described in STCs 19, 20, and 21. Consequently, this demonstration is not recognized as Minimum Essential Coverage (MEC) consistent with the guidance set forth in the State Health Official Letter #14-002, issued by CMS on November 7, 2014.

23. **Primary Care Referrals.** Primary care referrals to other social services and health care providers as medically indicated will be provided; however, the costs of those primary care services are not covered for beneficiaries of this demonstration. The state and MCOs must facilitate access to primary care services for beneficiaries and must assure CMS that written materials concerning access to primary care services are distributed by the state and MCOs to demonstration beneficiaries. The written materials must explain to beneficiaries how they can access primary care services.

24. **Delivery of Services.** Enrollees will receive demonstration services through a managed care delivery model. Note: Enrollees who are members of federally recognized tribes will be able to voluntarily enroll in managed care or opt to receive services in fee-for-service(FFS).

    a. Qualified Healthy Texas Women providers eligible for participation in this demonstration are those that do not perform or promote elective abortions nor affiliate with entities that perform or promote elective abortions.

The state contracts with managed care organizations on a geographical basis, and for this purpose, the state is divided into service areas. Table 1 provides the definitions of the service areas.

Table 1. Service Areas and Delivery Systems

HTW Service Area	Counties Served
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Central Texas	Bell, Blanco, Bosque, Brazos, Burleson, Colorado, Comanche, Coryell, DeWitt, Erath, Falls, Freestone, Gillespie, Gonzales, Grimes, Hamilton, Hill, Jackson, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Somervell, Washington
Dallas	Collin, Ellis, Hurt, Kaufman, Navarro, Rockwall, Ellis, Hurt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Harris, Matagorda, Waller, Wharton, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton
Hidalgo	Cameron, Duval, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry
Northeast Texas	Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood
Nueces	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Live Oak, Nueces, Refugio, San

HTW Service Area	Counties Served
	Patricio, Victoria
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Fayette, Hays, Lee, Travis, Williamson, Fayette, Hays, Lee, Travis, Williamson
West Texas	Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brown, Callahan, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Culberson, Dallam, Dawson, Dickens, Dimmit, Donley, Eastland, Ector, Edwards, Fisher, Foard, Frio, Gaines, Glasscock, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Irion, Jack, Jeff Davis, Jones, Kent, Kerr, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Palo Pinto, Parmer, Pecos, Presidio, Reagan, Real, Reeves, Roberts, Runnels, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Taylor, Terrell, Throckmorton, Tom Green, Upton, Uvalde, Val Verde, Ward, Wheeler, Wichita, Wilbarger, Winkler, Yoakum, Young, Zavala

25. Managed Care Requirements

a. General. The state must comply with the managed care regulations published at 42 CFR Part 438.

b. MCO Participant Advisory Committees. The state shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the State. Copies of meeting minutes will be made available to CMS upon request.

VI. GENERAL REPORTING REQUIREMENTS

26. Deferral for Failure to Submit Timely Demonstration Deliverables.

CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $1,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

a. The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale

for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the demonstration standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

27. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

28. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c. Submit deliverables to the appropriate system as directed by CMS.

29. Monitoring Reports. The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than ninety (90) calendar days following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which will be organized by milestone. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration. In addition, the Monitoring Report should document program outreach and education activities conducted and an assessment of the effectiveness of these outreach and education activities;

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

30. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial sustained directional change, inconsistent with state targets (such as substantial, sustained trends difficulty accessing services). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an

authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

31. Close out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out report.
c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
d. The final Close Out Report is due to CMS no later than thirty (30) calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 26.

32. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, and progress on evaluation activities.

a. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
b. The state and CMS will jointly develop the agenda for the calls.

33. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

VII. GENERAL FINANICAL REQUIREMENTS

34. Allowable Expenditures. This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval periods designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

35. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports to report total expenditures for services provided under this Medicaid section 1115(a) demonstration following routine CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined cost limits specified in STC 50.

36. Reporting Expenditures Subject to Title XIX Budget Neutrality Agreement. The following describes the reporting of expenditures subject to the budget neutrality limit:

a. Tracking Expenditures. In order to track expenditures under this demonstration, Texas must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of Title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made.
b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements not attributable to this demonstration, the adjustments should be reported on lines 9 or 10C as instructed in the State Medicaid Manual.

c. Use of Waiver Forms. The state must report demonstration expenditures on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver each quarter to report Title XIX expenditures for demonstration services.

37. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10.

38. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

39. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total

expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state shall submit Form CMS64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the State.

40. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP for family planning, family planning related, and other preconception women's health services at the applicable federal matching rates as described in STCs 19, 20 and 21, subject to the limits and processes described below:

a. For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), FFP will be available at the 90 percent federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis or indicator that specifically identifies them as a family planning service. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate of 90 percent, as described in STC 19, should be entered in Column (D) on the CMS-64.9 Waiver Form.

b. Pursuant to 42 CFR 433.15(b)(2), FFP is available at the 90 percent administrative match rate for administrative activities associated with administering the family planning services provided under the demonstration including the offering, arranging, and furnishing of family planning services. These costs must be allocated in accordance with OMB Circular A-87 cost allocation requirements. The processing of claims is reimbursable at the 50 percent administrative match rate.

c. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if provided by eligible Medicaid providers. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent federal matching rate. The match rate for the subsequent treatment would be paid at the applicable federal matching rate for the state. For testing or treatment not associated with a family planning visit, no FFP will be available.

41. Sources of Non-Federal Share. The state must certify that its match for non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section

1903(w) of the Act and applicable regulations. In addition, all sources of the non federal share of funding are subject to CMS approval.

a. The state acknowledges that CMS has the authority to review the sources of the non- federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

42.State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments related to taxes, including health care provider-related taxes, fees business relationship with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

43. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

44. Medicaid Eligibility Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculation, and other purposes related to monitoring and tracking expenditures under the demonstration. The following table provides a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Healthy Texas Women	Hypothetical	X		X	Detailed in STC 16

45. Reporting Expenditures and Member Months. The following describes the reporting of member months for the demonstration:

a. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the monitoring reports as required under STC 29, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual reports, certifying the accuracy of this information.

b. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months. For the purpose of calculating the budget neutrality expenditure limit, the state must provide to CMS, as part of the monitoring reports as required under STC 28, the actual number of eligible member months for all demonstration enrollees. The state must submit a statement accompanying the annual reports, certifying the accuracy of this information. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

46. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Table 2: Demonstration Years		
Demonstration Year 6	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 7	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 8	January 1, 2027 to December 31, 2027	12 months

Demonstration Year 9	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 10	January 1, 2029 to December 31, 2029	12 months

47. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustment to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditure limit or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulation, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

VIII. MONITORING BUDGET NEUTRALITY

48. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding it may receive on approved demonstration service expenditures incurred during the period of demonstration approval. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the approved demonstration period. Actual expenditures subject to budget neutrality expenditure limit shall be reported by the state using the procedures described in STC 36.

49. Risk. Texas shall be at risk for the per capita cost (as determined by the method described in this section), but not for the number of demonstration enrollees. By providing FFP for demonstration enrollees, Texas shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized has there been no demonstration.

50. Budget Neutrality Annual Expenditure Limits. For each demonstration year, an annual budget limit will be calculated for the demonstration. The Healthy Texas Women annual demonstration cycle is January 1 through December 31. The budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for the demonstration multiplied by the Composite Federal Share. In response to the Public Health Emergency, CMS will allow for a one-time adjustment to budget neutrality to account for impacts of COVID-19 on enrollment and expenditures.

Table 3: Hypothetical Budget Neutrality Test					
TREND	**DY 6**	**DY 7**	**DY 8**	**DY 9**	**DY 10**
4.6%	$27.13	$28.38	$29.69	$31.06	$32.49

a. PMPM Cost. The following table provides the approved demonstration cost trend (based on the state's historical rate of growth) and the PMPM (total computable) ceiling for each demonstration year. Revised CMS budget neutrality policies have been applied to assume an 80 percent rebasing based on actual/estimated state expenditures and 20 from prior approved WOW PMPMs.
b. Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported on the forms listed in STC 36 above, by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.
c. Structure. The demonstration's budget neutrality model is structured as a "pass- through" or "hypothetical" expenditure population. Therefore, the state may not derive savings from the demonstration.
d. Application of the Budget Limit. The budget limit calculated above will apply to demonstration expenditures reported by the state on the CMS-64 forms. If at the end of the demonstration period, the costs of the demonstration services exceed the budget limit, the excess federal funds will be returned to CMS. If the costs of the demonstration services do not exceed the budget limit, the state may not derive or utilize any such savings.

51. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of this demonstration extension approval period. No later than 90 days after the end of each demonstration year, the state will calculate and report to CMS an annual cumulative expenditure target for the completed year as part of the Annual Monitoring Report described in STC 29. This amount will be compared with the actual cumulative amount the state has claimed for FFP through the completed year. If cumulative spending exceeds the cumulative target by more than the indicated percentage, the state will submit a corrective action plan to CMS for approval. The state will subsequently implement the approved plan.

Year	Cumulative Target Expenditures	Percentage

DY 6	DY6 budget limit plus:	2.0 percent
DY7	DY6 and DY7 combined budget limit amount plus:	1.5 percent
DY8	DY6 through DY8 combined budget limit amount plus:	1.0 percent
DY9	DY6 through DY9 combined budget limit amount plus:	0.5 percent
DY10	DY6 through DY10 combined budget limit amount plus:	0 percent

52. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from January 1, 2025 to December 31, 2029. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

53. Mid-Course Correction. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold level in the tables below as a guide for determining when corrective action is required.

IX. EVALUATION OF THE DEMONSTRATION

54. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to: commenting on design and other federal evaluation documents; providing data and analytic files to CMS; entering into a data use agreement that explains how the data and data files will be exchanged; and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they make data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 26.

55. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party will conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

56. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with CMS guidance, including but not limited to attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) calendar days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.

57. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

58. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Hypotheses should include, but are not limited to, testing the effects of the demonstration on sustainability, and access to women's health, family planning, and preventative care services. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

59. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

60. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

61. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

62. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial sustained directional change, inconsistent with state targets (such as substantial, sustained trends indicating increases difficulty accessing services). A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with state targets, and the state has not implemented corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

63. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

64. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

65. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are

released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

Healthy Texas Women Section 1115 Demonstration Waiver Evaluation: Interim Report

As Required by Centers for Medicare and Medicaid Services and Texas Health and Human Services Commission

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Executive Summary

Introduction

On January 22, 2020, the Centers for Medicare and Medicaid Services (CMS) approved the Healthy Texas Women (HTW) Demonstration under a Section 1115 Medicaid Waiver for five years, from January 22, 2020, to December 31, 2024. Texas Health and Human Services Commission (HHSC), the agency that oversees Texas Medicaid programs, selected the University of Texas Health Science Center at Houston's (UTHealth) School of Public Health Center for Health Care Data (CHCD) as the independent evaluator for the 2020-2024 waiver.

The 1115 Demonstration Waiver for the HTW program (HTW Demonstration) is designed to further the goals of Title XIX of the Social Security Act (Medicaid) by increasing and strengthening coverage for low-income women in Texas through the provision of a unique benefit package for women who would not otherwise be eligible for family planning and preventive services under Texas Medicaid. Additionally, the HTW Demonstration is designed to improve health outcomes for the Medicaid population by providing preconception and interconception care to women eligible for Medicaid coverage if they become pregnant, aiming to improve birth outcomes and support optimal birth spacing. The HTW Demonstration services were implemented on February 18, 2020. HTW Demonstration covered services are the same as those provided through the previous state-funded HTW program.

This report presents UTHealth CHCD's interim findings for the CMS-approved Evaluation Design of the HTW Demonstration covering the pre-HTW Demonstration baseline period (2017-2019) and the first two years of the HTW Demonstration (2020-2021) referred to in this document as post-HTW Demonstration period. Notably, the first two years of the Demonstration coincide with the COVID-19 pandemic and the Public Health Emergency (PHE). As has been extensively documented, the pandemic impacted all healthcare access and utilization. Additionally, clients in HTW and Medicaid were not subject to eligibility disenrollment during the PHE, which began on March 18, 2020.[a] This meant women

[a] In March 2020, Congress passed the Families First Coronavirus Response Act, allowing states to receive enhanced federal match provided they maintained continuous coverage for most people enrolled in Medicaid until the end of the federal public health emergency (PHE). The Consolidated Appropriations Act of 2023 separated the continuous Medicaid coverage requirement of the Families First Coronavirus Response Act from the PHE declaration. The requirement to maintain continuous coverage ended as of March 31, 2023. Members

already in the HTW Demonstration were unlikely to leave the program unless they qualified for a more comprehensive program, such as Medicaid for Pregnant Women. Similarly, women whose pregnancy was covered under Medicaid and would have transitioned to HTW prior to the pandemic remained enrolled in Medicaid for the duration of the PHE. These changes to the composition of the HTW population are likely to have influenced the observed effects of the HTW Demonstration.

UTHealth CHCD assessed the impact of the HTW Demonstration in five key areas: access, utilization, health outcomes, costs, and effects of the provider eligibility criteria. Each area had a series of specific hypotheses and corresponding measures. Collectively, the HTW Demonstration is being evaluated using a mixed methods approach, including primary data collection through surveys and secondary administrative and public data analytics. The interim report, however, only contains results obtained from quantitative analysis of administrative data. Primary data collection efforts are described in the current report, but results from the qualitative analysis will not be available until the summative report.

Key Findings

Key findings and implications from this interim report are summarized below by evaluation question.

Evaluation Question 1: Did the HTW Demonstration increase access to family planning, family planning-related preconception care, and postpartum services for low-income women in Texas?

- The average number of unique clients by year during the post-HTW Demonstration period grew slightly (4%); however, the total number of Member Years (MY) grew by 43 percent. This was due to a substantial growth in the number of clients continuously enrolled (12 months) and an increase in the number of retained clients from one year to another. Additionally, there was, on average, a 51 percent reduction in the number of newly enrolled clients. These trends are directly associated with PHE-related policy changes

enrolled in Healthy Texas Women were continuously enrolled from March 2020 – March 31, 2023, in alignment with continuous Medicaid coverage requirements. Beginning on April 1, 2023, HHSC began the process of redetermining the eligibility for all individuals receiving Medicaid, including HTW, in alignment with Texas' federally approved End of Continuous Medicaid Coverage Mitigation Plan.

that implemented continuous eligibility during the HTW Demonstration period. During the post-HTW Demonstration period included in this report (2020 and 2021), postpartum women maintained enrollment in Medicaid for Pregnant Women, and teenagers who would have aged out of Medicaid maintained enrollment in full Medicaid instead of transitioning into the HTW program. In summary, continuous eligibility policies implemented under the PHE resulted in a change in the age composition as well as life circumstances of the HTW Demonstration population when compared to pre-HTW Demonstration years.

- Pre-HTW Demonstration, an average of 37 percent of HTW clients received services per year. This number grew by three percentage points post-HTW Demonstration (8% change, p-value <0.001). This increase was driven by a growth in medical services (12%) but countered by a 7 percent reduction in prescription services.
- The number of billing providers with at least one paid HTW claim per year grew by 20 percent between the pre- and post-HTW Demonstration periods. However, both pre- and post-HTW Demonstration, less than 10 percent of billing providers were responsible for 80 percent of all paid claims. Implications of this concentration of billing providers are unclear from this interim analysis, however, UTHealth CHCD hopes findings from the provider and client surveys included in the summative report will help elucidate why patient care is concentrated among providers.
- Network adequacy improved in Demonstration Year 2 (DY) compared to baseline network adequacy for primary care physicians (PCP) and pharmacies. However, PCP networks in Micropolitan counties were still 15 percent points below the standard (90%).

Evaluation Question 2: Did the HTW Demonstration increase the utilization of family planning, preconception care, and postpartum services?

- Post-HTW Demonstration, the use of most/moderately effective contraceptives among women with continuous annual enrollment declined by 7.7 percentage points and the use of Long Acting Reversible Contraceptives (LARCs) declined by 0.7 percentage points. It should be noted that the absolute number of women receiving contraception through HTW more than doubled in the post-HTW Demonstration period. However, this was accompanied by significant growth in the number of women with continuous

annual enrollment, which resulted in an overall decrease in contraception use rates. Additional years of data will help establish whether this finding is a prevailing trend or an outlier influenced by PHE eligibility policies. Additionally, the client surveys included in the summative report will provide additional insight into women's experiences accessing and utilizing services.

- Chlamydia screening did not change significantly post-HTW Demonstration and was similar to Texas Medicaid reported rates. Almost 100 percent of women screened for chlamydia were also screened for gonorrhea, in line with evidence-based guidelines.
- The evaluation of compliance with cervical cancer screening recommendations pre- and post-HTW Demonstration was not possible as the measure requires a 5-year look-back period. However, the 2021 rate (60%), which was the only year for which complete data was available for the interim report, is 2.8 percentage points higher than the corresponding rate among all Texas Medicaid recipients.

Evaluation Question 3: Did the HTW Demonstration improve women's health and pregnancy outcomes?

- Adherence to hypertension, diabetes, and cholesterol medication measured using prescription days covered, decreased post-HTW Demonstration. The prevalence of these three conditions was less than 2%, and after applying the criteria for the measure (having at least 2 prescriptions for the specific condition), few clients met the criteria. Therefore, results should be interpreted with caution. None of these changes were statistically significant after limiting the analysis to those women who were continuously enrolled in HTW for at least one year.
- Antidepressant medication management improved during the post-HTW Demonstration period, especially during the continuation phase (6 months of antidepressant medication).
- The rate of pregnancy complications (gestational hypertension, gestational diabetes, and preeclampsia) among all women included in the analyses who delivered under Medicaid increased between 2018 and 2021. However, the increase in pregnancy complications was significantly lower among women who had been enrolled in the HTW Demonstration the year prior to their delivery compared to those without HTW or Medicaid enrollment the year prior to the delivery under STAR Medicaid.

- The severe maternal morbidity rate also increased between 2018 and 2021 for all women included in the analyses who delivered under Medicaid. Changes in rates did not significantly vary based on prior HTW enrollment.
- Rates of adverse birth outcomes (low birth weight and preterm births) increased between 2018 and 2021 for all women included in the analyses who delivered under Medicaid. However, during the post-HTW Demonstration period, these increases were significantly smaller among women enrolled in the year prior to their delivery compared to those without prior HTW or Medicaid enrollment.

Despite methodological limitations discussed in the report, these findings suggest the HTW Demonstration was associated with a reduction in the incidence of pregnancy complications and newborn adverse outcomes during the years assessed, which coincide with the PHE. Whether the positive impact of HTW enrollment during the Demonstration years assessed was limited to the pandemic or will continue requires additional years of data which we recommend assessing for the summative report.

Evaluation Question 4: Did the HTW Demonstration effectively use public funds to provide women's health care in Texas?

- The Per Member Per Month (PMPM) costs for the HTW Demonstration remained considerably below the CMS pre-established cap. Additionally, PMPM costs declined over the first three years of the HTW Demonstration.

Evaluation Question 5: How does the implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services?

- On average, the proportion of active family planning billing providers in Medicaid delivering services through HTW (measure 5.1.1) grew by 5.2 percentage points (11.4% change) when comparing the pre versus post HTW demonstration periods. Though the actual proportion of family planning billing providers was highest in 2019, preliminary analysis found that on average the proportion of family planning Medicaid billing providers serving

HTW clients grew post-HTW Demonstration. The full evaluation of this question will be completed with collection and analysis of client surveys which will be presented in the summative report.

Conclusion

Overall, this interim report was limited in its ability to evaluate all of the measures specified in the CMS-approved Evaluation Design because the report primarily focuses on the first two years of the HTW Demonstration, which overlap entirely with the COVID-19 pandemic and the PHE. However, preliminary results showed some improvement in utilization, network adequacy, and particularly pregnancy and birth-related outcomes. Some of these measures, such as lack of network adequacy in specific regions are issues that precede the implementation of the HTW-Demonstration. Other, such as decline in contraceptive utilization could be influenced by the pandemic context. Additional information that will be available in the summative report from provider and client surveys can help understand these issues and inform strategies for addressing them. Furthermore, the summative report will include additional years of data, including data after the COVID 19-related PHE ended. This information will be critical for determining whether trends identified in this interim report, hold once we include further years in the analysis.

Overview

On January 22, 2020, the Centers for Medicare and Medicaid Services (CMS) approved the Healthy Texas Women (HTW) Demonstration under a Section 1115 Medicaid Waiver for five years, from January 22, 2020, to December 31, 2024. Texas Health and Human Services Commission (HHSC), the agency that oversees Texas Medicaid programs, selected the University of Texas Health Science Center at Houston's (UTHealth) School of Public Health Center for Health Care Data (CHCD) as the independent evaluator for the 2020-2024 waiver.

This report presents UTHealth's interim findings for the CMS-approved Evaluation Design of the HTW Demonstration, covering the first two years of the waiver (2020-2021)[2]. We assess the impact of the HTW Demonstration in five key areas: access, utilization, health outcomes, costs, and impact of changes in provider eligibility criteria.

General Background Information

The 1115 Demonstration Waiver for the HTW program (HTW Demonstration) is designed to further the goals of Title XIX of the Social Security Act (Medicaid) by increasing and strengthening coverage for low-income women in Texas through the provision of a unique benefit package for women who would not otherwise be eligible for family planning and preventive services under other Texas Medicaid programs. Additionally, the HTW Demonstration is designed to improve health outcomes for women in the program by providing preconception and interconception care, aiming to improve birth outcomes and support optimal birth spacing.

Historically, Texas has delivered women's health and family planning services through numerous programs administered by the Texas HHSC and the Texas Department of State Health Services (DSHS). On July 1, 2016, to consolidate the different women's healthcare programs, HHSC launched a state-funded program called Healthy Texas Women (HTW), combining the services of programs providing family planning and primary care services to low-income women ages 15-44. The state-funded HTW merged the Texas Women's Health Program (TWHP) administered by HHSC and the Expanded Primary Health Care (EPHC) program administered by DSHS. Two other HHSC programs—the Breast and Cervical Cancer Services (BCCS) program and the Family Planning Program (FPP)—continue to provide screening and family planning services to low-income women. The Children's Health Insurance Program (CHIP) and Medicaid also provide services to

low-income women, but women enrolled in either of these programs are not eligible for the HTW Demonstration.

Prior to the launch of the state-funded HTW, women could be enrolled in multiple family planning/women's health programs depending on need and eligibility. On July 1, 2016, eligibility guidelines were revised to automatically enroll women eligible for multiple programs into the most comprehensive program for which they qualified.

The HTW Demonstration

The HTW Demonstration is available to women aged 18 through 44 who met all other state-funded HTW program eligibility requirements.[1,2] Clients enrolled in the state-funded HTW program when the HTW Demonstration began were automatically transitioned into the HTW Demonstration without a coverage gap. Similar to the state-funded HTW program, women whose Medicaid for Pregnant Women coverage period ends are automatically tested for other types of assistance without the requirement for a new application, and if no longer eligible for Medicaid or CHIP but eligible for HTW, are automatically enrolled in the HTW Demonstration.[b] Texas has continued to serve women aged 15 through 17 who meet all other HTW program requirements through non-Medicaid funded programs.

The HTW Demonstration services were implemented on February 18, 2020. Covered services are the same as those provided through the state-funded HTW program. They can be categorized into three benefit types outlined in the HTW Demonstration Special Terms and Conditions (STCs) that govern the HTW Demonstration[3]. These benefits are provided at no cost to individuals and include:

Family Planning Benefits:

- FDA-approved methods of contraception;
- Contraceptive management, patient education, and counseling;
- Pelvic examinations with a family planning diagnosis;
- STI/sexually transmitted disease (STD) testing and treatment services; and

[b] As a result of the Families First Coronavirus Response Act (FFCRA), women enrolled in Medicaid for Pregnant Women maintained coverage beyond the standard 60-day postpartum period. This resulted in a significant reduction of women transitioning from Medicaid to Pregnant Women to HTW during the COVID-19 public health emergency.

- Drugs, supplies, or devices related to women's health services described above.

Family Planning-Related Benefits: Services provided as part of or follow-up to a family planning visit. Examples of family planning-related services and supplies provided include:

- Drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections.
- Other medical diagnosis, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting.
- Treatment of major complications arising from a family planning procedure, such as:
  - Treatment of a perforated uterus due to an intrauterine device insertion;
  - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
  - Treatment of surgical or anesthesia-related complications during a sterilization procedure.

Preconception Care Services: Women's health services related to better preconception care and birth outcomes, including:

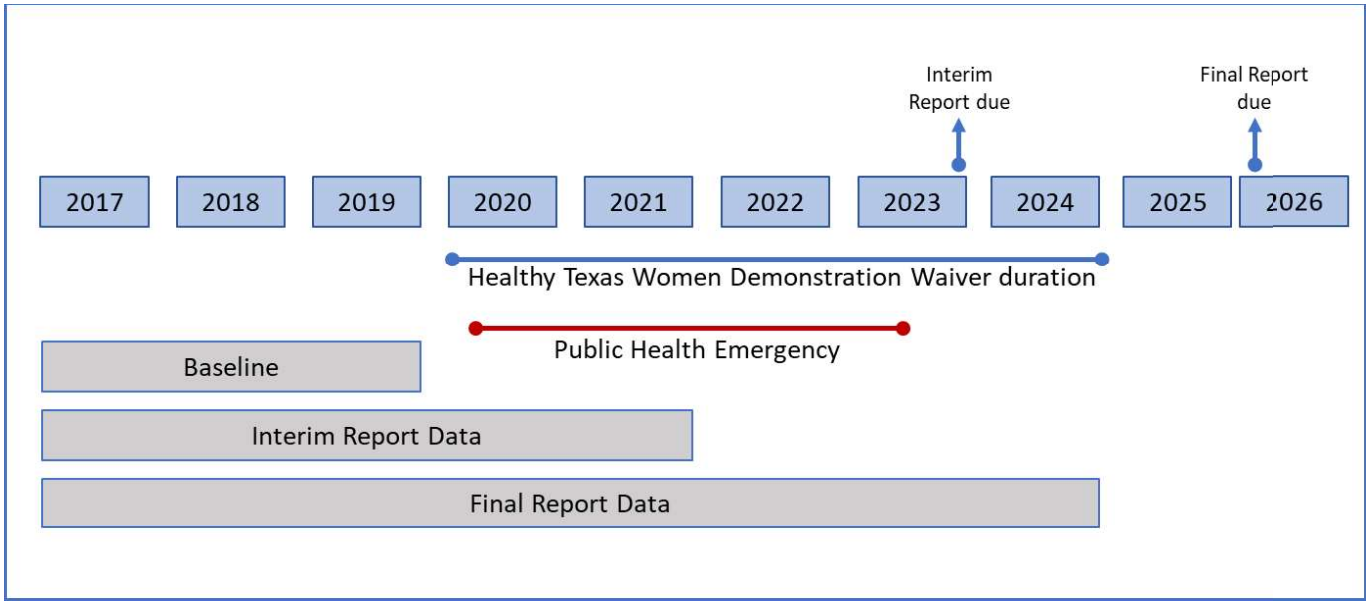
- Screening and pharmaceutical treatment for cholesterol, diabetes, and high blood pressure;
- Breast and cervical cancer screening and diagnostic services;
- Screening and treatment for postpartum depression;
- Immunizations; and
- Mosquito repellant prescribed by an authorized health professional.

The HTW Demonstration operates through a network of independent healthcare providers across the state who offer family planning and women's health services to HTW clients and refer them to secondary providers for service delivery outside their scope of practice. The HTW Demonstration is administered through a Fee-for-service (FFS) delivery model. Under this model, qualified Medicaid providers can provide HTW Demonstration services to eligible clients if they meet the provider eligibility requirements outlined under Title 1 of the Texas Administrative Code §382.17.

Evaluation Activities

States with Section 1115 Medicaid Waivers are required to contract with an independent party to conduct the Demonstration evaluation. Texas HHSC selected UTHealth CHCD as the independent evaluator to conduct the waiver evaluation in accordance with the CMS-approved Evaluation Design. The evaluation includes two key deliverables: this interim report, to be delivered to CMS on December 31, 2023, and a summative evaluation report, to be delivered to CMS by June 30, 2026. Figure 1 summarizes the timeline and deliverables for the evaluation. This report covers the pre-HTW Demonstration baseline period (2017-2019) and the first two years of the HTW Demonstration (2020-2021), referred to as "post-HTW Demonstration period" in this report, which coincide with the COVID-19 pandemic and the Public Health Emergency (PHE).[4] Box 1 clarifies how to interpret the results from this report. The summative evaluation report, including data through 2024 will be able to assess performance after the end of the PHE, which expired on May 11, 2023.[5]

Figure 1: Evaluation Timeline



Considerations when reading this report (Box 1):

On March 4, 2020, Texas DSHS reported its first Coronavirus-19 case.[6] Two weeks later, on March 18, 2020, Texas adopted maintenance of eligibility (MOE) requirements under the Families First Coronavirus Response Act (FFCRA), including continuous coverage of individuals enrolled in Medicaid.[7] As a result, this interim report could only assess the impact of the HTW Demonstration during the COVID-19 pandemic. As has been documented, the pandemic impacted healthcare access and utilization.[8] We encourage the reader to interpret the results within the context of the pandemic. Clients in HTW and Medicaid were not subjected to eligibility redetermination or disenrollment during the PHE. This meant women already in the HTW Demonstration were unlikely to leave the program unless they qualified for a more comprehensive program, such as Medicaid for Pregnant Women. Similarly, women who delivered under Medicaid and would have transitioned to HTW prior the pandemic remained enrolled in Medicaid for the duration of the PHE. Therefore, the characteristics and life circumstances of women enrolled in HTW changed during the pandemic. These changes to the HTW population will influence observed impacts of the HTW Demonstration.

Evaluation Questions and Hypothesis

The HTW Demonstration evaluation has focused on answering five questions aimed at assessing whether the goals of the HTW Demonstration were met. The goals (Box 2) target a variety of client-focused and system-focused outcomes. Each evaluation question (Table 1) is addressed through a minimum of one corresponding hypothesis. The evaluation questions and hypotheses are intended to promote the objectives of Title XIX by examining if the expansion of family planning and preventative services for low-income women in Texas supports overall health and birth-related outcomes in Texas Medicaid.

Demonstration Goals (Box 2):

1. Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families;

2. Increase access to preventive health care, including screening and treatment for hypertension, diabetes, and high cholesterol, to positively impact maternal health and reduce maternal mortality;

3. Increase access to women's breast and cervical cancer services to promote early cancer detection;

4. Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective services that are consistent with these goals; and

5. Implement the state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Table 1 below lists the five evaluation questions, their respective hypotheses, and their related domains (access, utilization, health outcomes, costs, or provider eligibility changes). The following section details how these hypotheses have been operationalized into specific measures, and which study populations, data sources, and analytic methods are being used to evaluate them.

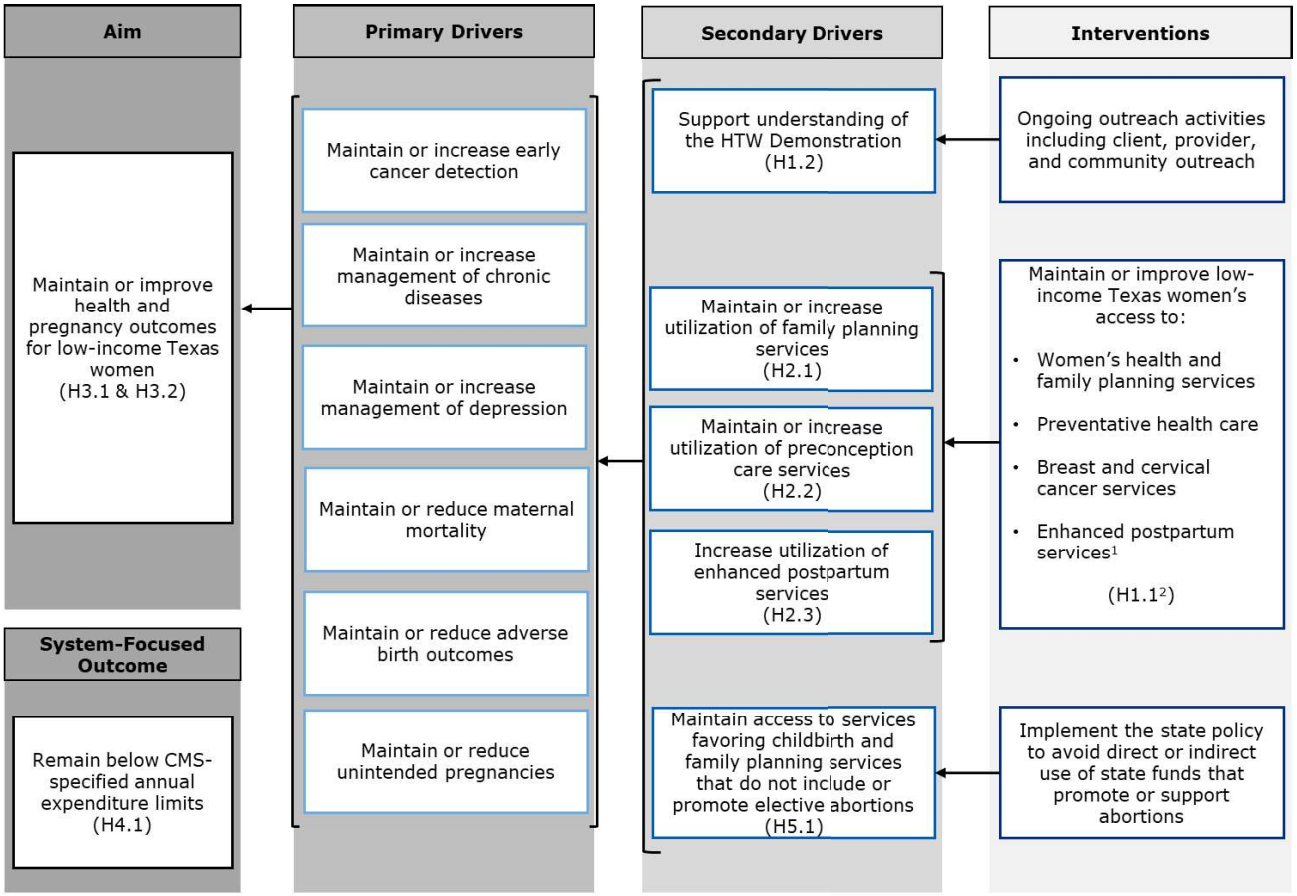
Table 1: Evaluation Questions and Hypotheses

Domain	Evaluation Questions	Hypotheses
Access, Utilization & Health Outcomes	**Evaluation Question 1.** Did the HTW Demonstration increase access to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas?	H.1.1. The HTW Demonstration will maintain or increase access to family planning, family planning-related preconception care, and postpartum services for low-income women in Texas. H.1.2. The state's outreach and engagement activities support understanding of the HTW Demonstration.
	Evaluation Question 2. Did the HTW Demonstration increase the utilization of family planning, preconception care, and postpartum services?	H.2.1. The HTW Demonstration will maintain or increase utilization of family planning services among HTW clients. H. 2.2. The HTW Demonstration will maintain or increase the utilization of preconception care services among HTW clients.
	Evaluation Question 3. Did the HTW Demonstration improve women's health and pregnancy outcomes?	H.3.1. The HTW Demonstration will maintain or improve women's health among HTW clients.
		H.3.2. The HTW Demonstration will maintain or improve pregnancy outcomes and maternal health among HTW clients
Cost	**Evaluation Question 4.** Did the HTW Demonstration effectively use public funds to provide women's health care in Texas?	H. 4.1. The HTW Demonstration will remain at or below the CMS-specified annual expenditures limits.
Provider Eligibility	**Evaluation Question 5.** How does the implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services?	H. 5.1. The implementation of HTW provider eligibility criteria does not adversely affect access to and utilization of women's health and family planning services.

The Demonstration Driver Diagram (Figure 2) shows how these hypotheses align with the interventions, drivers, and outcomes in the HTW Demonstration. The diagram depicts the interventions associated with the HTW Demonstration and how they are expected to impact the Demonstration's overall goals. The initial diagram

proposed in the HTW Demonstration Evaluation Design included under question 2, hypothesis 2.3, which proposed that the waiver would increase utilization of postpartum services through the HTW Plus program. This program was intended to cover a specific set of postpartum benefits for the subsequent 12 months after delivery for women who had been pregnant in the 12 months before enrollment in HTW. However, the HTW Plus program is pending CMS approval and therefore is not currently covered under the HTW Demonstration. Consequently, the assessment of the HTW Plus program (and related hypothesis) are excluded from this interim report.

Figure 2. HTW Demonstration Driver Diagram



Notes. [1] CMS approval of the HTW Plus program is still pending and is therefore not part the HTW Demonstration. Therefore, it was agreed with HHSC that the assessment of the HTW Plus program would not be part of this evaluation. [2] H1.1-H5.1 refers to the corresponding HTW evaluation hypotheses.

Evaluation Approach and Methods

Design

The questions and hypotheses are being assessed through 31 measures covering access, utilization, health outcomes, cost, and the effect of provider eligibility criteria. Outcome measures associated with each hypothesis can be found in Table 2. These measures are being evaluated using a mixed methods approach, including primary data collection through surveys and secondary administrative and public data analytics. The interim report, however, only contains results obtained from quantitative analysis of administrative data. Primary data collection efforts are described in the current report, but results from the qualitative analysis will not be available until the summative evaluation report.

Table 2 provides an overview of the interim report evaluation data, study populations, and quantitative methods. Further details on quantitative and qualitative methods can be found in the CMS-approved Evaluation Design and *Appendix A: Methods*.

Table 2: Evaluation Hypotheses and Measures Evaluation in the Interim Report

Evaluation Hypotheses	Measures
Evaluation Question 1: Did the HTW Demonstration increase <u>access</u> to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas?	
1.1 The HTW Demonstration will maintain or increase access to family planning, family planning-related and preconception care, for low-income women in Texas.	1.1.1 HTW clients
	1.1.2 HTW clients who received an HTW service
	1.1.3 HTW active billing providers
	1.1.4 Network adequacy
Evaluation Question 2: Did the HTW Demonstration increase the <u>utilization</u> of family planning, preconception care, and postpartum services?	
2.1 The HTW Demonstration will maintain or increase the utilization of family planning services among HTW clients.	2.1.1 Provision of most effective or moderately effective contraceptive methods
	2.1.2 Long-acting reversible contraceptive use
	2.1.3 Tests for sexually transmitted infections
2.2 The HTW Demonstration will maintain or increase the utilization of preconception care services among HTW clients	2.2.1 Compliance with Cervical Cancer Screening Recommendations

Evaluation Hypotheses	Measures
Evaluation Question 3: Did the HTW Demonstration improve women's health and pregnancy outcomes?	
3.1 The HTW Demonstration will maintain or improve women's health among HTW clients.	3.1.1 Hypertension Medication Adherence
	3.1.2 Diabetes medication adherence
	3.1.3 Cholesterol medication adherence
	3.1.4 Antidepressant Medication management
3.2 The HTW Demonstration will maintain or improve maternal health and pregnancy outcomes among HTW clients.	3.2.1 Unintended pregnancies
	3.2.2 Birth spacing
	3.2.3 Pregnancy complications: Gestational diabetes and preeclampsia.
	3.2.4 Adverse birth outcomes: Low birth weight and preterm births
	3.2.5 Severe maternal morbidity
Evaluation Question 4: Did the HTW Demonstration effectively use public funds to provide women's health care in Texas?	
4.1 The HTW Demonstration will remain at or below the CMS-specified annual expenditures limits.	4.1.1 Per member per month costs
Evaluation Question 5: How does the implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services?	
5.1 The implementation of HTW provider eligibility criteria does not adversely affect access to and utilization of women's health and family planning services.	5.1.1 Proportion of active family planning providers in Medicaid delivering services through HTW

Data

UTHealth CHCD relied on the following data sources to calculate measures for the evaluation:

- Medicaid enrollment, encounters, and claims for medical and pharmacy services provided by HHSC (Calendar Year [CY] 2017-2021) for HTW and Medicaid clients, which serve as the control group for a limited set of measures.
- Provider-level enrollment files (CY 2017-2021).

- Mother-newborns crosswalk for mothers delivering under Medicaid (CY 2018 & 2021) prepared by HHSC.
- Pregnancy Risk Assessment Monitoring System (PRAMS) data for Medicaid recipients (2017-2021) received from DSHS.
- Medical and Pharmacy Network Adequacy reports (CY 2020-2021).
- Budget Neutrality estimations for (Demonstration Years [DY] 1-3) and total enrollment and spending reports (CY 2017-2019) obtained from HHSC.

UTHealth CHCD will also rely on primary data collected from surveying clients and providers. However, that information will not be available until the summative report.

Population

The target population for the HTW evaluation includes all clients enrolled in the HTW Demonstration. In general, no additional inclusion or exclusion criteria have been applied. The target population is conceptually consistent with an intent-to-treat framework. All women who transitioned to or self-enrolled in the HTW Demonstration are considered part of the intervention group, regardless of whether they actively receive services. HTW enrollees who turned 45 during a measurement year and were still HTW clients were grouped into the 40-44 category. Women 45 or older at the beginning of the year were excluded as women would not be normally eligible for HTW but remained in the program due to PHE continuous enrollment policies. Additionally, some measures had additional population requirements that restricted the target population for that measure (e.g., age limitations or continuous enrollment requirements). These measure-specific exclusions are noted under each measure section and detailed in *Appendix A: Methods.* In addition, for the purposes of the evaluation, we excluded clients 15 to 17 years old from the pre-HTW Demonstration baseline (or comparison group) to match the clients' age range in the HTW Demonstration period.

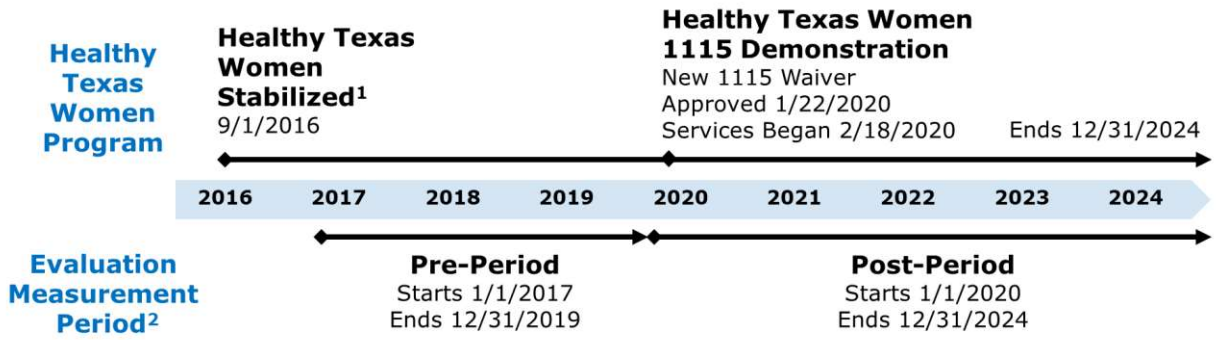
The HTW evaluation also assesses other populations, including that of providers serving HTW clients, and for the assessment of Measure 3.2.1 (Unintended Pregnancies) survey information for women identified as "Medicaid," which could have included both Medicaid and HTW clients available through the Pregnancy Risk Assessment Monitoring System (PRAMS). Additionally, measures under Hypothesis 3 rely on Medicaid-paid births from 2018 and 2021. Mothers who were not enrolled in HTW the year prior to the birth were used as control groups and are therefore part of the population studied.

Lastly, population-level data (rather than a sample) has been used for most measures to assess processes and outcomes. Measures relating to clients and providers have been stratified into key demographic subgroups such as age, race/ethnicity, region, or provider type, where applicable.

Study Period

The study period for the HTW evaluation is January 1, 2017, to December 31, 2024 (Figure 3), as explained in the CMS-approved Evaluation Design and corresponds to an approximate three-year period before the HTW Demonstration, and a five-year period under the HTW Demonstration. For this interim report, the data analyzed ranged from January 2017 through December 2021, corresponding to two years post-implementation of the HTW Waiver. As outlined in the CMS-approved Evaluation Design, for the purpose of the evaluation, the start of the HTW Demonstration is assumed to be January 1, 2020, although the Demonstration was approved January 22, 2020 and services did not begin until February of that year.

Figure 3: HTW Evaluation Period



Notes. [1] The state-funded Healthy Texas Women program began on 7/1/2016, but the EPHC program continued to operate for two additional months, ending 8/31/2016. The program environment for women's health services in Texas has been stable since 9/1/2016. [2] The HTW Demonstration period is from 1/22/2020 to 12/31/2024. However, the HTW evaluation measurement post-period begins on 1/1/2020 to ensure consistent calculation of metrics in pre- and post-periods.

Some measures under Hypothesis 3.2 use a truncated portion of the study period due to operationalization constraints or source-specific data lags. Details can be found in CMS-approved Evaluation Design.

Quantitative Analysis

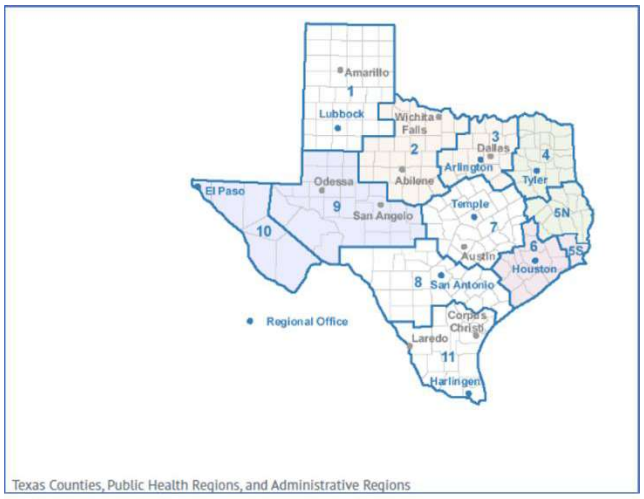
The quantitative analysis has been approached through three quasi-experimental methods: one group pre-posttest design, one group post-test only, and a nonequivalent comparison group pretest-posttest design. Most measures are being tested through a one-group pre-posttest design due to the longstanding nature of the HTW program and the absence of a suitable comparison group. Quantitative analytics methods used include:

- Descriptive analysis assessing measures of central tendency and dispersion. Pre-post and sub-group comparisons using inferential statistics as appropriate. Methods used include the Chi-square test, Wilcoxon rank sum test, t-tests, Kruskall-Wallis, and ANOVA. When possible, a comparison with other benchmark information or peer review publications was performed to evaluate differences.
- Descriptive trend analysis was used when pre- and post-HTW Demonstration data was available, plotting and analyzing time series data and testing for the presence of a trend through regression modeling when possible. For several measures, reported only as annual rates, the years of follow-up provided little power to test for trends appropriately. We describe the trajectory and evaluate differences between pre- and post-period averages to assess changes further.

  Difference-in-differences (DID) models were used to assess all measures under hypothesis 3.2 as a comparison group was available for the pre- and post-HTW Demonstration period. To balance group characteristics of the pre- and post/post-intervention and control groups, a propensity score weighting approach recommended for use in DID modeling for policy evaluations was used.[9]

Additionally, all descriptive statistics and analysis are stratified by age, race/ethnicity, and region, if feasible. The regional analysis was based out of Texas Public Health Regions. The map and counties included in each region are shown in the map below (Figure 4). The summative report will adjust regional stratifications to reflect Managed Care Service Areas to align with existing HTW reporting.

Figure 4: Texas Public Health Regions



Center for Health Statistics Texas County Numbers and Public Health Regions. https://www.dshs.texas.gov/center-health-statistics/center-health-statistics-texas-county-numbers-public-health-regions

Details on the methodological and quantitative analysis approaches used for each measure can be found in *Appendix A: Methods.*

Qualitative Data Methods and Collection Updates

Primary data from clients and providers have been collected as part of this evaluation as it offers valuable insight about the HTW Demonstration not otherwise available through administrative data. The primary data collected assessed client and provider perspectives on the HTW Demonstration, including eligibility requirements, covered services, how to access services, and communication channels.

UTHealth designed and implemented a provider survey and a client survey in May 2023. UTHealth relied on a stratified random sample of HTW providers and clients to ensure survey responses reflected the overall HTW Demonstration population. A total of approximately 181 providers and 1,612 clients participated in the survey.

Due to the level of effort required to implement surveys and conduct qualitative analysis, findings from these surveys were not available at the time of writing. However, findings from both surveys will be included in the summative evaluation report. Additional details on the HTW provider and client surveys can be found in *Appendix C: Updates of Primary Data Collection and Qualitative Analyses.*

Access, Utilization, and Health Outcomes

Overview

This section evaluates changes in access, utilization, and health outcomes among the HTW population post-HTW Demonstration. It represents the bulk of the interim report evaluation and is addressed collectively because, while specific measures vary, study populations, data sources, and analytic methods are similar. These three areas are evaluated through six hypotheses and 23 measures. Results for each measure are organized under the corresponding hypothesis, and include changes, trends over time, outcomes by subgroups, and finally, when possible, differences from comparison groups. Under each hypothesis, we highlight considerations the reader should be aware of when interpreting results. Results for Hypothesis 1.2 and its six measures, which require analysis of primary data collected from clients, will not be included in this interim report, though progress updates are included.

Methods

Detailed methodology for the analysis of each measure and additional descriptive tables can be found in *Appendices A: Methods* and *B: Additional Results*, respectively.

Key Findings

- The average number of unique HTW clients per year (Measure 1.1.1) during the post-HTW Demonstration period grew slightly (4%); however, the average number of Member Years (MY) for the post demonstration calendar years grew by 43 percent. This was due to a significant growth in the number of clients continuously enrolled and an increase in the number of retained clients from one year to the next—both of which may be due to policies enacted during the PHE to maintain client enrollment. This trend was most evident among women aged 25 and older, resulting in an older age distribution among the post-HTW Demonstration population when compared to pre-Demonstration baseline.
- Pre-HTW Demonstration, an average of 37 percent of HTW clients received services per year (Measure 1.1.2). This number grew by three percentage points post-HTW Demonstration (9% change, p-value <0.001). This increase was driven by growth in clients utilizing medical services (12% change), but

was countered by a 7 percent reduction in clients utilizing prescription services.

- The number of active billing providers, or the number of providers billing at least one claim per year (Measure 1.1.3) grew by 20 percent between the pre- and post-HTW Demonstration period. However, fewer than 10 percent of billing providers were responsible for 80 percent of all paid claims pre- and post-HTW Demonstration.
- Network adequacy (Measure 1.1.4) improved in Demonstration Year (DY) 2[c] compared to baseline network adequacy reports for primary care physicians (PCP) and pharmacies. However, PCP networks in Micropolitan counties were still 15 percent below the desired performance standard (90%). In both baseline and DY 2 reports, network adequacy for PCPs and pharmacies was lowest in the MRSA Northeast Texas service area.
- Post-HTW Demonstration use of most/ moderately effective contraceptives among women with continuous annual enrollment declined by 7.7 percentage points (Measure 2.1.1) and use of Long Acting Reversible Contraceptives (LARCs) declined by 0.7 percentage points (Measure 2.2.2). The absolute number of women receiving contraception through HTW more than doubled in the post-HTW Demonstration period. The significant growth in eligible enrolled women and the shift towards an overall older population may have contributed to the decreases in these rates.
- The percentage of HTW clients tested for sexually transmitted diseases (Measure 2.1.3) did not change significantly through time. Specifically, chlamydia screening did not change significantly post-HTW Demonstration either, and was, in fact, very close to Texas Medicaid reported rates. Almost 100 percent of women screened for chlamydia were also screened for gonorrhea, in line with evidence-based guideline recommendations.[10-12]
- This interim report could not examine changes in compliance with cervical cancer screenings (Measure 2.2.1), as that measure requires a five-year measurement window. However, preliminary findings based on a partial three-year measurement window suggest compliance with cervical cancer screenings slightly decreased post-HTW Demonstration. However, the 2021 rate (60%), which was the only year for which complete 5-year data was available, was 2.8 percentage points higher than the cervical cancer screening rate for Texas Medicaid recipients in general.

[c] Demonstration Years reflect a given year of the HTW Demonstration and operate on a Calendar Year (January 1 to December 31).

- Medication adherence for hypertension (Measure 3.1.1), diabetes (Measure 3.1.2), and cholesterol (Measure 3.1.3) drugs decreased post-HTW Demonstration. The prevalence of these three conditions was less than 2%, and after applying the criteria for the measure (having at least 2 prescriptions for the specific condition), few clients met the criteria. Therefore, results should be interpreted with caution. None of these changes were statistically significant after limiting the analysis to those women who were continuously enrolled in HTW for at least one year.
- Antidepressant medication management (Measure 3.1.4) improved, especially during the continuation phase (6 months of antidepressant medication).
- The ability to evaluate pregnancy intentions was limited as the response rate for the question used to assess this in PRAMS did not reach the 50 percent threshold across the year; therefore, CDC recommends interpreting cautiously. No significant changes in unintended pregnancy rates (Measure 3.2.1) were evident for the Texas Medicaid population pre- and post-HTW Demonstration. Unintended pregnancies among Medicaid-insured mothers were significantly higher than those reported for the overall state.
- The interim report could not assess birth spacing (Measure 3.2.2) post-HTW Demonstration as this requires 27 months of follow up after a delivery and data was only available through 2021. However, among women with a live Medicaid-paid birth in 2018 we evaluated their rate of subsequent births within 27 months of the index 2018 delivery based on their HTW enrollment the year prior (2017). The difference by HTW enrollment status was small (17.7% for HTW clients and 17.4% for non-HTW clients). Additionally, we evaluated the same measure based on their HTW enrollment following the index birth (HTW enrollment in 2019). HTW clients had a lower rate (better) of inadequate birth spacing in the subsequent 27 months than those who were not enrolled in HTW (17.1% vs 17.9%). This difference became insignificant after adjusting for age, race/ethnicity, and maternal comorbidity conditions. The assessment of birth spacing changes pre- and post-HTW Demonstration will require more years of data which will be available in the summative evaluation report.
- Overall, propensity score weighted rates for pregnancy complications (Measure 3.2.3; gestational hypertension, gestational diabetes, and preeclampsia) among women who delivered under STAR Medicaid increased between 2018 and 2021. However, the increase in pregnancy complications was significantly smaller among women who had been enrolled in the HTW Demonstration the year prior to giving birth, compared to those without HTW

or Medicaid enrolling in the year prior to the delivery under STAR Medicaid. (DID -1.0%, p=0.002).

- The propensity score weighted severe maternal morbidity rate (Measure 3.2.5) also increased between 2018 and 2021. However, severe maternal morbidity did not differ based on HTW enrollment in the prior year (DID 0.2% p=0.137).
- Propensity score weighted rates of adverse birth outcomes (Measure 3.2.4; low birth weight and preterm births) increased between 2018 and 2021. Differences were smaller among women with previous HTW enrollment compared to those without HTW or Medicaid enrollment in the year prior to the delivery under STAR Medicaid (DID for low birth weight -1.0%, p<0.001; DID for preterm -0.9%, p<0.001).

Access to family planning, family planning-related and, preconception care services

Access to family planning, family planning-related, preconception care, and postpartum services was maintained or increased during the HTW Demonstration. (Hypothesis 1.1).

We assessed whether there had been changes in access to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas post-HTW Demonstration program through the following measures:

1.1.1 Unique count of women enrolled in HTW

1.1.2 Proportion of HTW clients who receive any HTW service

1.1.3 Unique count of providers billing for any HTW service

1.1.4 Percentage of HTW clients within prescribed network adequacy standards

Additionally, Hypothesis 1.2 will assess clients' perspectives on the HTW Demonstration eligibility requirements, access to services, communication channels, and covered services. Primary data for these measures is currently being collected and analysis results will be presented in the summative report. Updates on the status of this hypothesis assessment are provided measure in *Appendix C: Updates on Primary Data Collection and Qualitative Analyses*.

The state's outreach and engagement activities support understanding of the HTW Demonstration (Hypothesis 1.2).

This hypothesis is being evaluated through the following measures:

1.2.1 Motivating factors for HTW enrollment and renewal
1.2.2 Understanding of eligibility requirements
1.2.3 Understanding of HTW benefits
1.2.4 Awareness of how to obtain services
1.2.5 Effectiveness of outreach channels
1.2.6 Effectiveness of HTW Demonstration resources

Clients Characteristics, Enrollment, and Use of Services (Measures 1.1.1 and 1.1.2)

The unique number of women enrolled in the HTW program was 344,920 at the beginning of the study period (2017) and increased to 453,316 by 2021. The highest number of unique enrolled clients occurred in 2019 when the program had 497,107 unique women enrolled. Detailed tables on women's characteristics can be found in *Appendix B: Additional Results.*

Table 3 shows the total number of unique clients enrolled in HTW each year, stratified by newly enrolled versus those retained from the prior year, as well as the actual number of member years (MY), or 12-member months within a calendar year (Jan-Dec). Pre- and post-enrollment numbers were estimated as the average for the specific period, and the difference between the averages was reported. The percentage change is the difference between pre- and post-enrollment averages divided by the pre-Demonstration average value. The actual number of unique clients grew by 4 percent over time; however, the number of MY, or 12-member months within a calendar year, grew between the pre- and post-HTW Demonstration periods, on average, 43 percent--likely an effect of the continuous enrollment requirements implemented during the PHE. The orange line in Figure 5 depicts this trend.

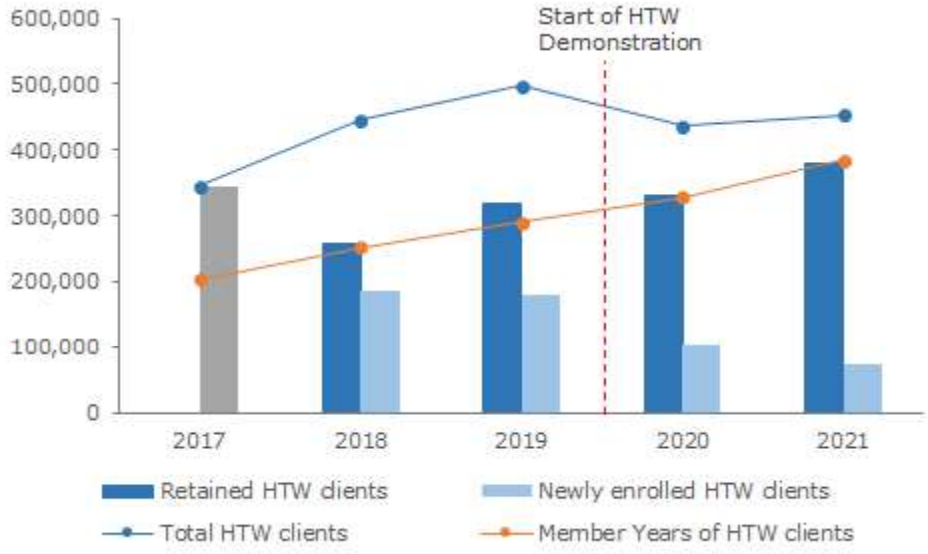
Table 3: HTW Clients, Retained and Newly Enrolled, and Member Years

Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total Unique HTW Clients	MYs[1] of HTW Clients
2017	N/A	N/A	344,920	203,662
2018	257,579	187,515	445,094	253,073
2019	318,330	178,777	497,107	290,332
2020	331,656	104,889	436,545	329,219
2021	380,370	72,946	453,316	385,187
Annual Pre-HTW Demonstration Average (2017-2019)	287,955	183,146	429,040	249,022
Annual Post-HTW Demonstration Average (2020-2021)	356,013	88,918	444,931	357,203
Pre/Post Point Diff.	68,059	-94,229	15,890	108,181
% Change[2]	*23.6%*	*-51.4%*	*3.7%*	*43.4%*
p-value[3]	*<0.001*	*<0.001*	*<0.001*	*<0.001*

Notes. [1] MY, Member Year. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-HTW Demonstration periods by the value of the measure at the pre-HTW Demonstration period. [3]P-values are reported from Poisson regressions.

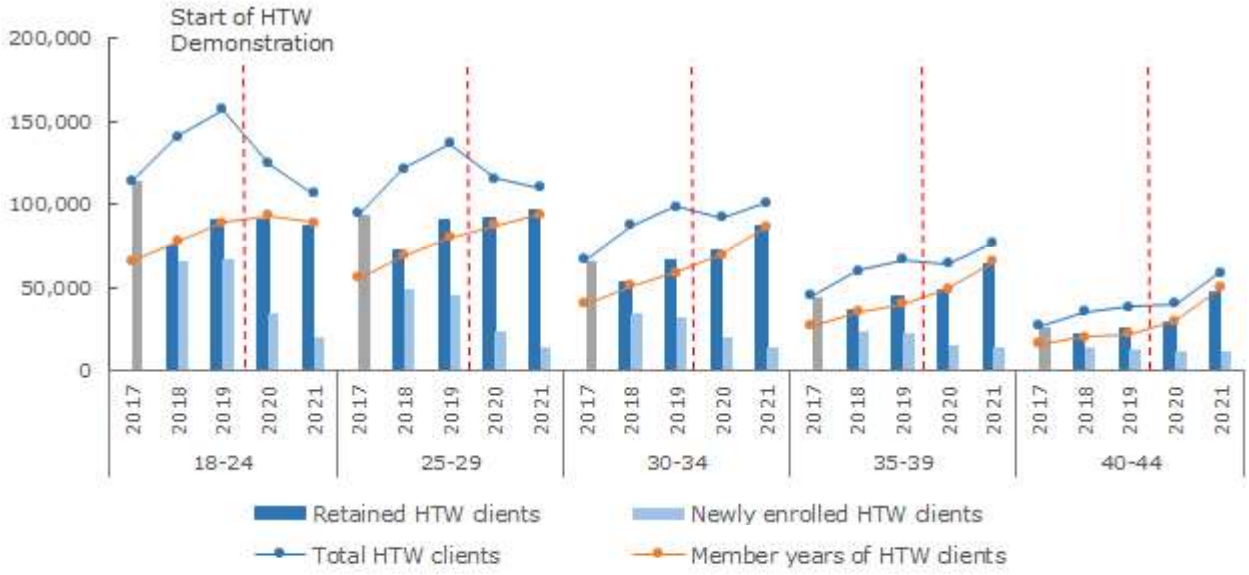
Two factors can explain the growth in MY. First is the 24 percent growth in retained clients post-HTW Demonstration (evidenced by the dark blue bars in Figures 5 and 6), alongside the 51 percent decline in newly enrolled clients (shown by the light blue bars in Figures 5 and 6). This change in the proportion of retained versus new clients was similar across all race and ethnic groups, with similar growth in overall numbers of unique clients and growth in MY. However, the difference was not consistent across age groups. Among the younger age groups (18-24) there was a reduction of 16 percent of unique clients, 59 percent reduction of newly enrolled clients, and only an 8 percent growth in retained clients. All other older age groups behaved similarly to the overall population. Overall, this resulted in a statistically significant older population post-HTW Demonstration (2020-2021) than the pre-HTW Demonstration period (2017-2019). When evaluating this by Public Health Region (Figure 4: Map of Texas Public Health Regions), we should note the actual average number of unique enrollees shrunk across most regions with the exception of Regions 3 and 6 where it grew closely to the state average, and Region 11 where there were no changes. The total number of MY grew across regions aligned with the overall state growth (see all detailed tables and figures in *Appendix B: Additional Results*).

Figure 5: Trends in Unique Client Enrollment, Member Years, and Retained vs. Newly Enrolled Clients: Total



Notes. Dark blue bars represent HTW clients retained from the prior year, while light blue bars represent those newly enrolled. Since 2017 is the first year of data, the grey bar indicates HTW clients enrolled in 2017 regardless of their previous enrollment.

Figure 6: Trends in Unique Client Enrollment, Member Years, and Retained vs. Newly Enrolled Clients: By Age Groups

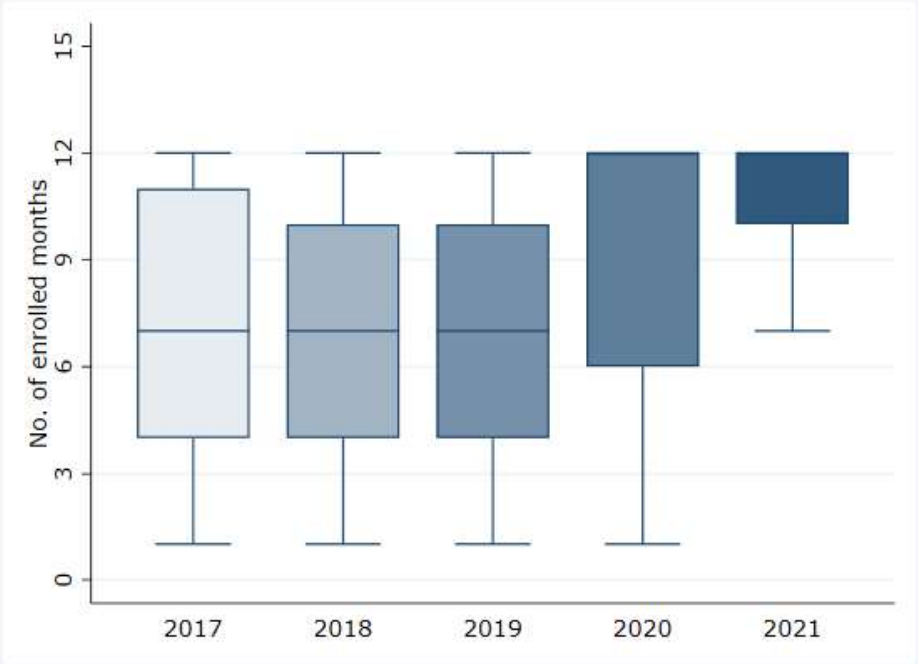


Notes. Dark blue bars represent HTW clients retained from the prior year, while light blue bars represent those newly enrolled. Since 2017 is the first year of data, the grey bar indicates HTW clients enrolled in 2017 regardless of their previous enrollment.

The second factor explaining the growth of MY is the significant growth in continuous enrollment for each individual. The boxplots in Figure 7 show the change in enrollment patterns, displaying the median number of months enrolled per client by year (central line in the box), the interquartile range (IQR) (25th and 75th percentiles shown as the upper and lower edges of each box), and the minimum and maximum values (displayed as whiskers).

Average length of enrollment was quite similar across the pre-HTW Demonstration period, with a median enrollment for the 3-year period of 7 months (IQR 4-10). However, post-HTW Demonstration, the median enrollment changed to 12 months. The graph also shows how variation in enrollment shrunk even more in 2021, where the median was 12 months and the 25th percentile was 10 months. Variation in median and mean enrollment between pre- and post-Demonstration periods was statistically significant (p-value <0.001). Overall, these findings were still evident and followed the same direction when stratifying by age, race, and ethnicity. Detailed tables with statistical comparisons across periods and subgroups are available in *Appendix B: Additional Results.*

Figure 7: Enrolled Months for HTW Clients: Box Plots of Median, Interquartile Range, and Maximum/Minimum values (2017-2021)



Notes. Horizontal lines inside the boxes denote medians; bottom and top borders of the boxes, IQR; whiskers, range of values.

As explained previously, the implementation of the HTW Demonstration coincides with the initiation of the PHE. Clients were traditionally enrolled in HTW for 12-month periods; however, this could occur anytime in the year. The changes in

annual average enrollment by calendar year during the post demonstration period reflect changes due to the PHE. During this period, re-determination of eligibility was suspended and clients were guaranteed continuous enrollment, therefore increasing the number of months enrolled in a given calendar year. Additionally, postpartum women did not transition to HTW after delivering as they stayed enrolled in the traditional Medicaid program. This can help explain the reduction in new enrollees post-HTW Demonstration and the overall growth of retained clients from previous years.

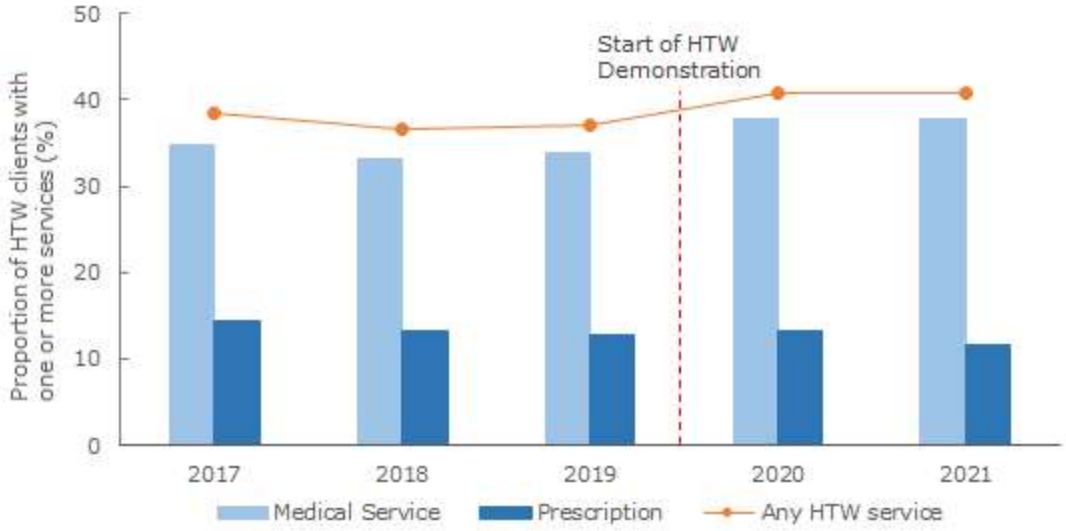
The evaluation of service utilization among HTW clients showed that on average, pre-HTW Demonstration, 37 percent of women enrolled in HTW received at least a service per year, 34 percent received medical services, and 13.4 percent received prescription services. Post-HTW Demonstration, overall proportion of women who used at least a service grew by 3.4 percentage points (9.2% growth); this was driven by growth in medical services of 3.9 percentage differences points (11.7% growth), as prescription services decreased by 0.5 percentage points (-6.9% decline). Similar changes occurred across all age groups and race/ethnic groups with no significant differences in direction or magnitude (see *Appendix B: Additional Results*).

Table 4: Proportion of HTW Clients Receiving Any Services (Medical and Prescription Services by Year): Averages and Changes

Year	HTW Clients Receiving Any Service	HTW Clients Receiving a Medical Service	HTW Clients Receiving a Prescription
2017	38.5%	34.7%	14.4%
2018	36.6%	33.2%	13.2%
2019	37.0%	33.8%	12.7%
2020	40.7%	37.7%	13.3%
2021	40.7%	37.9%	11.6%
Annual Pre-HTW Demonstration Average (2017-2019)	37.3%	33.8%	13.4%
Annual Post-HTW Demonstration Average (2020-2021)	40.7%	37.8%	12.4%
Pre/Post Percentage Point Diff.	*3.4%*	*3.9%*	*-0.9%*
% Change[1]	*9.2%*	*11.7%*	*-6.9%*
p-value[2]	<0.001	<0.001	<0.001

Notes. [1] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [2] P-values are reported from Chi-square tests.

Figure 8: Trends in Proportion of HTW Clients Receiving Any Services (Medical and Prescription Services by Year)



Providers Billing for Any HTW Service (Measure 1.1.3)

The number of active providers with at least a paid claim for HTW clients was assessed through three different provider designations: billing providers, performing providers, and prescribing providers. We first evaluated the number of billing providers, understood as providers who billed for and were paid for services under the HTW program during the study period. Billing providers often include or represent more than a single performing provider. For instance, a physician group would appear as a single billing provider under which several physicians would bill for different services performed. We therefore also evaluated the number of performing providers with paid claims during the same period. Additionally, we reported on the number of providers who prescribed medications for paid pharmacy claims among the HTW population. It should be noted that provider categories are not necessarily mutually exclusive. For example, a single practice physician could be a billing, performing and prescribing provider. Additionally, though most prescribing providers are likely performing providers, a performing provider might not have a paid prescribed claim. Therefore, numbers should not necessarily be the same.

Table 5 details the number of unique active providers by each of the described categories and the change in the average between pre- and post-HTW Demonstration periods. Both billing and performing providers grew during the HTW Demonstration period, with 20 percent and 13 percent increases respectively.

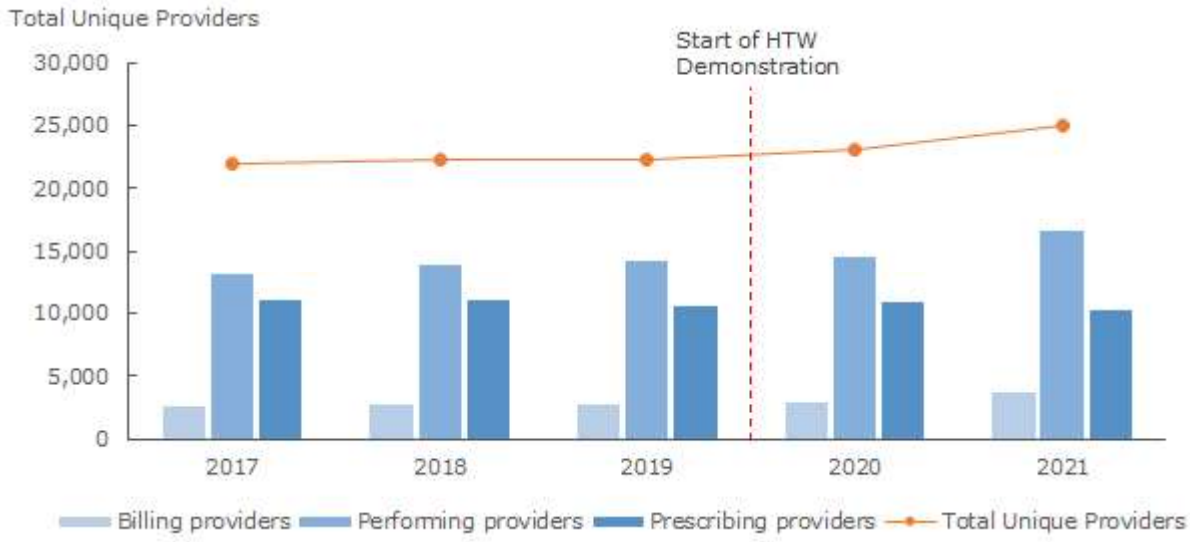
Table 5: Unique Providers Providing Services for HTW Clients

Year	Unique Billing Providers	Unique Performing Providers	Unique Prescribing Providers	Total Unique Providers
2017	2,636	13,143	11,104	21,950
2018	2,706	13,951	10,972	22,319
2019	2,791	14,275	10,552	22,311
2020	2,880	14,549	10,949	23,070
2021	3,612	16,678	10,161	25,039
Annual Pre-HTW Demonstration Average (2017-2019)	2,711	13,790	10,876	22,193
Annual Post -HTW Demonstration Average (2020-2021)	3,246	15,614	10,555	24,055
Pre/Post Point Diff.	535	1,824	-321	1,861
% Change[1]	*19.7%*	*13.2%*	*-3.0%*	*8.4%*
p-value[2]	*<0.001*	*<0.001*	*0.001*	*<0.001*

Notes. [1] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-HTW Demonstration periods by the value of the measure at the pre-HTW Demonstration period. [2] P-values are reported from Poisson regressions.

As can be seen in Figure 9, the incremental changes were evident for both years in the HTW Demonstration period, 2020 and 2021. The number of prescribing providers declined by 3 percent, mostly driven by a reduction in 2021 to 10,161 prescribing providers, which seems to align with the identification of a reduction in prescriptions for the same period. It should be noted that in 2020 the number of prescribing providers (10,949) was higher than the number in 2019 (10,552). Therefore, more years of follow-up data would be needed to assess whether this is an outlier or an ongoing trend. A complete assessment for the full report will be possible at the end of the evaluation period. The overall number of unique providers in paid claims grew through time. The change in the average count between the pre- and post-HTW Demonstration period was 8 percent.

Figure 9: Providers Providing Services for HTW Clients



We additionally looked into the number of claims paid per provider. We found the distribution of claims filed and paid per provider was significantly skewed. Table 6 below shows the mean, median, and interquartile ranges in number of medical paid claims by year for billing providers. There was an 18 percent increase in the mean number of claims filed post-HTW Demonstration, but it was not statistically significant, principally due to the large confidence intervals. Tables for pharmacy claims per prescribing provider had a similar distribution and are reported in *Appendix B: Additional Results.*

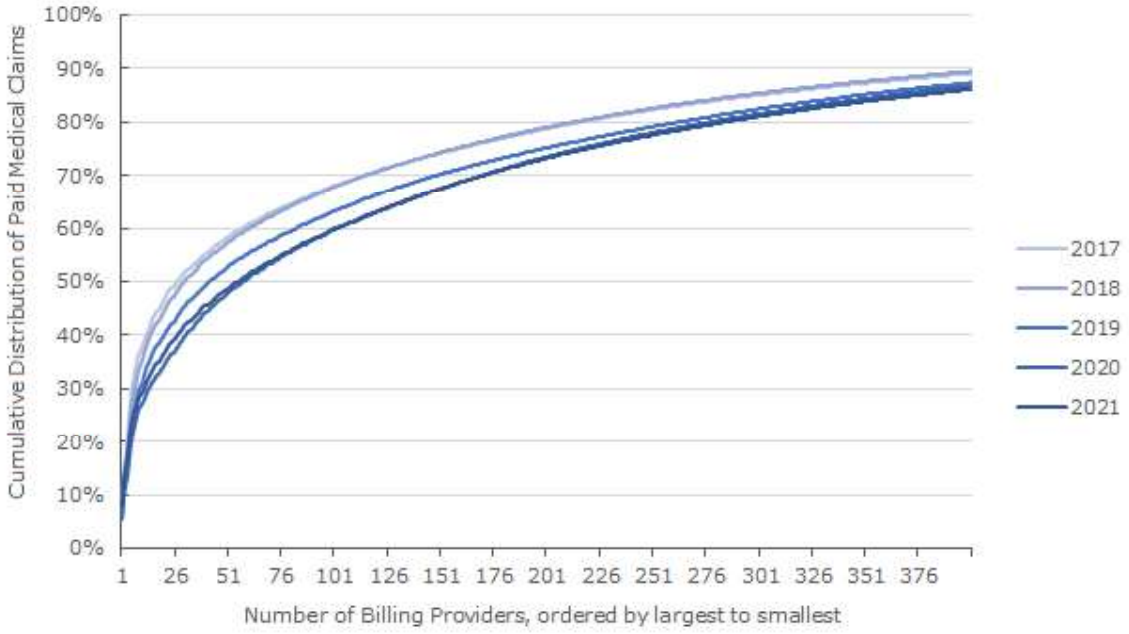
Table 6: Annual Medical Claims per Billing Provider

Year	Mean Annual Claims per Billing Provider	Median Annual Claims per Billing Provider	25th Percentile	75th Percentile
2017	130.6	8	2	49
2018	163.9	8	2	59
2019	189.2	10	2	78
2020	207.5	11	2	88
2021	178.9	7	2	53
Annual Pre-HTW Demonstration Average (2017-2019)	161.8	9	2	62
Annual Post -HTW Demonstration Average (2020-2021)	191.6	8	2	69
Pre/Post Point Diff.	29.8	-1.0		
% Change[1]	*18.4%*	*-11.1%*		
p-value[2]	0.12	0.64		

Notes. [1] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [2] P-values are reported for statistical testing using Wilcoxon rank sum (medians) and t-tests (means).

Additionally, we found that 218 billing providers were responsible for 80 percent of the medical claims filed in 2017. In 2021, 286 billing providers were responsible for 80 percent of claims. Therefore, though the number of billing providers filing for HTW claims has grown through time, there is a consistent trend that less than 10 percent of active billing providers are responsible for the vast majority of the paid HTW services (Figure 10).

Figure 10: Cumulative Distribution of Paid Medical Claims by Billing Providers (Graph displays up to the first 400 billing providers)



Network Adequacy (Measure 1.1.4)

Network adequacy standards are developed to ensure that health plans maintain a network of appropriate providers sufficient to provide adequate access to services for the identified population. The HTW program developed network adequacy standards based on previously established distance standards for the Texas HHSC STAR program. Distance standards measure the distance between the HTW client's address of residence and the service address of active providers. For this interim report, PCPs and pharmacies are the selected providers for this measure. Percentages of clients that reside within the standard accessible distance are reported by Medicaid Managed Care Service Areas and county type: Metropolitan (metro), Micropolitan (micro), and rural (as defined by HHSC). Rates are reported on an annual basis.

This interim report relies on network adequacy reports, produced by HHSC, for DYs 1 and 2. DY 1 report relied on 2019 data and is considered our baseline measurement. For the sake of this analysis DY 2 report is considered the post HTW Demonstration network adequacy data source. For both PCPs and pharmacies, the network adequacy calculations were derived from the PCP/pharmacy addresses within HHSC Medicaid provider databases and compared to the HTW client residence addresses. ESRI's ArcGIS geo-mapping software was used to measure the distance between HTW clients and the closest pharmacy to them.

A PCP was considered "active" if they had an HTW claim in the prior calendar year. The performance standard for all PCP locations (metro counties– 10 miles, micro counties – 20 miles, rural counties – 30 miles) is set at 90 percent for each year. For pharmacies, the distance standards were set at within 2 miles for a metro county, 5 miles for a micro county, and 15 miles for a rural county. Similar to the methodology for the PCP calculation, an active pharmacy was defined as a Texas Medicaid pharmacy with HTW claims during the prior calendar year. The service areas remain the same as previously reviewed for the PCP network adequacy. The standards were set at 80 percent for metro counties, 75 percent for micro counties, and 90 percent for rural counties across all service areas except Medicaid Rural Service Areas (MRSA) which are 75 percent for metro, 55 percent for micro, and 90 percent for rural.

In the baseline assessment, 99.9 percent of HTW clients were included in the calculation for both PCP and Pharmacy network adequacy distance standards, and 95 percent were included in the post HTW assessment (DY 2).

Network Adequacy for Primary Care Physician Access

General improvement was evident in the DY 2 network adequacy rates for PCPs. The overall measurement for the program was only 0.7 percentage points from the 90 percent goal. There was variation by county type, though. Micro counties were still 15 percentage points below the standard, but metro counties met the standard. There was also variation by region, shown in detailed tables available in *Appendix B: Additional Results.* Overall, in DY 2, 23 out of 39 service areas met or exceeded the standard—a growth of 6 service areas, or 35 percent, when compared to the baseline's assessment. Micro counties in the Hidalgo service area remained low and had a decrease in the percentage of HTW clients within the standard distance, from 49 percent during the baseline to 27 percent in DY 2. In DY 2, rural counties in the El Paso service area had a rate of 0, but the enrolled client count also dropped from 35 to 3. Of special note was the MRSA Northeast Texas service area, overall, only 66% of counties met the network adequacy standard for PCP, both at baseline and in DY 2. Additionally, at both at baseline and DY 2, only 56 percent of metro counties in the MRSA Northeast Texas service area met PCP standards. However, micro counties meeting standards grew by 4.4 percent points (76% counties at baseline vs 80% counties during DY 2).

Table 7: PCP Network Adequacy Standards, Proportion of HTW Clients Meeting Standards and Changes by County Type (Baseline vs. DY 2)

County Type	Distance Standard from Two PCPs	Estimated Percent of HTW Clients Within Distance Standard from Two PCPs	Variation from Standard (90%)	Absolute Change (Baseline-DY 2)
Baseline Statewide Summary (DY1)		87.0	-3	
Metro	10 Miles	87.5	-2.5	
Micro	20 Miles	72.7	-17.3	
Rural	30 Miles	92.1	2.1	
DY 2 Statewide Summary		89.3	-0.7	• 2.3
Metro	10 Miles	90.0	0.0	• 2.5
Micro	20 Miles	75.0	-15	• 2.3
Rural	30 Miles	92.2	2.2	• 0.1

Reference

Meets Standard

Does Not Meet Standard

Increased

Decreased

Network Adequacy for Pharmacy Access

Statewide, the pharmacy network adequacy was within the standards, overall, and for each of the three county types at both baseline and DY 2. Statewide, micro counties increased their coverage considerably in DY 2 to reach 85.8 percent. When assessed by service area, only two of service areas had metro counties below the standard: metro counties in Hidalgo and MRSA Northeast (each below performance standards by 2-5 percentage points).

Among the micro counties, Travis County service area was the lowest, falling 21 and 22 percentage points below the standard (during baseline and DY 2, respectively), followed by Bexar service area (15 and 14 points below standard, respectively) and Tarrant service area (9 and 15 points below standard, respectively). The rural counties generally met standards, with the exception of El Paso, Hidalgo, and MRSA West Texas at baseline, but each surpassed the standard

in DY 2. Table 8 shows standard comparisons and changes pre- and post-HTW Demonstration implementation. Detailed tables by service areas can be found in *Appendix B: Additional Results.*

Table 8: Pharmacy Network Adequacy Standards, Proportion of HTW Clients Meeting Standards and Changes by County Type (Baseline vs. DY 2)

County Type	Distance Standard from a Pharmacy (County Type Specific)	Performance Standard Percentage	Estimated Percent of HTW Clients Within Distance Standard from a Pharmacy	Variation from Standard	Absolute Change (2020-2019)
Baseline (DY1) Statewide Summary			**87.2**		
Metro	2 Miles	80	87.2	7.2	
Micro	5 Miles	75	75.5	0.5	
Rural	15 Miles	90	94.5	4.5	
DY 2 Statewide Summary			**87.7**		• 0.5
Metro	2 Miles	80	87.0	7.0	• -0.2
Micro	5 Miles	75	85.8	10.8	• 10.3
Rural	15 Miles	90	96.3	6.3	• 1.8

Meets Standard
Does Not Meet Standard
Increased
Decreased

Utilization of Family Planning Services Among HTW Clients

The HTW Demonstration will maintain or increase utilization of family planning services among HTW clients. (Hypothesis 2.1)

We assessed changes in family planning services provided pre- and post-HTW Demonstration waiver by evaluating the following measures:

2.1.1 Provision of most or moderately effective contraceptive methods
2.1.2 Long-acting reversible contraceptive use

2.1.3 Tests for any sexually transmitted infection/disease

Use of the Most Effective/Moderately Effective Contraceptive methods and Long Acting Reversible Contraceptives (Measures 2.1.1 and 2.1.2)

The evaluation of contraceptive care is was evaluated using the Contraceptive Care Women (CCW)[13] measures specified by Medicaid Core Set of Adult's Health Care Quality Measures. The specifications on inclusion, and exclusion criteria, and the codes used for measuring these on medical and pharmacy claims data can be found in the Technical Specifications and Resource Manual for FFY 2021 Reporting document from the Center for Medicare and Medicaid (CMS).[14]

Two rates are assessed and reported here together as they have similar interpretations and implications. The first reflects the provision of the most effective or moderately effective contraceptive methods. The second rate reflects the provision of long-acting reversible contraceptive (LARC) methods. We evaluated these measures following the specification described by Medicaid Core Set of Adult's Health Care Quality Measures, including only women continuously enrolled in HTW for a calendar year, with no more than a 45-day gap as specified in the CMS-approved Evaluation Design.

Overall, both contraception measures decreased over time, see Table 9. Values for most and/moderately effective contraception rates ranged from 23.5 percent in 2017 to 14.2 percent in 2021. The average annual rate during the pre-Demonstration period was 24.2 percent, and 16.5 percent during the post-Demonstration period (2020-20210), a 7.7 percent points difference or 31.8 percent reduction. The absolute number of women receiving these services however, grew from 18,850 to 43,178 in the same time period. However, the denominator or number of eligible women for these services grew considerably as well during the post-Demonstration period, as a result of the policies implemented during the PHE.

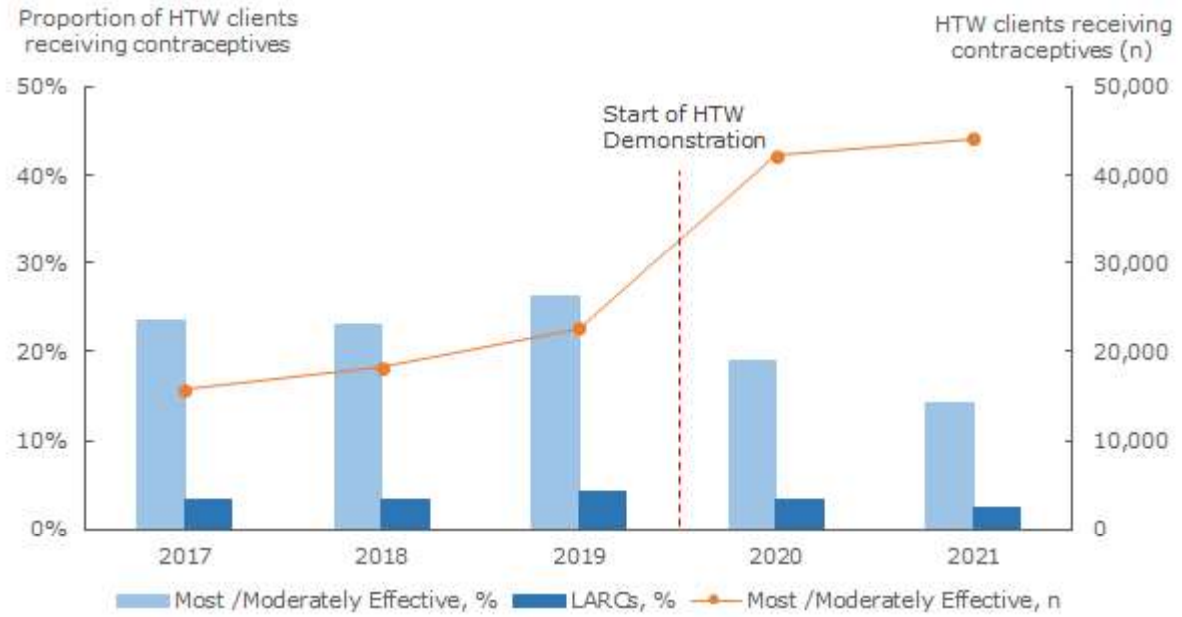
Table 9: Rates for Most Effective/ Moderately Effective Contraception and LARCs in HTW Clients. Changes Across Time

Year	HTW Clients (Measure Denominator)[1]	Clients Receiving Most/ Moderately Effective Contraceptives	Percent (%)	Clients Receiving LARCs	Percent (%)
2017	66,906	15,721	23.5%	2,165	3.2%
2018	78,961	18,165	23.0%	2,649	3.4%
2019	86,601	22,664	26.2%	3,656	4.2%
2020	223,872	42,197	18.8%	7,553	3.4%
2021	310,845	44,158	14.2%	7,766	2.5%
Annual Pre-HTW Demonstration Average (2017-2019)	77,489	18,850	24.2%	2,823	3.6%
Annual Post - HTW Demonstration Average (2020-2021)	267,359	43,178	16.5%	7,660	2.9%
Pre/Post Diff.	189,869	24,328	-7.7%	4,836	-0.7%
% Change[2]			*-31.8%*		*-18.5%*
p-value[3]			<0.001		<0.001

Notes. [1] HTW clients age 18 to 44 at end of the demonstration year (DY) and continuously enrolled who were not pregnant during DY, pregnant during DY but whose pregnancy ended in first 10 months, or pregnant during DY but whose pregnancy ended in ectopic pregnancy, stillbirth, miscarriage, or induced abortion are included. HTW clients who were infertile, had live birth in last 2 months of DY, or were still pregnant at end of DY are excluded. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-demonstration periods by the value of the measure at the pre-demonstration period. [3] P-values are reported from Chi-square tests.

LARC utilization was 3.2 percent at the beginning of the study period (2017) but had dropped to 2.5 percent by 2021. The annual average for the pre-Demonstration period was 3.6 percent and 2.9 percent during the post-Demonstration period (2020-2021). This 0.7 percent point difference translated to an 18.5 percent reduction in the number of HTW clients receiving LARCs. As can be seen in Figure 11, both contraceptive measures had their highest utilization rates in 2019 and then decreased in subsequent years.

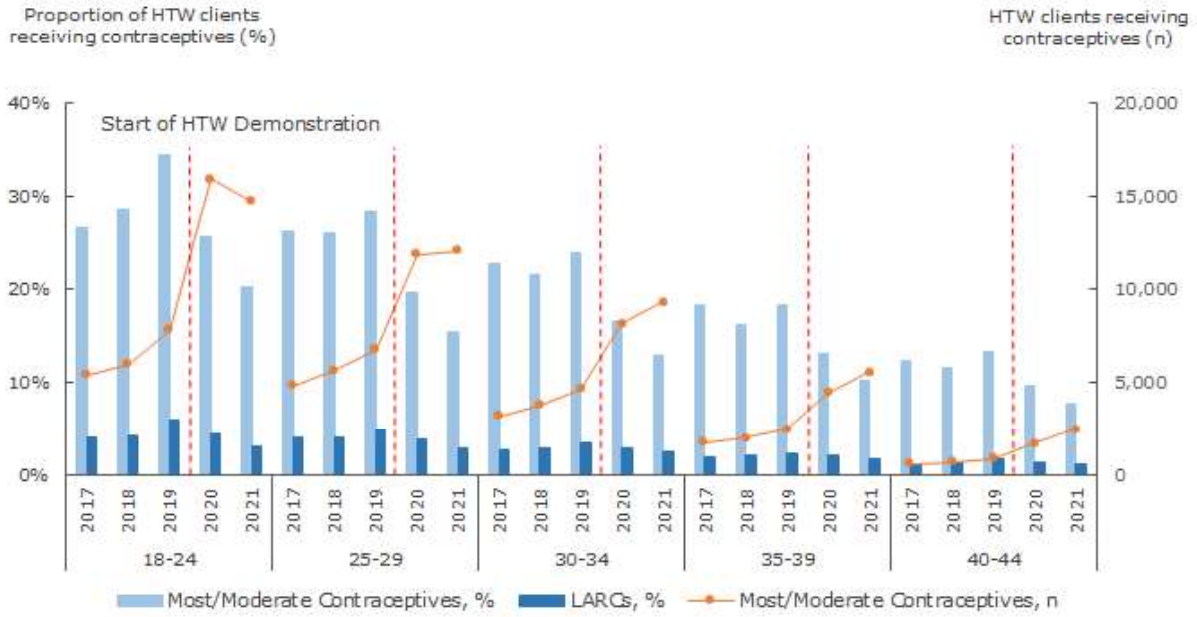
Figure 11: Trends in Rates for Most Effective/ Moderately Effective Contraception and LARCs in HTW Clients through Time



Notes. HTW clients age 18 to 44 at the end of the demonstration year (DY) and continuously enrolled who were not pregnant during DY, pregnant during DY but whose pregnancy ended in first 10 months, or pregnant during DY but whose pregnancy ended in ectopic pregnancy, stillbirth, miscarriage, or induced abortion are included. HTW clients who were infertile, had live birth in the last 2 months of DY, or were still pregnant at the end of DY are excluded. The light blue bar presents the proportion of HTW clients who received a most or moderately effective method of contraception in DY. The dark blue bar presents the proportion of HTW clients receiving a long-acting reversible method of contraception (LARC). The solid line shows total number of unduplicated HTW clients receiving a most or moderately effective method of contraception in DY.

Women aged 18 to 24 or 25 to 29 were more likely to be using any of the contraceptive methods measured. Detailed tables in *Appendix B: Additional Results* show variation across time, age, race/ethnicity, and regions for both contraceptive measures. Though utilization decreased across all age groups and methods, the youngest group (18-24) had the smallest proportional reduction in the use of most/moderately effective methods, a 7.6 percent points (25.3% reduction) reduction when comparing the pre- to the post-Demonstration periods. The inverse was true for the use of LARCs, where women aged 18 to 24 or 25 to 29 had the largest proportional reductions. Women in these age groups reduced LARC utilization by approximately one percent point post-HTW Demonstration (a 19.2 percent and 22.3 percent reduction, respectively). Figure 12 visualizes the trends described for the age groups.

Figure 12: Trends in Use of Most/ Moderately Effective Contraceptives and LARCs by Age Groups



Notes. HTW clients age 18 to 44 at end of the demonstration year (DY) and continuously enrolled who were not pregnant during DY, pregnant during DY but whose pregnancy ended in first 10 months, or pregnant during DY but whose pregnancy ended in ectopic pregnancy, stillbirth, miscarriage, or induced abortion are included. HTW clients who were infertile, had live birth in last 2 months of DY, or were still pregnant at end of DY are excluded. The light blue bar presents the proportion of HTW clients who received a most or moderately effective method of contraception in DY. The dark blue bar presents the proportion of HTW clients receiving a long-acting reversible method of contraception (LARC). The solid line shows total number of unduplicated HTW clients receiving a most or moderately effective method of contraception in DY.

The decline in Most/ Moderately Effective Contraceptive and LARCs use was also evident across all different racial and ethnic groups, though the average reduction was higher among White Non-Hispanics. Please refer to *Appendix B: Additional Results* for tables and figures by subgroups.

The evaluation of changes in contraceptive use by Public Health Regions showed in general reductions between pre- and post-Demonstration periods, which aligned with the State's overall trend. However, Region 11 grew its contraceptive use, both for Most/ Moderately Effective Contraceptives and LARCs by 1.7 percent and 25.1 percent respectively. The table below (Table 10) summarizes these findings. Detailed analysis by regions and other subgroups can be found in *Appendix B: Additional Results.*

Table 10: Changes Between Pre- and Post-HTW Demonstration Years in Average Rate of Contraceptives Used

Public Health Region	Most/ Moderately Effective Contraceptive (% Change[1])	LARC (% Change[1])
1	-27.2%	-7.2%
2	-33.9%	-11.8%
3	-37.1%	-31.1%
4	-45.6%	-28.4%
5	-36.0%	-6.0%
6	-32.3%	-19.4%
7	-42.1%	-14.8%
8	-41.8%	-37.9%
9	-38.3%	22.0%
10	-44.3%	-31.6%
11	3.7%	24.9%
Region Unknown	31.9%	82.7%

Reduction Higher than State
Reduction Smaller than State
Increased

Notes. [1] Percent (%) change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period.

Use of most or moderately effective contraceptive methods among Medicaid clients declined (2 percent points) as well from 2017 to 2021, though LARC utilization actually grew during this same period from 7.4 percent (2017) to 9.1 percent (2021).[15] There is ample evidence in the literature that women, in particular those without insurance and facing economic hardships, were significantly more likely to experience barriers in accessing contraceptive care during the pandemic years.[15-17] Without an appropriate comparison group and within the context of the pandemic, it is difficult to evaluate the effect of the Demonstration itself in access to contraceptive care. A better evaluation will be possible for the summative evaluation report, where additional years of data will be available.

Testing for Sexually Transmitted Infections/Disease (Measure 2.1.3)

The CMS-approved Evaluation Design asked for the assessment of total number of unduplicated clients with at least one test for any sexually transmitted infection (STI) per year over the total number of unduplicated clients during that year. This rate decreased from 23.8 percent in 2017 to 20.0 percent in 2021. The average

annual rate for the pre-HTW Demonstration period was 22.8 and that for the post-HTW Demonstration 22.2, not a significant change. In addition to the measure required in the CMS-approved Evaluation Design. UTHealth CHCD examined differences in chlamydia screenings to allow for comparisons and benchmarking with other standard reporting. The Medicaid Core Set of Adult Health Care Quality Measures[14] recommends Medicaid programs assess "Testing for Chlamydia" among actively sexual women ages 21 to 24 continuously enrolled in the year of measurement. This measure is also employed by Texas to evaluate testing for STI among its Managed Care Organization (MCO) plans.[18] Additionally, this measure is reported by commercial plans under their Healthcare Effectiveness Data and Information Set (HEDIS) reporting.[19] Details on this measure can be found in *Appendix A: Methods.*

As can be seen on Table 11, the proportion of sexually active women aged 21 to 24 who were screened for chlamydia infection changed very little over time with no significant trend. The annual average rate pre-HTW Demonstration was 66.8 percent and decreased by only one percentage point to 65.9 percent post-HTW Demonstration.

Table 11: Chlamydia Screening Rates by Year, Averages and Changes Pre- and Post-HTW Demonstration

Year	Eligible Population (HTW clients 21-24 years old)[1]	Chlamydia Screening	Percent (%) Chlamydia Screening
2017	18,720	12,685	67.8%
2018	19,927	13,250	66.5%
2019	21,416	14,196	66.3%
2020	25,311	16,395	64.8%
2021	22,006	14,742	67.0%
Annual Pre-HTW Demonstration Average (2017-2019)	20,021	13,377	66.8%
Annual Post -HTW Demonstration Average (2020-2021)	23,659	15,569	65.8%
Pre/Post Diff.	3,638	2,192	-1.0%
% Change[2]			*-1.5%*
p-value[3]			*0.001*

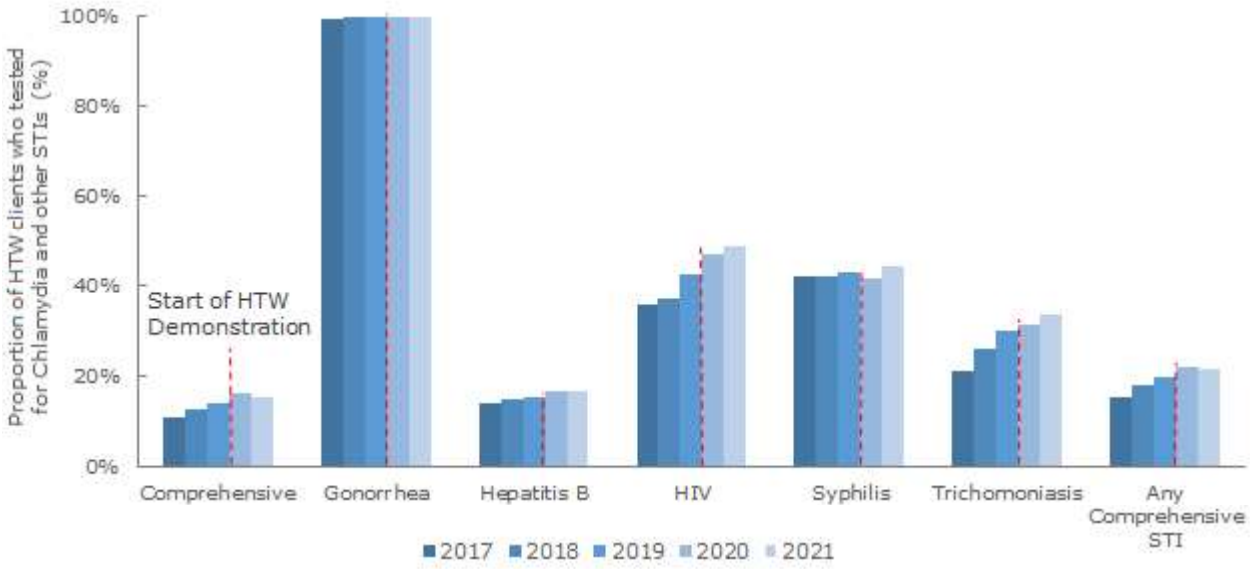
Notes. [1] HTW clients age 21-24 at end of the demonstration year (DY) and continuously enrolled who tested for chlamydia are included. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [3] P-values are reported from Chi-square tests.

Changes in screening rates pre- and post-Demonstration were very similar across all racial/ethnic groups ranging from a 0.7 percentage point reduction among White non-Hispanics, a 1.4 percentage point reduction among Hispanics, and a 1.3 percentage point reduction among Black, non-Hispanic women. Finally, Public Health Region 11 had higher screening rates than the State's with values ranging from 76 percent to 82 percent, which was on average 13 percentage points above the state mean (19.5% higher). Detailed tables for all subgroup analyses can be found in *Appendix B: Additional Results*.

Chlamydia screening rates for women in the HTW Demonstration were slightly higher than those reported for the overall Texas Medicaid population during the same time frame, which started as 61.5 percent in 2017 and decreased to 55.4 percent in 2021. In fact, chlamydia screening, which was almost unchanged among the HTW population, decreased by almost 10 percentage points on average during the same period among Medicaid recipients.[20]

According to the Center for Disease Control[10] and the US Preventive Services Task Force (USPSTF),[11] sexually active women who are at risk for STIs should also be screened for gonorrhea. UTHealth CHCD, therefore, also examined whether women in HTW screened for chlamydia were screened for other STIs, including gonorrhea, other STIs and a comprehensive STI screening code. As can be seen in Figure 13, almost 100 percent of women tested for chlamydia were also tested for gonorrhea, in accordance with USPSTF recommendations. Additionally, screening for other STIs grew through time.

Figure 13: Screening Trends for Other Sexually Transmitted Infections Among HTW Clients Tested for Chlamydia



Notes. HTW clients age 21-24 at end of the demonstration year (DY) and continuously enrolled who tested for chlamydia are included. Percentages of HTW clients who were also screened for other sexually transmitted infections (STI) are reported. Comprehensive screening includes testing for multiple organisms. Any comprehensive STI screening includes testing for any of the following diseases: Gonorrhea, Hepatitis B, HIV, Syphilis, and Trichomoniasis.

Utilization of Preconception Care Services Among HTW Clients

The HTW Demonstration will maintain or increase utilization of preconception care services among HTW clients (Hypothesis 2.2)

This hypothesis is being evaluated through the following measure:

2.2.1. Compliance with cervical cancer screening recommendations

Compliance with Cervical Cancer Screening (CCS) Recommendations (Measure 2.2.1)

The assessment of this hypothesis was done by evaluating adherence to guideline recommendations for cervical cancer screening (CCS). For this purpose, we used the CCS measure recommended by the Medicaid Core Set of Adult's Health Care Quality Measures.[14] According to the measure specifications, women should be considered as having been screened for cervical cancer if they meet any of the following criteria:

- Women aged 21 or older who had cervical cytology performed within the last 3 years
- Women aged 30 or older who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years
- Women aged 30 or older who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing (or within four days of each other) within the last 5 years.

The required look-back period was 3 to 5 years. For this interim report, we were only able to evaluate years 2019 through 2021 using a 3-year look-back period for each measurement year, which complied with cervical cytology requirements but truncated the measurement of hrHPV. For the reporting year 2019, we used 2017-2019 data, for the measurement year 2020, 2018 through 2020, and for 2021, 2019 through 2021. All hrHPV testing was measured using only three retrospective years, though official recommendations suggest at least once every five years. Therefore, comparisons with other national and state benchmarks should be avoided as rates are not comparable. For the purpose of being able to compare with other external reports, we report a separate rate "CCS Rate for 2021", that uses 5 years of historical data to fully assess CCS as specified by CMS.

Table 12 shows the rates estimated for CCS using a 3-year lookback period. Using this approach, rates declined from 54 percent in 2019 to 38 percent in 2021. Notably, the measure report for 2021 covers screening that occurred from 2019 through 2021 and therefore includes 2 years of pandemic data.

Table 12: Partial 3 years Cervical Cancer Screening Measure for 2019-2021

Year	Eligible population[1]	Cervix Cytology testing	hrHPV[2] testing	HPV or Cervix Cytology Lab	Cervical Cancer Screening Rate (%)
2019	22,321	11,856	6,237	11,969	53.6%
2020	40,269	19,363	10,487	19,557	48.6%
2021	89,963	34,038	18,928	34,291	38.1%

Notes. [1] HTW clients age 21 or older at end of the demonstration year (DY) and continuously enrolled during past 3 years including DY are included. HTW clients who had one or more gaps in HTW enrollment lasting more than 45 days (or more than one month if enrollment determined monthly), received hospice care or had hysterectomy any time during the client's history through end of DY are excluded. [2] hrHPV, High-Risk Human Papilloma Virus testing.

There is evidence in the literature of moderate declines in CCS, approximately 11 percent, during 2020 as compared to previous years (2018) using Behavioral Risk Factor Surveillance System data.[21] Though we were not able to assess trends or perform before and after comparisons relative to the HTW Demonstration for this interim report, our 3-year CCS aligns with what can be expected based on the

literature. The 2020 rate decreased by 5 percentage points, (9% reduction) with respect to 2019, similar to what was described. By 2021, the decline was more pronounced, 10 percentage points lower than in 2020 (22% reduction). Since the 2020 rate includes one year of data occurring during the pandemic, and 2021 includes two years, it is reasonable to assume effects of the pandemic could have accumulated. As mentioned, caution should be used in the interpretation of these results.

The full assessment of 2021 CCS rates using five years of historical data shows a screening rate of 60 percent. As can be seen in Table 13, the eligible population decreased considerably compared to the report for 3-year measures as it required five years of continuous enrollment. Information pulled on 2021 Texas Adult Medicaid Cervical Cancer Screening (CCS)[20], following the same specification, shows a screening rate of 57.2 percent. Though we cannot fully assess a trend or changes between pre- and post-HTW Demonstration implementation for CCS, we can see that CCS rates in 2021 were similar to those reported for other women in Medicaid Texas.

Table 13: 2021 Texas Adult Medicaid Cervical Cancer Screening (CCS)

Measure in 2021	Eligible population[1]	hrHPV[2] or Cervix Cytology Lab	Cervical Cancer Screening Rate
CCS[1] for the HTW population	11,299	6,820	60.4%
CCS[1] for the Texas Medicaid	400,865	229,295	57.2%

Notes. [1] CCS: Cervical Cancer Screening. [2] hrHPV: High-Risk Human Papilloma Virus testing.

Detailed information on subgroup analysis for the 2021 Cervical Cancer Screening measure can be found in *Appendix B: Additional Results*.

Health Outcomes

This section reports on findings from the assessment of two hypotheses focused on evaluating the potential effects of the HTW Demonstration on women's health and pregnancy outcomes.

The HTW Demonstration will maintain or improve women's health among HTW clients (Hypothesis 3.1).

We evaluated whether there had been changes in women's health among HTW enrollees pre- and post-HTW Demonstration by assessing adherence to

medication for chronic conditions whose screening and pharmacological treatment are covered under the HTW program. These measures included:

3.1.1 Hypertension medication adherence

3.1.2 Diabetes medication adherence

3.1.3 Cholesterol medication adherence

3.1.4 Antidepressant medication management: effective acute and continuation phase treatment

The HTW Demonstration will maintain or improve maternal health and pregnancy outcomes among HTW clients (Hypothesis 3.2)

We assessed whether there had been changes in maternal health and pregnancy outcomes among low-income women in Texas post-HTW Demonstration through the following measures:

3.2.1 Unintended pregnancies

3.2.2 Birth spacing

3.2.3 Pregnancy complications: gestational diabetes, gestational hypertension, and preeclampsia

3.2.4 Adverse birth outcomes: low birth weight and preterm births

3.2.5 Severe maternal morbidity

Most of these measures were assessed through quantitative analysis of Texas HTW and Medicaid claims data. The evaluation of unintended pregnancies (3.2.1) required the use of data prepared by the Department of State Health Services (DSHS) Maternal and Child Health Epidemiology Unit, which was pulled from the Pregnancy Risk Assessment Monitoring System (PRAMS). The evaluation of birth spacing (3.2.2), pregnancy- and birth-related complications (3.2.3 and 3.2.5), and adverse birth outcomes (3.2.4) was based on Medicaid claims and encounters data, as well as a crosswalk provided by HHSC that linked maternal client IDs to newborn client IDs (used to examine low birth weight and preterm births), for deliveries occurring in 2018 and 2021. Explanations of the approach used can be found under each measure and detailed methods information in *Appendix A: Methods*.

Effect of the HTW Demonstration on Women's Health (Measures 3.1.1-3.1.4)

Women's health was evaluated by assessing HTW clients' adherence to medication for diabetes, hypertension, and hypercholesterolemia as well as the initiation and continuation of treatment for antidepressant medication among those who needed

it. HTW benefits pre- and post-HTW Demonstration include screening and pharmaceutical treatment of hypercholesterolemia, diabetes, hypertension, and depression. To evaluate adherence to hypertension, diabetes, and hypercholesterolemia treatment, we used the proportion of days covered (PDC) measures specified in the CMS-approved Evaluation Design, and developed by the Pharmacy Quality Alliance.[34] To evaluate antidepressant medication management, as required by the CMS-approved Evaluation Design, we relied on measures developed and specified under Adults Health Care Quality Measures for Medicaid,[14] a National Committee for Quality Assurance measure. This measure assesses two rates, acute-phase phase treatment (initial 12 weeks) and continuation phase (6 months).

Table 14 below depicts the disease prevalence for hypertension, diabetes, hypercholesterolemia and depression among women enrolled in HTW pre- and post-HTW Demonstration. Importantly, not all women with these diagnoses required pharmacological treatment. As mentioned, as of March 2020, HTW and Medicaid clients were not required to go through re-assessment of their eligibility and could stay enrolled in their respective programs.[4] Under measure 1.1.1, we established that this created changes in the HTW Demonstration population when compared to the pre-Demonstration population. Women enrolled after March 2020 tended to be slightly older as well as less likely to be in their postpartum year. These changes can affect the prevalence of chronic disease. In fact, the prevalence of hypertension, which is low in this population, grew 0.46 percentage points (60.0% change) post-HTW Demonstration, hypercholesterolemia grew 0.33 percentage points (28% change) and depression grew by 0.22 percentage points (12.6% change). However, diabetes decreased by 0.17 percentage points (10.4% change) post-HTW Demonstration. All these changes were statistically significant.

Table 14: Prevalence of Select Chronic Health Conditions, Pre- and Post-HTW Demonstration Averages and Changes

Year	HTW Clients	Hypertension[1]		Diabetes[1]		Hyperchole-sterolemia[1]		Depression[1]	
		N	Prev. (%)	N	Prev. (%)	N	Prev. (%)	N	Prev. (%)
2017	344,920	2,299	0.67%	5,326	1.54%	3,553	1.03%	5,823	1.69%
2018	445,094	3,321	0.75%	7,486	1.68%	5,217	1.17%	7,866	1.77%
2019	497,107	4,266	0.86%	8,257	1.66%	6,285	1.26%	9,185	1.85%
2020	436,545	4,955	1.14%	6,096	1.40%	6,107	1.40%	8,810	2.02%
2021	453,316	5,979	1.32%	6,954	1.53%	7,227	1.59%	9,003	1.99%
Annual Pre-HTW Demonstration Average (2017-2019)	429,040	3,295	0.77%	7,023	1.64%	5,018	1.17%	7,625	1.78%
Annual Post - HTW Demonstration Average (2020-2021)	444,931	5,467	1.23%	6,525	1.47%	6,667	1.50%	8,907	2.00%
Pre/Post Diff.			0.46%		-0.17%		0.33%		0.22%
% Change[2]			*60.0%*		*-10.4%*		*28.1%*		*12.6%*
p-value[3]			<0.001		<0.001		<0.001		<0.001

Notes. [1] These conditions were determined based on ICD-10 Diagnoses. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [3] P-values are reported from Chi-square tests.

Adherence, to medication for hypertension, diabetes, and hypercholesterolemia treatment all decreased significantly post-HTW Demonstration. Adherence to antihypertensive medication decreased by 5.9 percentage points, and adherence to diabetes and high cholesterol medication by 2.8 and 5.3 percentage points, respectively, when comparing the averages of the pre-HTW Demonstration years with those of the post-HTW Demonstration years.

Table 15: Medication Adherence Among Those with Prescriptions for the Treatment of Hypertension, Diabetes, and Hypercholesterolemia

Year	Hypertension		Diabetes		Hypercholesterolemia	
	HTW Clients Treated with Medication[1]	Medication Adherence (%)[2]	HTW Clients Treated with Medication[1]	Medication Adherence (%)[2]	HTW Clients Treated with Medication[1]	Medication Adherence (%)[2]
2017	600	25.2%	680	21.2%	208	22.2%
2018	607	27.9%	965	23.0%	273	23.9%
2019	566	30.3%	991	24.7%	287	25.1%
2020	571	23.5%	916	21.0%	383	19.6%
2021	695	20.5%	1,047	19.7%	526	17.8%
Annual Pre-HTW Demonstration Average (2017-2019)	591	27.7%	879	23.2%	256	23.9%
Annual Post - HTW Demonstration Average (2020-2021)	633	21.9%	982	20.3%	454	18.6%
Pre/Post Diff.	42	-5.9%	103	-2.8%	198	-5.3%
% Change[3]	*7.1%*	*-21.1%*	*11.7%*	*-12.3%*	*77.4%*	*-22.2%*
p-value[4]		0.002		0.042		0.018

Notes. [1] HTW clients are only included if the first fill of their medication occurs at least 91 days before the end of the enrollment period and weighted by the month of enrollment. [2] Medication adherence reports the proportion of HTW clients filled their prescription often enough to cover 80 percent or more of the measurement period weighted by the months of enrollments. [3] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration. [4] P-values are reported for statistical significance of the rate difference using Poisson regression.

The proportion of individuals meeting the antidepressant medication management rates grew post-HTW Demonstration implementation. The Effective Acute Phase Treatment grew by 5.2 percentage points (12.1% change; p-value = 0.078), and the Effective Continuation Phase Treatment rate grew by 5.3 percentage points, or 28.8 percent change (p-value = 0.008) post-HTW Demonstration (see Table 16).

Table 16: Antidepressant Medication Management: Acute and Continuation Phase

Year	HTW Clients Treated with Antidepressant Medication[1]	Rate of Effective Acute Phase Treatment (%)[2]	Rate of Effective Continuation Phase Treatment (%)[2]
2017	131	39.4%	8.9%
2018	338	44.5%	21.4%
2019	456	42.6%	19.0%
2020	853	43.6%	20.5%
2021	619	54.0%	28.2%
Annual Pre-HTW Demonstration Average (2017-2019)	308	42.9%	18.5%
Annual Post-HTW Demonstration Average (2020-2021)	736	48.0%	23.8%
Pre/Post Diff.	428	5.2%	5.3%
% Change[3]	*138.7%*	*12.1%*	*28.8%*
p-value[4]		0.078	0.008

Notes. [1] HTW clients who were treated with antidepressant medication, had a diagnosis of major depression, and had continuous enrollment 105 days prior to the earliest prescription dispensing date for antidepressant medication through 231 days are included. [2] Rates are weighted by the month of enrollment and calculated as Member Years for HTW clients divided by Member Years for HTW with adherence. [3] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-demonstration periods by the value of the measure at the pre-demonstration period. [4] P-values are reported for statistical significance of the rate difference using Poisson regression.

The prevalence for the four conditions assessed in this section was relatively low among HTW clients, all of them below two percent. Measures 3.1.1 through 3.1.3 required, as specified in the CMS-approved Evaluation Design, having at least 2 prescriptions to be included in the measure. Similarly, Measure 3.1.4 required continuous enrollment in a given year and at least one prescription for antidepressant medication. This meant, very few individuals met the inclusion criteria for these measures as can be seen in Table 15 and 16. This needs to be considered when interpreting the findings.

As part of a sensitivity analysis on the adherence measures (3.1.1 -3.1.3) we re-ran analyses limiting the denominator in each measure to individuals who had 12 months of continuous enrollment. Detailed tables with these results are available in *Appendix B: Additional Results.* Overall, changes pre- and post-HTW Demonstration were not statistically significant, and the sample size decreased substantially.

Effect of the HTW Demonstration on Pregnancy Outcomes (Measures 3.2.1-3.2.5)

Approach and Analysis

Unintended pregnancies (3.2.1) were assessed using data from the PRAMS survey specific to Texas. This is a surveillance system designed to monitor maternal attitudes and behaviors before, during, and after pregnancy. Conducted in partnership with the Center for Disease Control and Prevention (CDC) and the Texas DSHS, Texas PRAMS is a statewide population-based assessment that monitors the health and behaviors of new mothers in Texas. Approximately half of the births in the PRAMS sample are paid by Medicaid, and the survey allows for stratification by payer type. However, it is not specific to HTW clients, so results are reported for the overall Medicaid population. PRAMS data includes a two-year lag from the birth year. Therefore, the interim report includes PRAMS data on unintended pregnancies from 2017 through 2021.

The assessment of pregnancy intention is done using the following question:

"Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?". The potential answers are classified as "I wanted to be pregnant later" (unintended), "I wanted to be pregnant then or sooner" (intended), "I didn't want to become pregnant then or any time in the future" (unintended); "I wasn't sure what I wanted" (not sure).

Descriptive trend analysis and plotting was done to evaluate this measure, looking into results for the Medicaid population and that for overall Texas.

The assessment of pregnancy complications (Measure 3.2.3), severe maternal morbidity (Measure 3.2.5), and newborn delivery outcomes (Measure 3.2.4) was done as a retrospective evaluation of women delivering under Texas STAR Medicaid (2018 and 2021), comparing results by HTW enrollment status the year before their delivery (2017 and 2020). All Medicaid deliveries that were under a program other than STAR Medicaid, such as Emergency Medicaid or other Medicaid or CHIP programs (STAR Health, STAR+PLUS, STAR KIDS, CHIP, CHIP-Perinate) were excluded to allow for better comparisons. This was done to exclude women who would not have been eligible for HTW prior to delivery, for example, due to immigration status or eligibility for other Medicaid coverage.[22]

The analysis was done using a Difference-in-differences (DID) model. DID mimics an experimental study by examining the average change in individual-level

outcomes for intervention and comparison group clients over time and helps mitigate selection concerns that might exist with a single cross-sectional comparison between groups. A common concern with DID models used for policy evaluations is that the control and intervention groups may differ in ways that are related to their trends over time, or their compositions may change over time. To address this, we conducted a DID analysis using propensity score weighted linear regression model suggested by Stuart et al.[23] We included age, race/ethnicity, and maternal comorbidities using the conditions and specifications from the Maternal Comorbidity Index (MCI) to create propensity scores.[24] Given that some conditions listed within the MCI overlapped with our outcome measures (such as gestational diabetes, gestational hypertension or a number of severe maternal morbidity (SMM) conditions) separate models were run for each analysis to create weights that did not account for the condition being evaluated in the adjustment. This allowed for the assessment and subsequent adjustment of our measures by demographics and appropriate maternal comorbidities. Further details on the methods used in this interim report for each measure are available in *Appendix A: Methods.* These methods, including sample identification, matching techniques and comorbidity weights, will be reviewed and refined for the summative report, especially in light of the PHE-related maintenance of eligibility policies that may alter HTW enrollment the year prior to their delivery for women who gave birth in 2021.

Tables 17 and 18 describes the four groups created for this evaluation and their characteristics. These groups are defined by their delivery being pre-HTW Demonstration (2018) or post-HTW Demonstration implementation (2021) and by the mother's enrollment in HTW the year prior to the delivery (HTW and Non-HTW clients enrolled in 2017 and 2020, respectively). Women not enrolled in HTW the year prior to their delivery reflects women who were not enrolled in HTW or Medicaid. However, for the ease of interpretation, this group of women is referred to as "Non-HTW clients" for the remainder of this section. As can be seen, some differences across groups, though small in magnitude, are statistically significant.

Mothers with preexisting hypertension and pre-existing diabetes were excluded from the pregnancy complication assessment (Measure 3.2.3) to avoid potential bias or measurement errors. We found that mothers who had diabetes before being pregnant were frequently flagged as having gestational diabetes during their pregnancy. Therefore, to facilitate comparison and reduce the risk of measurement biases due to diagnosis recording, we excluded them from the analysis.

Table 17: Description of Study Population for Pregnancy Complications and Severe Maternal Morbidity

	Total	Medicaid-paid Births in 2018 with HTW Enrollment During the Previous Year (1)	Medicaid-paid Births in 2021 with HTW Enrollment During the Previous Year (2)	Medicaid-paid Births in 2018 with No HTW Enrollment During the Previous Year (3)	Medicaid-paid Births in 2021 with No HTW Enrollment During the Previous Year (4)
Number of Deliveries	247,739	27,188	21,143	122,948	76,460
Maternal Age, Median (IQR)	25 (22-30)	26 (23-30)	27 (23-30)	25 (22-29)	26 (22-30)
Race/ Ethnicity					
NH White	56,620 (22.9)	5,272 (19.4)	4,076 (19.3)	29,842 (24.3)	17,430 (22.8)
NH Black	45,076 (18.2)	6,092 (22.4)	4,495 (21.3)	21,172 (17.2)	13,317 (17.4)
Hispanic	132,351 (53.4)	14,707 (54.1)	11,764 (55.6)	64,581 (52.5)	41,299 (54.0)
Other/ Unknown	13,692 (5.5)	1,117 (4.1)	808 (3.8)	7,353 (6.0)	4,414 (5.8)
Public Health Region					
1	8,929 (3.6)	1,096 (4.0)	768 (3.6)	4,262 (3.5)	2,803 (3.7)
2	5,519 (2.2)	660 (2.4)	464 (2.2)	2,675 (2.2)	1,720 (2.2)
3	56,322 (22.7)	5,437 (20.0)	4,436 (21.0)	28,434 (23.1)	18,015 (23.6)
4	12,010 (4.8)	1,257 (4.6)	1,052 (5.0)	5,893 (4.8)	3,808 (5.0)
5	8,449 (3.4)	1,047 (3.9)	775 (3.7)	4,075 (3.3)	2,552 (3.3)
6	59,106 (23.9)	6,413 (23.6)	5,103 (24.1)	29,266 (23.8)	18,324 (24.0)
7	20,679 (8.3)	2,216 (8.2)	1,761 (8.3)	10,125 (8.2)	6,577 (8.6)
8	28,756 (11.6)	3,326 (12.2)	2,462 (11.6)	14,474 (11.8)	8,494 (11.1)
9	8,298 (3.3)	858 (3.2)	610 (2.9)	4,261 (3.5)	2,569 (3.4)
10	9,145 (3.7)	1,086 (4.0)	752 (3.6)	4,600 (3.7)	2,707 (3.5)
11	30,526 (12.3)	3,792 (13.9)	2,960 (14.0)	14,883 (12.1)	8,891 (11.6)

Notes. All numbers present the number and percentage of deliveries except for maternal age that presents median age and interquartile range (IQR). Maternal comorbidities and severe maternal morbidity were identified from Medicaid paid birth hospitalization claims.

Table 18: Description of Study Population for Pregnancy Complications and Severe Maternal Morbidity Continued

	Total	Medicaid-paid Births in 2018 with HTW Enrollment During the Previous Year (1)	Medicaid-paid Births in 2021 with HTW Enrollment During the Previous Year (2)	Medicaid-paid Births in 2018 with No HTW Enrollment During the Previous Year (3)	Medicaid-paid Births in 2021 with No HTW Enrollment During the Previous Year (4)
Maternal Comorbidities					
Any	145,784 (58.8)	17,373 (63.9)	13,035 (61.7)	71,860 (58.4)	43,516 (56.9)
Obstetrics	93,687 (37.8)	11,014 (40.5)	8,870 (42.0)	44,929 (36.5)	28,874 (37.8)
General Health	85,099 (34.4)	10,439 (38.4)	7,158 (33.9)	42,813 (34.8)	24,689 (32.3)
Substance Use	21,625 (8.7)	3,148 (11.6)	1,609 (7.6)	11,807 (9.6)	5,061 (6.6)
Autoimmune	2,445 (1.0)	344 (1.3)	239 (1.1)	1,155 (0.9)	707 (0.9)
Cardio	1,016 (0.4)	114 (0.4)	85 (0.4)	511 (0.4)	306 (0.4)
Renal	442 (0.2)	60 (0.2)	35 (0.2)	218 (0.2)	129 (0.2)
COVID at Delivery	3,793 (1.5)		898 (4.2)		2,895 (3.8)
Pregnancy Complications					
Any	47,534 (19.2)	4,731 (17.4)	4,289 (20.3)	22,047 (17.9)	16,467 (21.5)
High Blood Pressure	17,933 (7.2)	1,746 (6.4)	1,499 (7.1)	8,557 (7.0)	6,131 (8.0)
Gestational Diabetes	19,387 (7.8)	2,137 (7.9)	1,922 (9.1)	8,911 (7.2)	6,417 (8.4)
Preeclampsia	17,126 (6.9)	1,545 (5.7)	1,416 (6.7)	7,930 (6.4)	6,235 (8.2)
Adverse Birth Outcomes					
Low Birth Weight	20,312 (8.2)	2,245 (8.3)	1,763 (8.3)	9,545 (7.8)	6,759 (8.8)
Preterm Birth	27,112 (10.9)	3,141 (11.6)	2,512 (11.9)	12,660 (10.3)	8,799 (11.5)
Severe Maternal Morbidity	3,815 (1.5)	373 (1.4)	421 (2.0)	1,648 (1.3)	1,373 (1.8)

Notes. All numbers present the number and percentage of deliveries. Maternal comorbidities and severe maternal morbidity were identified from Medicaid paid birth hospitalization claims.

As mentioned, to avoid biases due to group differences, the analysis of measures 3.2.3 through 3.2.5 used propensity score weighted linear regression models. After this, the standardized mean difference between groups across all measures described on table 17 and 18 was never greater than 0.03. The propensity score weighted standardized mean difference for all aspects considered for each measure can be found in *Appendix B: Additional Results*. Details on the specific outcome and measure specifications are provided under each section, and additional information about Approach, Methods, and Analysis can be found in *Appendix A: Methods.*

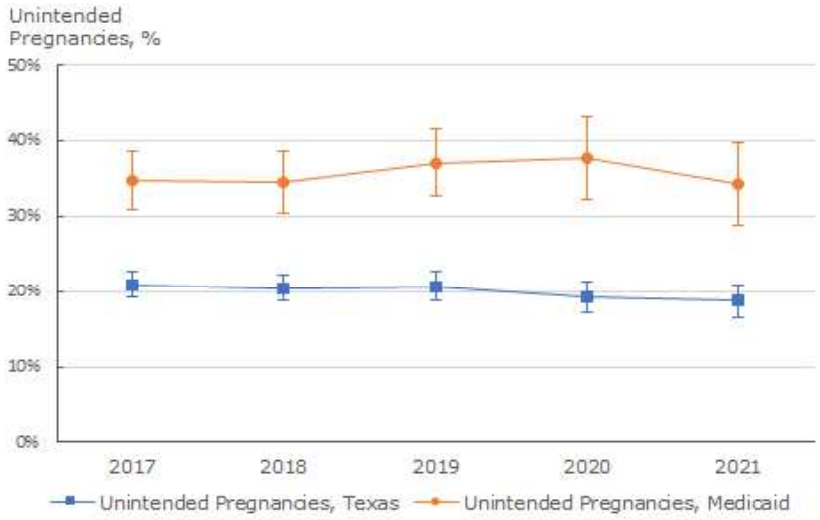
For the interim report, Measure 3.2.2, pertaining to birth spacing, had to rely only on 2018 Medicaid STAR live birth and their associated data as it required 27 months of prospective follow-up and therefore has a different population than the remaining three measures (3.2.3-3.2.5). The descriptive table for that sub-cohort can be found in *Appendix B: Additional Results*. Crude Risk Ratio and Adjusted Risk Ratio comparing those with HTW vs. non-HTW enrollment and accounting for age, race, ethnicity, and MCI were created using Modified Poisson regression.

Unintended Pregnancies (3.2.1)

As mentioned, this was assessed using data from the PRAMS survey specific to Texas. Though the survey allows for stratification by payer type, it does not differentiate between women with or without HTW enrollment. Therefore, results are reported for the overall Medicaid population. The rate of unintended pregnancies in Texas ranged from 18.7 percent to 20.9 percent, though confidence intervals across years overlapped, and there was no significant difference pre and post-HTW Demonstration (Figure 14). The rate of unintended pregnancies for women who were enrolled in Medicaid at the time of the delivery was consistently higher than the statewide rate, ranging from 34.2 percent to 37.8 percent. Differences within this group across years were not significant pre- and post-HTW Demonstration. Therefore, based on the data available, unintended pregnancy rates were not significantly changed among Medicaid-insured women pre- and post-HTW Demonstration.

It should be noted that for 2017 through 2021, the response rate was below the 50 percent threshold, and both the CDC and Texas Department of State Health Services recommended results should be interpreted cautiously.

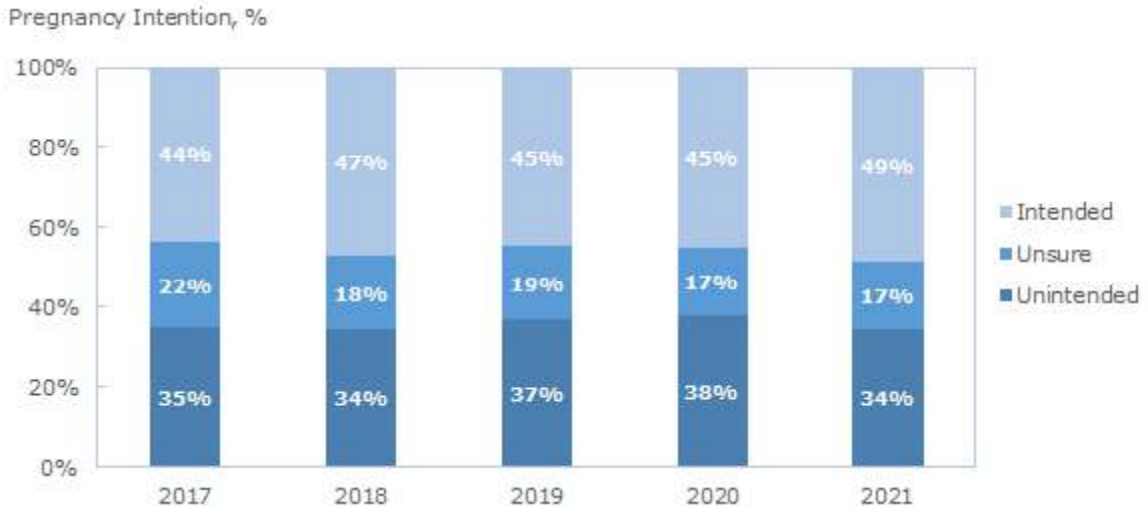
Figure 14: Unintended Pregnancy Rate for Texas and Texas Medicaid.



Notes. Error bars represent 95% confidence intervals.

As noted above, potential responses to pregnancy intention were categorized as unintended, intended, and not sure. Among women enrolled in Medicaid, women were most likely to indicate their pregnancy was intended (ranged from 43.6 percent to 48.7 percent). There were no statistically significant changes through time, however. Figure 15 shows the different proportions of responses to the pregnancy intendedness question and changes across time.

Figure 15: Pregnancy Intention, Texas Medicaid (2018-2021)



Birth Spacing (3.2.2)

The assessment of birth spacing among HTW clients required identifying all Medicaid live births and following mothers for 27 months to identify a subsequent delivery (short interbirth interval). Short interbirth intervals, particularly periods shorter than 6 or 12 months, have been associated with adverse maternal and neonatal outcomes such as postpartum hemorrhage or preterm birth.[25] Given that this interim report was done using data through 2021, we could only identify mothers with subsequent births within 27 months among women with a live birth in 2018 (follow up period through March 2021). As a result, this interim report can only assess birth spacing rates pre-HTW Demonstration but the 2021 cohort will be included in the summative report.

Following the measure specification from the CMS-approved Evaluation Design, we evaluated subsequent births within 27 months among women with a live Medicaid-paid birth in 2018, based on their HTW enrollment the year prior (2017). The difference by HTW enrollment status was small (17.7% for HTW clients and 17.4% for non-HTW clients).

Additionally, we classified the 2018 cohort by HTW enrollment at any point in time during the year after the index delivery in Medicaid (see Table 19). We evaluated rates of subsequent deliveries within 27 months between women enrolled in HTW after initial delivery in 2018 vs. non-HTW clients. As mentioned, the Crude Risk Ratio and Adjusted Risk Ratio, accounting for age, race, ethnicity, and maternal comorbidities index, are reported using Modified Poisson regression. A descriptive table that lists the characteristics of the mothers who delivered in 2018 and were included in the analysis can be found in *Appendix B: Additional Results.*

Overall, 17.5 percent of women with a live Medicaid-paid birth in 2018 had a interbirth interval less than 27 months. Mothers who were enrolled in HTW at some point in the 12 months after the delivery were slightly less likely to have a interbirth interval less than 27 months (Crude Risk Ratio 0.96; p-value<0.001) than non-HTW clients (17.1% vs. 17.9%; which reflects 4% change). However, this statistically significant difference was no longer significant after adjustments for age, race, ethnicity, and maternal comorbidities (Adjusted Risk Ratio 0.98; p-value 0.09). See Table 19.

Table 19: Birth Spacing Rates and Risk Ratios Based on HTW Enrollment

	Women with Index Delivery in 2018	HTW Enrollment after Index Delivery	No HTW Enrollment after Index Delivery
Total (N)	150,136	80,572	69,564
One or More Deliveries in Subsequent 27 Months N (%)	26,241 (17.5)	13,818 (17.1)	12,423 (17.9)
Risk Ratios	**Crude Risk Ratio (95% CI)**		**p-value**
	0.96 (0.94-0.98)		<0.001
	Adjusted Risk Ratio (95% CI)		**p-value**
	0.98 (0.96-1.00)		0.090

Notes. HTW: Healthy Texas Women. CI: Confidence Interval. Adjusted Risk Ratio was estimated using Modified Poisson regression accounting for age, race/ethnicity, and Maternal Comorbidity Index.

Pregnancy Complications and Severe Maternal Morbidity (3.2.3 and 3.2.5)

Tables 17 and 18 shows the characteristics of the cohort and each specific subgroup included in the analysis performed under this section. Tables displaying the characteristics of the groups and standardized mean differences after propensity score weighting can be found in *Appendix B: Additional Results.*

Pregnancy complications were defined as the presence of a diagnosis code for any of the following conditions during pregnancy or delivery: gestational diabetes, gestational hypertension, or preeclampsia. Due to measurement errors and potential confounding, we excluded mothers with historical hypertension and diabetes from the pregnancy complications assessment. This meant 16,155 women (6%) were not included in the analysis of this measure. This exclusion did not affect group balance and no specific demographic group suffered a higher proportion of exclusions than others. Additional information is available in *Appendix B: Additional Results.* Severe maternal morbidity (SMM) was assessed as the presence of any of the 21 conditions identified by CDC[26] and further classified and studied by the Alliance for Innovation on Maternal Health (AIM).[27] Recent recommendations and studies have suggested excluding the receipt of blood transfusion from the SMM definition.[26] We follow the same approach in this report and only include non-transfusion indicators in the SMM rates used for analysis.

Table 20 shows the results of the DID analysis for measures 3.2.3 and 3.2.5. Overall, rates of pregnancy complications and SMM increased for both cohorts between 2018 to 2021. However, among women who were in HTW in the year prior to their birth, the difference in pregnancy complications post-HTW Demonstration

was significantly smaller among non-HTW clients. Though the magnitude of this reduction is small, a 1 percent reduction, this was statistically significant. The difference in SMM rate changes between those enrolled versus those not enrolled in HTW was not significant (0.2%; CI (0.0-0.4)). It should be highlighted that the proportion of women in both HTW and non-HTW enrolled groups suffering either a pregnancy complication or an SMM event grew from 2018 to 2021 (see Figures 16 and 17). However, it grew less among those enrolled in HTW, and this difference was significant for the pregnancy complications outcome measure.

Table 20: Results from Difference in Difference Propensity Score Weighted Models for Pregnancy Complications and Severe Maternal Morbidity

	Pregnancy Complication		Severe Maternal Morbidity	
	Rate (95% CI)	**p-value**	**Rate (95% CI)**	**p-value**
HTW, pre (1)	15.5% (15.1 – 15.8)		1.4% (1.3 – 1.5)	
HTW, post (2)	18.2% (17.9 – 18.6)		2.0% (1.9 – 2.1)	
No HTW, pre (3)	17.9% (17.6 – 18.3)		1.4% (1.3 – 1.6)	
No HTW, post (4)	21.7% (21.4 – 22.0)		1.9% (1.8 – 2.1)	
DID estimate	-1.0% (-1.6 - -0.4)	0.002	0.2% (0.0 – 0.4)	0.137

Notes. CI: Confidence Interval. DID: Difference-in-differences model. Pregnancy complications are a composite measure of Gestational Diabetes, Gestational Hypertension, and Pre-eclampsia. Severe Maternal Morbidity includes the 21 criteria identified by CDC and AIMs initiative, but excludes transfusion-only cases.

Whether the growth in pregnancy complications was due to increased morbidity, difficulty in access to care, or other changes in non-medical drivers of health that could have affected women during the COVID-19 pandemic is beyond the scope and ability of this analysis. Moreover, there could likely be differences among women eligible for the HTW program who were not enrolled in the program versus those that did which this model could not account for, such as education, access or understanding of the health care system. The reader should consider these contextual characteristics when interpreting results. Additionally, we can assume that women who were not enrolled in HTW before their pregnancy and included in this evaluation were either uninsured or had commercial insurance. We are not able to assess this as we have no data on women not enrolled in HTW or Medicaid. However, we can assume that the context and vulnerability of uninsured women and potentially the distribution of uninsured versus commercially insured could have also changed during the pandemic. Lack of data on these potential scenarios creates some uncertainty in the interpretation of the beneficial effect of HTW enrollment in 2021 identified.

Figure 16: Pregnancy Complications: Difference in Differences Adjusted Model Estimates

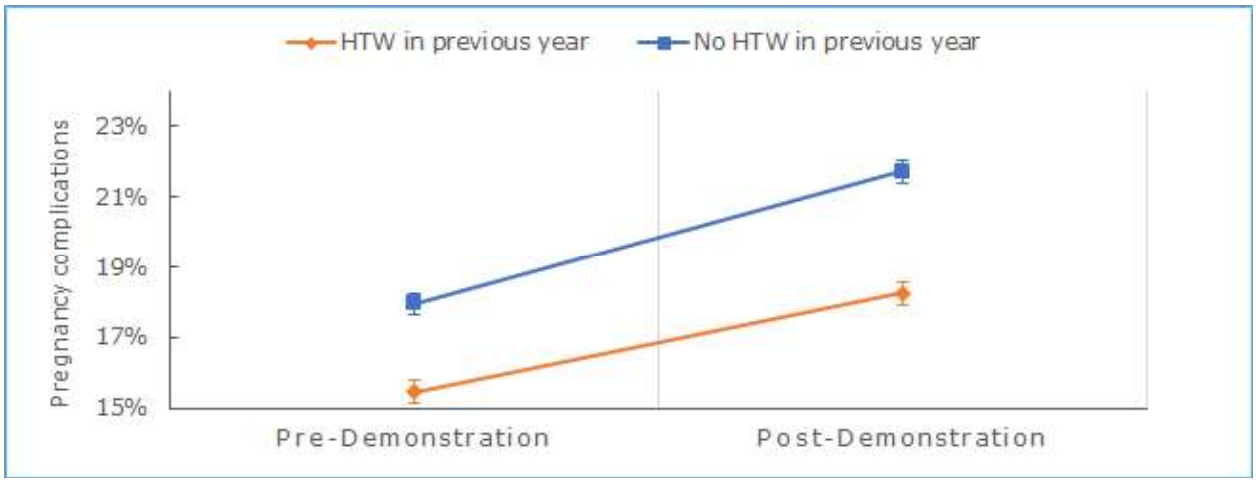
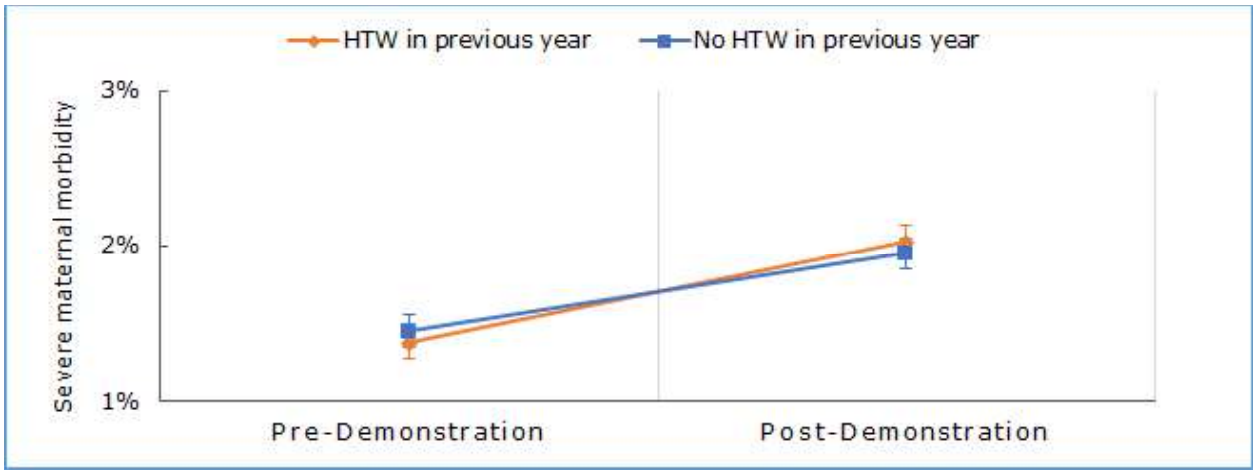


Figure 17: Severe Maternal Morbidity Rates: Difference in Differences Adjusted Model Estimates



Adverse Birth Outcomes (3.2.4)

We evaluated newborn outcomes by assessing rates of low birth weight (LBW) and preterm birth (PT). LBW was defined as births below 2,500 grams and identified based on flags created by HHSC in provided files that rely on ICD-10 codes. Pre term births was defined as births less than 37 weeks and identified following the same approach.[28]

Rates of adverse birth outcomes increased between periods pre- and post-HTW Demonstration for both HTW and non-HTW enrolled women. However, differences were smaller among women with previous HTW enrollment compared to those without HTW enrollment. The propensity score-weighted LBW rate for women enrolled in HTW before their pregnancy grew from 8.3 percent in 2018 to 8.5

percent in 2021. This change was not statistically significant. On the other hand, the LBW rate for those who did not have a record of being enrolled in HTW before pregnancy grew from 8.4 percent to 9.6 percent during the same period. The DID estimate comparing differences in changes over time between HTW and non-HTW groups was -1.0 percent (95% CI -1.4% - -0.5%), which was statistically significant (p<0.001).

Table 21: Results from Difference in Differences Propensity Score Weighted Models for Low Birth Weight and Preterm Births

	Low Birth Weight		Preterm birth	
	Rate (95% CI)	**p-value**	**Rate (95% CI)**	**p-value**
HTW, pre (1)	8.3% (8.0 – 8.5)		11.6% (11.3 – 11.8)	
HTW, post (2)	8.5% (8.3 – 8.7)		12.0% (11.7 – 12.2)	
No HTW, pre (3)	8.4% (8.2 – 8.6)		11.2% (10.9 – 11.4)	
No HTW, post (4)	9.6% (9.4 – 9.8)		12.5% (12.3 – 12.8)	
DID Estimate	-1.0% (-1.4 - -0.5)	<0.001	-0.9% (-1.4 - -0.4)	<0.001

Notes. DID: Difference-in-differences model. Rates and estimates accounted for age, race, ethnicity, region, and maternal comorbidities using propensity score estimated weights.

Results from the analysis of PT birth rates were similar to those found for LBW. PT births among women enrolled in HTW were 11.6 percent in 2018 and 12.0 percent in 2021. This change was not statistically significant. PT births among non-HTW clients was 11.2 percent and grew significantly to 12.5 percent during the same period. The propensity score-weighted DID model estimate comparing differences in changes over time between HTW and non-HTW groups was -0.9 percent (p-value <0.001). Figure 18 shows how baseline PT rates in 2018 were not significantly different between the HTW and non-HTW cohorts. In 2021, post-HTW Demonstration, PT birth rates grew for both HTW and non-HTW enrolled groups, but the growth was significantly higher for women who were not enrolled in HTW in 2020.

Figure 18: Low Birth Weight: Difference in Differences Adjusted Model Estimates

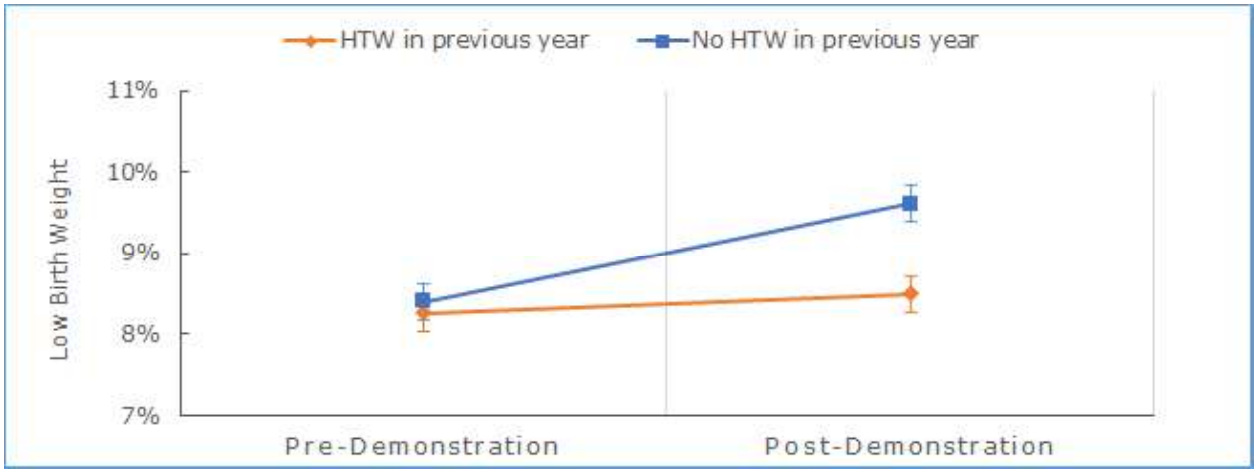
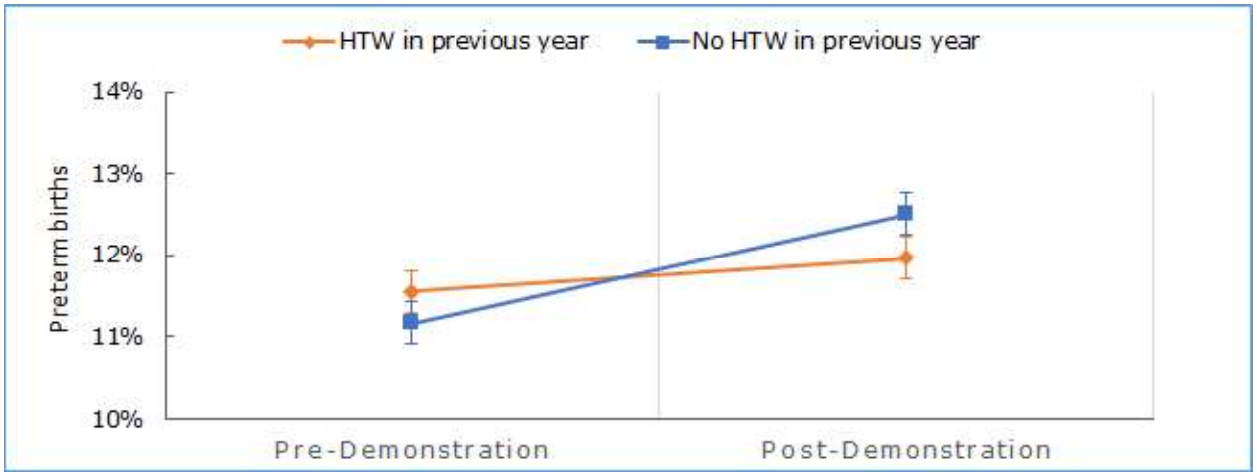


Figure 19: Preterm Birth Rates: Difference in Differences Adjusted Model Estimates.



As mentioned earlier, the post-HTW Demonstration period assessed in this interim report coincides with the COVID-19 pandemic and the Public Health Emergency. It is necessary to keep this context in mind when interpreting the results from this evaluation. However, our analysis shows that women enrolled in HTW in 2020 who delivered a baby in 2021 were at lower risk of having low birth weight and preterm infants than those who were not enrolled in HTW previously. This protective effect was not evident in our baseline measurement (2018). Whether this protective effect was limited to the pandemic or goes beyond those years requires additional years of data, which will be available in the summative evaluation report.

Limitations

Results from the analysis above should be interpreted alongside several limitations which affect the ability to evaluate the HTW Demonstration program in and of itself. First and foremost is the fact that the data included for the post-HTW Demonstration period assessed during this interim report overlapped in its totality with the COVID-19 pandemic. The pandemic has had a well-documented impact on access to care, preventive care receipt, and morbidity, particularly on minorities and uninsured/underinsured populations, which are demographic categories that a large proportion of HTW clients fall into.

Additionally, the implementation of the FFCRA and the removal of re-determination requirements to maintain enrollment status in both Medicaid and HTW changed the composition of the HTW population after 2020, as demonstrated in Measure 1.1.1. Teenagers remained in Medicaid instead of transitioning into HTW as they aged and women who delivered under Medicaid remained enrolled after their immediate postpartum period instead of being automatically assessed for enrollment in HTW. Furthermore, women in HTW were more likely to remain enrolled in the program. Therefore, the post Demonstration demographic composition of HTW was older, less likely to be postpartum, and had actually longer periods receiving the HTW benefits. Though we tried to account for as many variables as we could when comparing pre and post Demonstration outcomes, the analysis could not address all of these systematic differences.

When assessing the internal validity of the interim evaluation, readers should consider that most measures in this section rely on pre- and post-Demonstration comparisons and that post-Demonstration implementation measurements can be influenced by the socioeconomic and public health context. A lack of a concurrent control group did not allow for assessing how much of the results seen were due to the effects of the pandemic versus those of the HTW Demonstration. Future analysis of data from later years, which will be available for the summative evaluation report, would allow for assessment of the program beyond the pandemic and public health emergency years. Stratified results have been provided to allow for better evaluation of changes across the different populations.

Measures 3.2.2-3.2.5 had the advantage of a control group (Medicaid deliveries among women not previously enrolled in HTW) to strengthen inference by comparing trends among individuals exposed to the same external factors, such as the pandemic. We implemented exclusion criteria (excluded births in emergency Medicaid, CHIP-Perinate, or other Medicaid programs other than STAR) and used analytical techniques, such as propensity score weighting, to ensure a comparable

group. However, there may still be systematic differences between women previously enrolled in HTW and the control group that the exclusion criteria and analytic approaches are not able to account for. For example, the proportion of women not enrolled in HTW pre-pregnancy who were uninsured versus commercially insured may have changed over time, but this analysis did not have the relevant data to account for possible compositional changes. Additionally, there could likely be differences among women eligible for the HTW program who were not enrolled in the program versus those that did, which this model could not account for, such as education, access, or understanding of the health care system.

Lastly, the evaluation of unintended pregnancies had to rely on PRAMS survey data. The results of these surveys did not meet the minimum required threshold and, therefore, need to be interpreted with caution. These data can be stratified by payer but do not allow for identification of women enrolled in HTW. Therefore, this interim report is limited in the ability to evaluate changes in unintended pregnancies among HTW clients in Texas.

Though all these caveats need to be considered when trying to interpret the results, preliminary findings from the interim report provide some evidence the HTW Demonstration was positively associated with women's pregnancy- and birth-related outcomes.

Costs

Overview

This section describes the results of the assessment of Evaluation Question 4: "Did the HTW Demonstration effectively use public funds to provide women's health care in Texas?" The CMS-approved Evaluation Design operationalized this assessment using the following hypothesis:

The HTW Demonstration will remain at or below the CMS-Specified annual expenditures limits (Hypothesis 4.1)

For each year of the HTW Demonstration, CMS assigned a budget neutrality expenditure target that acts as an annual ceiling on per capita costs. The annual Per Member Per Month (PMPM) expenditure limit is specified in the STC[3] and presented in Table 22. The study population for PMPM costs includes all women enrolled in HTW.

Table 22: Annual PMPM Expenditure Limit

DY1	DY2	DY3	DY4	DY5
$27.13	$28.38	$29.69	$31.06	$32.49

Methods

The evaluation of this question used data from the budget neutrality worksheets provided by HHSC. This worksheet provided the total expenditures for the With Waiver (WW) Demonstration years and the hypothesized expenditures for the Without a Waiver (WOW) HTW population for the Demonstration years. HHSC System Forecasting used Per Member Per Month (PMPM) WOW estimations multiplied by the actual member month caseload for a Demonstration year to estimate what the hypothetical WOW HTW expenditures would have been. The hypothetical and total expenditures and PMPMs for Dys 1-3 (2020-2022) were provided in the budget neutrality worksheet. Additionally, actual pre-HTW Demonstration total expenditures and PMPM for years 2017-2019 were sent separately by HHSC and generated using actual expenditures recorded.

The assessment for this interim report included the comparison of the CMS-specified PMPM expenditure limit, the hypothetical PMPM and total expenditures for a WOW scenario, and the actual PMPM and total expenditures pre- and post-HTW

Demonstration years (DY 1-3). For this purpose, we performed descriptive statistics and descriptive trend analysis for total expenditures, PMPMs, and growth rates.

Key Findings

The HTW PMPM costs stayed considerably below the CMS pre-established cap amount. Additionally, the trend in HTW PMPM declined over the study period.

Total expenditures on the HTW program were $56 million in CY 2017 and $75 million in CY 2021. For years pre-HTW Demonstration, the hypothesized and actual HTW spending were the same as these are WOW scenarios. Post-HTW Demonstration, the WW total spending varied, but it was always considerably lower than the hypothesized WOW spending for the state, as can be seen in Table 23.

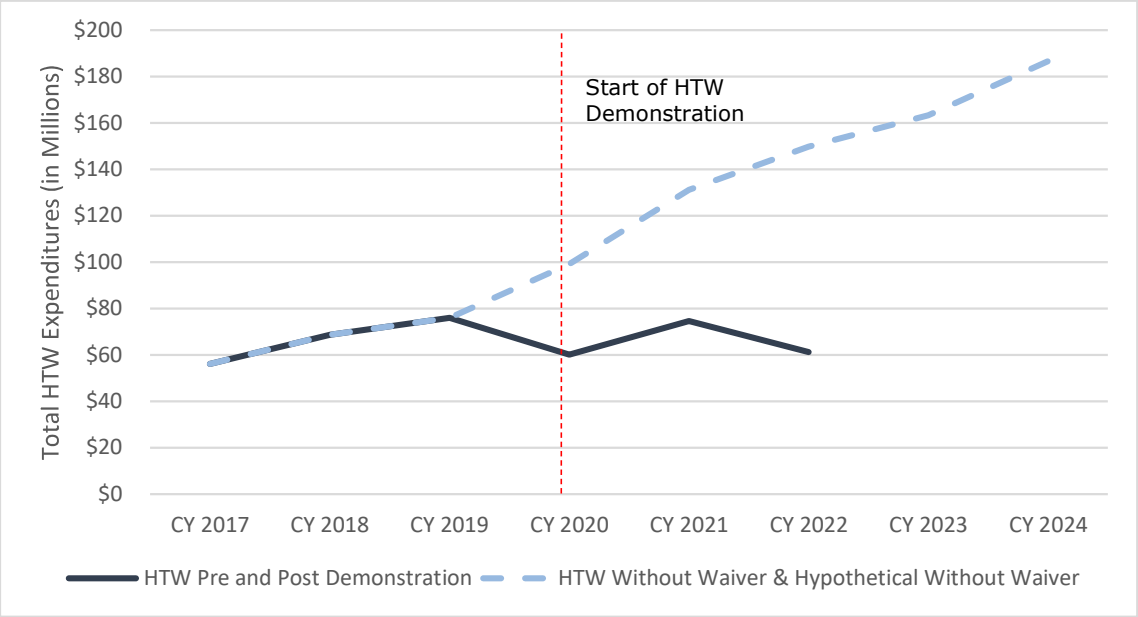
Table 23: Total Expenditures for Years 2017-2024, Without Waiver Estimations and Differences

Time Period	HTW Pre- and Post-Demonstration Actual Expenditures	HTW Hypothetical Without Waiver Expenditures	Difference (WOW-WW)	Savings Relative to a WOW Scenario
CY 2017	$56,062,850	N/A	N/A	N/A
CY 2018	$68,726,851	N/A	N/A	N/A
CY 2019	$75,929,204	N/A	N/A	N/A
CY 2020 (DY 1)	$60,140,934	$99,175,940	$39,035,006	39%
CY 2021 (DY 2)	$74,526,920	$131,189,047	$56,662,127	43%
CY 2022 (DY 3)	$61,248,561	$149,850,278	$88,601,717	59%
CY 2023 (DY 4)	TBD	$163,276,887	TBD	TBD
CY 2024 (DY 5)	TBD	$186,697,814	TBD	TBD

Notes. WW: With Waiver. WOW: Without Waiver. TBD: to be determined. N/A: not applicable

The figure below (Figure 20) shows the WOW estimations in light blue and how they were projected to grow. The darker blue line depicts the actual total spending that was observed. The pre-waiver expenditures (2017-2019) overlap with the WOW scenario. WW expenditures during the HTW Demonstration (DY 1-3, 2020-2022) stay below the hypothetical WOWs. Savings ranged from $39 million to $88 million, or 39 percent to 59 percent less costly than a no-waiver scenario. Differences when comparing the total spending estimated in a WOW PMPMs scenario versus actual total expenditures during the HTW Demonstration account for $184.3 million.

Figure 20: Total Expenditures for HTW, Pre- and Post-HTW Demonstration



The growth rate for total expenditures of the HTW program varied considerably over time. The average growth rate in total expenditures during the 3 years of pre-HTW Demonstration expenditures (2017-2019) was 17 percent, while the average growth rate for the 3 years post-Demonstration period was -5 percent. However, it should be noted that there was considerable variation within these two time periods. Table 24 shows the average monthly enrollment during the pre- and post-Demonstration years evaluated, total expenditures and PMPMs, as well as their growth rates through the time span. Of note, the average monthly enrollment had positive growth across all 5 years. Between 2017 and 2019, the growth in the number of enrollment months was aligned with the changes in overall expenditures, reflected in the very small changes in PMPMs during those years (1% and 4 % growth in 2018 and 2019, respectively). However, in 2020 (DY 1), the average enrollment month grew by 5 percent while total expenditures decreased by 21 percent, which explains the 24 percent drop in PMPM. Growth in enrollment was very much in line with changes in expenditures in 2021 (DY 2), reflected in almost no changes in 2021 (DY 2) PMPM when compared to 2020 (DY 1). Finally, during 2022 (DY 3), there was a 9 percent growth in enrollment compared to 2021 (DY 2) and an 18 percent decrease in expenditures, which explains the 25 percent decrease in PMPM.

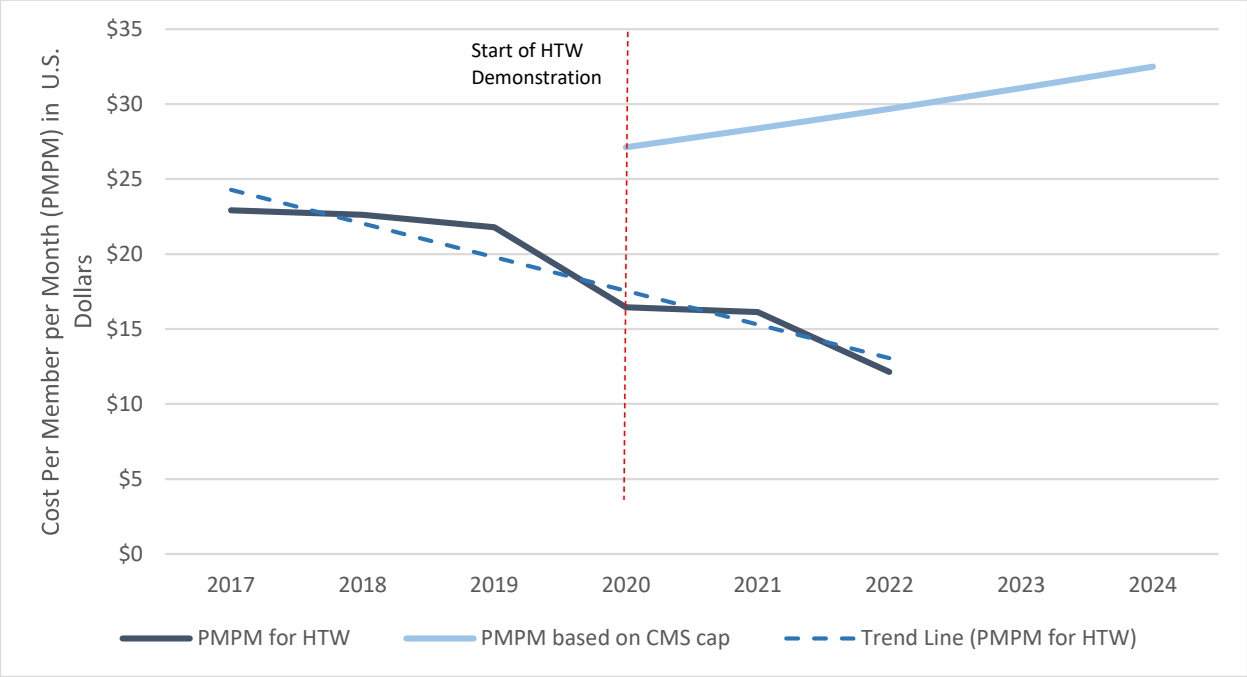
Table 24: Healthy Texas Women Pre- and Post-HTW Demonstration Growth (%) for Enrollment, Total Expenditures and PMPM

Year	Average Monthly Enrollment	Total ($)	PMPM	Growth in Average Monthly Enrollment	Growth in Total Expenditures	Growth in PMPM
CY2017	203,914	$56,062,850	$22.91	N/A	N/A	N/A
CY2018	253,302	$68,726,851	$22.61	24%	23%	-1%
CY2019	290,549	$75,929,204	$21.78	15%	10%	-4%
CY2020 (DY 1)[1]	329,277	$74,530,527	$18.86	13%	-2%	-13%
CY2021 (DY 2)	385,216	$74,526,920	$16.12	17%	0%	-15%
CY2022 (DY 3)	420,597	$61,248,561	$12.14	9%	-18%	-25%

Notes. [1] HTW Demonstration services were not implemented until February 18, 2024, but DY1 caseload and costs were adjusted to reflect all of CY2020 (as of January 1, 2020), to allow for a more accurate comparison to other CYs reported. PMPM: Per Member Per Month. DY: Demonstration Year.

The analysis of the spending pre- and post-HTW Demonstration showed a negative linear trend, with values in PMPM decreasing from $22.91 in 2017 to $12.14 in 2022. This is a 47 percent decrease from 2017 and an average 11 percent reduction per year. As mentioned, decreases were considerably larger in 2020 (DY 1) and 2022 (DY 2). Overall, all PMPMs post-HTW Demonstration were considerably below the estimated CMS PMPM cap (see Figure 21).

Figure 21: Trend in Per Member Per Month (PMPM) Expenditures for HTW through 2022 and CMS Cap PMPM



During this evaluation period, the HTW PMPM has stayed consistently below the hypothetical WOW PMPMs. The difference ranges from -$11 to -$18 in PMPM spending. Overall, the WW PMPMs always stayed below the CMS cap.

Table 25: Demonstration Years Per Member Per Month and Total Expenditures

	Demonstration Years (DY)				
	DY 1 (2020)	**DY 2 (2021)**	**DY 3 (2022)**	**DY 4 (2023)**	**DY 5 (2024)**
PMPM Based on WOW Scenario	$27.13	$28.38	$29.69	$31.06	$32.49
Member Months (actual and projected)	3,655,582	4,622,588	5,047,163	5,256,822	5,746,316
Total Spending (DY1-3) and Estimates for WOW Scenario (DY 4-5)	$99,175,940	$131,189,047	$149,850,278	$163,276,887	$186,697,814
Actual WW PMPM	$16.45	$16.12	$12.14		
Difference between WOW and WW PMPM	$ -11	$ -12	$ -18		

Limitations

The analysis of HTW expenditures was limited to the data that could be derived from the budget neutrality worksheets provided by HHSC. In particular, the worksheets were limited to the aggregated budget data reports previously compiled by HHSC. The WOW scenario, or hypothetical counterfactual, had to rely completely on hypothetical estimations due to a lack of a real control group. The hypothetical estimation relied on PMPMs estimated using data prior to the COVID-19 pandemic. They, therefore, do not account for changes in utilization and type of services used during this period. The differences between the WW and WOW estimates could be biased due to a lack of an appropriate control group that can account for external factors such as the pandemic.

As previously mentioned, other external factors may have affected the measures during the HTW Demonstration. Specifically, national Medicaid expenditures per enrollee decreased by 4.4 percent during FY 2021.[29] These estimations included spending for several services that grew considerably through the COVID-19 pandemic and are not covered by the HTW program, such as COVID-19-related hospital admissions and emergency care services. A steeper reduction in PMPM spending for HTW clients in a similar period could, therefore, be expected.

It has previously been documented that there was an overall decrease in outpatient and planned services during the first months of the pandemic, specifically, a decline in women's use of preventive care.[30] Additionally, the FFCRA extended eligibility for Medicaid beneficiaries, including HTW enrollees. Postpartum women stayed enrolled in Medicaid after March 2020 rather than transitioning to HTW after 60 days. Therefore, the types of services used among the HTW population after the initiation of the PHE likely experienced modifications as well.

Provider Eligibility Criteria

Overview

This section describes the interim results of the Evaluation, question 5: "Does implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services?" The CMS-approved Evaluation Design operationalized this assessment using the following hypothesis:

Hypothesis 5.1: The implementation of HTW provider eligibility criteria does not adversely affect access to and utilization of women's health and family planning services

Provider eligibility criteria for the HTW program were implemented over ten years ago, placing limits on providers who can provide HTW services.[31] The impact of the provider eligibility criteria on the HTW Demonstration was assessed using estimates of a hypothetical counterfactual in which the provider eligibility criteria do not exist and descriptive analyses of the current program environment under HTW provider eligibility criteria.

Assessing this hypothesis required a mixed methods approach, which included a quantitative analysis of medical and pharmacy claims data and provider files as well as a qualitative analysis of primary data on client and provider perspectives related to accessing and delivering services under the HTW Demonstration. The measures used for the evaluation of this hypothesis are listed below. This interim report details the findings of the quantitative analysis (measure 5.1.1) as specified in the CMS-approved Evaluation Design. Updates on primary data collection efforts (measures 5.1.2-5.1.5) are provided in *Appendix C: Updates on Primary Data Collection and Qualitative Analyses*.

5.1.1 Proportion of active family planning providers in Medicaid delivering services through HTW.

5.1.2 Appointment wait times

5.1.3 Barriers to Receiving Care

5.1.4 Providers accepting new clients

5.1.5 Barriers to providing care

Methods

The analysis of measure 5.1.1 required identifying the universe of active family planning billing and rendering providers in Medicaid FFS claims, encounters from managed care covered services, and HTW claims. Active family planning billing providers in Medicaid and HTW were defined as those providers in HTW or other FFS or Medicaid managed care programs with a paid claim for family planning services covered by HTW. We then classified active family planning billing providers as serving HTW or not based on whether they had a paid family planning claim in the HTW program in a given calendar year. Additionally, we confirmed whether the providers were HTW certified or not based on files provided by HHSC.

Importantly, it is unknown why providers offering similar services in Medicaid do not participate in HTW; while some providers may decline to participate due to various program criteria, others may be unaware of the program, unable to accept additional clients, or only serve specialized populations.

The interim report only summarizes the ratio of Active HTW Family Planning billing providers to the sum of these providers in addition to those active family planning billing providers with no HTW claims and that are not HTW certified. We assessed whether this ratio changed pre- and post-HTW Demonstration started. Additional information on providers' perspectives on the HTW program, which may provide insight into reasons for participating in HTW or not, will be summarized in the summative evaluation report.

Key Findings

The proportion of active family planning providers in Medicaid delivering services through HTW grew 5.2 percent points (11.4% growth) on average from pre-HTW Demonstration to post-HTW Demonstration, a statistically significant growth.

Proportion of Active Family Planning Providers in Medicaid delivering services through HTW (Measure 5.1.1)

On average, the proportion of active family planning billing providers in Medicaid delivering services through HTW grew by 5.2 percentage points (11.4% change) when comparing the pre versus post HTW demonstration periods. The average proportion for the pre-HTW Demonstration period was 45.3 percent and that of the post-HTW Demonstration was 50.5 percent.

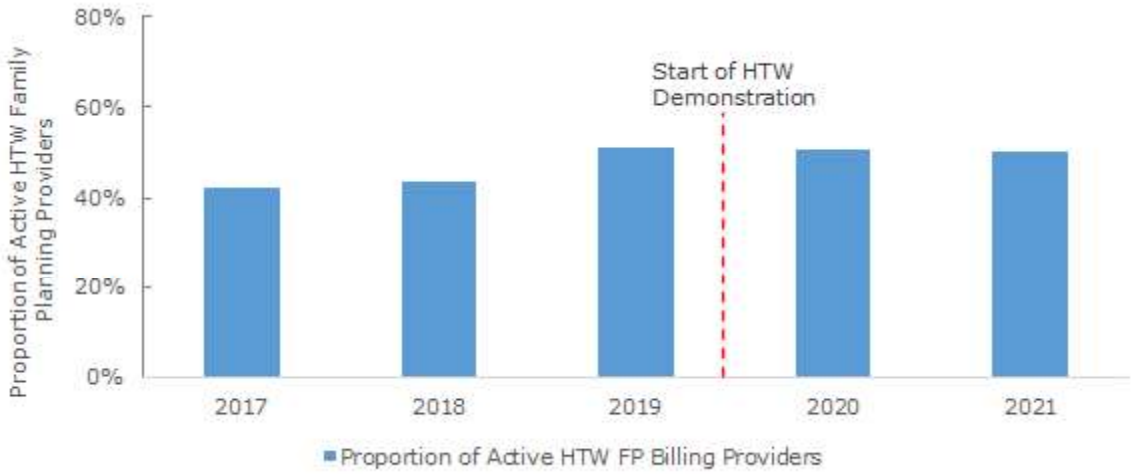
Table 26: Proportion of Active Family Planning Billing Providers in Medicaid delivering services through HTW

Year	Active FP-Billing Providers[1]	Active HTW FP-Billing Providers	Proportion of Active HTW FP Billing Providers
2017	2,863	1,203	42.0%
2018	2,736	1,192	43.6%
2019	2,546	1,298	51.0%
2020	2,472	1,255	50.8%
2021	2,476	1,245	50.3%
Annual Pre-HTW Demonstration Average (2017-2019)	2,715	1,231	45.3%
Annual Post -HTW Demonstration Average (2020-2021)	2,474	1,250	50.5%
Pre/Post Diff.			5.2%
% Change[2]			*11.4%*
p-value[3]			<0.001

Notes. FP: family planning. [1] Active FP-billing providers include HTW providers and non-HTW/non-HTW certified Medicaid providers identified using "billing provider NPI" on at least one paid claim for FP during the measurement year. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [3] P-values are reported from Chi-square tests.

Though the change in averages for the pre- and post-HTW Demonstration period was statistically significant, it should be noted that the growth in the number of active HTW billing providers began in 2019 (Figure 22). The highest proportion of active family planning providers in Medicaid who bill services for HTW clients was highest in 2019 (51.0%), but the pre-HTW Demonstration average was smaller due to years 2017 and 2018 when the proportion was 42.0 and 43.6 percent respectively.

Figure 22: Trends in Active HTW Family Planning Billing



Notes. FP, family planning. Proportion of active HTW FP-billing providers was calculated by dividing the number of HTW FP-billing providers that had at least one paid FP claims by the number of HTW FP-billing providers and non-HTW/non-HTW certified Medicaid billing providers that had at least one paid FP claims during the measurement year.

Limitations

The effect of provider eligibility criteria on HTW access to and use of services could not be thoroughly evaluated in this interim report due to the absence of a control group that could act as a counterfactual. Therefore, this report seeks to assess the proportion of Texas Medicaid and HTW providers who bill or render family planning services for HTW clients. However, it is unknown why providers offering similar services in Medicaid are not providing those services to HTW clients. Existing data do not provide information on whether providers delivering family planning services outside of HTW meet HTW provider eligibility criteria or whether they would participate in HTW under a different set of standards. Although the primary data collection and analysis will look into provider experiences working with the HTW program, it will be limited to providers currently serving HTW clients. Therefore, this evaluation will not be able to provide an answer about that.

Evaluation Limitations

Several methodological limitations can affect the results described in this interim report and should be considered when reading and interpreting results. The primary challenge, as mentioned in the CMS-approved Evaluation Design, is the similarity of the HTW Demonstration to its predecessor program. While the HTW Demonstration seeks to enhance access to these services, it has not changed them substantively or the populations receiving them. Therefore, changes are hypothetically likely to be modest, given the similarity of the counterfactual condition.

Additionally, the implementation of the HTW Demonstration coincides almost entirely with the COVID-19 pandemic, and this interim report does not include any post-Demonstration period data after the end of the PHE. The pandemic has had a well-documented impact on access to care, preventive care receipt, and morbidity, particularly on minorities and uninsured/underinsured populations, much like HTW clients.[8] Under the FFCRA, Texas suspended Medicaid eligibility redetermination requirements, which changed the characteristics of women enrolled in HTW during the PHE. Women who gave birth under Medicaid for Pregnant Women were no longer automatically assessed for HTW eligibility after 60 days postpartum but instead remained enrolled under traditional Medicaid. These environmental confounders may have impacted the results seen during the post-Demonstration period. Except for measure 3.2, all other measures lack a control group for whom outcomes can be assessed during the 2020-2021 period. Therefore, for most of this evaluation, we rely on pre-post observations and cannot explain how much of the results are due to the effects of the pandemic and associated policies versus those of the HTW Demonstration.

The HTW evaluation relies primarily on secondary data from HHS sources, given the availability of this information for the entire HTW population. However, the central purpose of administrative claims and encounters data is to collect information for billing purposes, not to conduct research. Claims and encounters, for example, do not include specific health information such as a newborn's birthweight or a patient's A1c levels, only a broad birthweight category or that an A1c test was performed. This limitation is widely recognized in health services research. Additionally, relying on diagnosis codes and procedure codes introduces the risk of bias in measurement as these are all subject to issues such as upcoding and miscoding. To avoid this, whenever possible, measures were developed using standard, validated, and commonly used measures for research and industry performance measurement purposes.

Only data from 2017 through 2021 were available for this interim report, therefore, certain measures that require a long period of follow-up (2.2.1 and 3.2.2) were impossible to assess appropriately.

To help mitigate these limitations, results are reported with additional benchmark measures, when available, for the rest of the Texas Medicaid population or using national references to contextualize some of the changes observed pre- and post-HTW Demonstration. A more comprehensive evaluation that includes additional years of data after the end of the PHE will be possible for the summative evaluation report.

Conclusions and Implications

On January 20, 2020, CMS granted approval to the HTW Demonstration for a duration of five years. Texas HHSC, the overseeing agency for Texas Medicaid programs, designated UTHealth CHCD as the independent evaluator for the 2020-2024 waiver period.

This report outlines the interim findings of the evaluation for the HTW Demonstration, which encompasses the pre-Demonstration baseline period (2017-2019) and the initial two years of the HTW Demonstration (2020-2021). It is essential to acknowledge that the initial two years of the Demonstration coincided with the COVID-19 pandemic and the Public Health Emergency (PHE). As widely documented, the pandemic had a substantial impact on healthcare access and utilization. Moreover, clients in HTW and Medicaid were exempted from eligibility reassessment or disenrollment during the PHE that commenced on March 18, 2020. Consequently, women already enrolled in the HTW Demonstration were unlikely to exit the program unless they qualified for a more comprehensive alternative, such as Medicaid for Pregnant Women. Similarly, pregnant women who would have transitioned to HTW from Medicaid before the pandemic remained enrolled in Medicaid for the entire PHE period. These changes to the composition of the HTW population can be presumed to have influenced the observed effects of the HTW Demonstration assessed in this report.

UTHealth's CHCD evaluation of the HTW Demonstration encompassed five critical areas: access, utilization, health outcomes, costs, and the impact of provider eligibility criteria. Each area was accompanied by specific hypotheses and corresponding measures. The evaluation process employs a mixed methods approach, including primary data collection through surveys and secondary analysis of administrative and public data. However, this interim report exclusively presented results derived from the quantitative analysis of administrative data. Outcomes from the qualitative analysis will be incorporated into the final summative report. The results of the interim evaluation are summarized below. The different sections of this report dive into the analysis approach, detailed results, variation by subgroup analysis, and statistically significant changes.

Hypothesis 1.1 postulated the HTW demonstration would increase or maintain access to family planning, family planning related, and preconception services for low-income women in Texas. Our analysis revealed there were modest increases and improvements on the measures included for this assessment during the post Demonstration period evaluated. The average number of unique clients per year in

the post-HTW Demonstration period increased modestly by 4%. Pre-HTW Demonstration, approximately 37% of HTW clients received at least one service per year. This increased by three percentage points post-HTW Demonstration (8% change), primarily due to a 12% increase in medical services, offset by a 7% reduction in prescription services. The number of billing providers with at least one paid HTW claim per year increased by 20% between the pre- and post-HTW Demonstration periods. Network adequacy improved in Demonstration Year 2 (DY) compared to the baseline for primary care physicians (PCP) and pharmacies.

Interestingly, the analysis of Hypothesis 1.1. also revealed there was significant growth in continuous enrollment in the program, a trend influenced by the continuous eligibility policies during the HTW Demonstration period in response to the Public Health Emergency (PHE). In summary, the PHE-induced continuous eligibility policies led to changes in the age composition and life circumstances of the HTW Demonstration population who were less likely postpartum, compared to pre-HTW Demonstration years. Additionally, the evaluation of Measure 1.1.3 also revealed both, pre- and post-HTW Demonstration, less than 10% of billing providers accounted for 80% of all paid claims. The implications of this remain unclear in this interim analysis, but findings from provider and client surveys in the summative report may shed light on it. Though network adequacy parameters improved considerably, PCP networks in Micropolitan counties still lagged 15 percentage points below the standard (90%).

The analysis of Hypothesis 2.1 which stated the HTW Demonstration would increase or maintain the utilization of family planning services showed a decrease in the use of most/moderately effective contraceptives among women with continuous annual enrollment (7.7 percentage points decline) as well as a decline in the use of LARCs (0.7 percentage points). Chlamydia screening, used to evaluate testing for STIs changed minimally post-HTW Demonstration and was similar to Texas Medicaid reported rates. Almost 100 percent of women screened for chlamydia were also screened for gonorrhea, in line with evidence-based guidelines. Though utilization rates of family planning services declined in the post-HTW period, it should be noted the absolute number of women receiving contraception through HTW more than doubled in the post-HTW Demonstration period. However, this was accompanied by significant growth in the number of women with continuous annual enrollment, which resulted in an overall decrease in contraception use rates. Additional years of data will help establish whether this finding is a prevailing trend or an outlier influenced by PHE eligibility policies. Additionally, the client surveys included in the summative report will provide additional insight into women's experiences accessing and utilizing services.

Hypothesis 2.2 which postulated the HTW Demonstration would increase or maintain utilization of preconception services could not be appropriately assessed. The evaluation of compliance with cervical cancer screening recommendations pre- and post-HTW Demonstration was not possible as the measure requires a 5-year look-back period. However, the 2021 rate (60%), which was the only year for which complete data was available for the interim report, is 2.8 percentage points higher than the corresponding rate among all Texas Medicaid recipients.

Hypothesis 3.1 proposed the HTW Demonstration would improve or maintain women's health among HTW clients. The analysis of the measures under this hypothesis showed mixed results. Adherence to hypertension, diabetes, and cholesterol medication measured using prescription days covered, decreased post-HTW Demonstration. On the other hand, antidepressant medication management improved post-HTW Demonstration, especially during the continuation phase (6 months of antidepressant medication). The prevalence of these conditions was less than 2%, and after applying the criteria for the measure (having at least 2 prescriptions for the specific condition) few clients met the criteria. Therefore, results should be interpreted with caution and might not accurately reflect the health of the overall HTW population.

Hypothesis 3.2 postulated the HTW Demonstration would maintain or improve maternal health and pregnancy outcomes. The interim report found the rate of pregnancy complications (gestational hypertension, gestational diabetes, and preeclampsia) among all women included in the analyses who delivered under STAR Medicaid increased between 2018 and 2021. However, the increase in pregnancy complications was significantly lower among women who had been enrolled in the HTW Demonstration the year prior to their delivery compared to those without HTW enrollment the year prior to the delivery. Additionally, though rates of adverse birth outcomes (low birth weight and preterm births) increased between 2018 and 2021, the increase was significantly smaller among women enrolled in the HTW Demonstration the year prior to their delivery compared to those without prior HTW enrollment. The evaluation could not identify a significant difference in severe maternal morbidity (SMM) among women based on their history of HTW enrollment prior to delivery. Despite methodological limitations discussed in the report, these findings suggest the HTW Demonstration had a positive impact in reducing the incidence of pregnancy complications and newborn adverse outcomes during the years assessed which coincide with the PHE. Whether the positive impact of HTW enrollment during the Demonstration years assessed was limited to the pandemic or will continue requires additional years of data which we recommend assessing for the summative report.

The interim analysis showed the HTW Demonstration stayed below the annual expenditure limits set by CMS (Hypothesis 4). In fact, the PMPM expenditures declined during the first three years of the HTW Demonstration. Additionally, the interim report identified a small but significant growth in the proportion of active family planning providers delivering services through HTW (Hypothesis 5.1). Though the actual proportion of family planning providers was highest in 2019, preliminary analysis found the proportion of family planning providers delivering services through HTW clients grew post-HTW Demonstration.

Overall, this interim report was limited in its ability to evaluate the impact of the HTW Demonstration. The primary challenge, as mentioned in the CMS-approved Evaluation Design, is the similarity of the HTW Demonstration to its predecessor program. While the HTW Demonstration seeks to enhance access to these services, it has not changed them substantively or the populations receiving them. Therefore, changes are hypothetically likely to be modest given the similarity of the counterfactual condition.

The HTW interim report relies primarily on secondary data from HHS sources given the availability of this information for the entire HTW population. However, the central purpose of administrative claims and encounters data is to collect information for billing purposes, not to conduct research. Claims and encounters, for example, do not include specific health information such as a newborn's birthweight or a patient's A1c levels, only a broad birthweight category or that an A1c test was performed. This limitation is widely recognized in health services research. Additionally, relying on diagnosis codes and procedure codes introduces the risk of bias in measurement as these are all subject to issues such as upcoding and miscoding. Finally, only data from 2017 through 2021 were available for this interim report, therefore certain measures that require multiple years of post-Demonstration data such as cervical cancer screening or birth spacing (2.2.1 and 3.2.2) could not be appropriately assessed.

To help mitigate these limitations, whenever possible the evaluation used standard, validated, and commonly used measures for research and industry performance measurement purposes. Additionally, results are reported with additional benchmark measures, when available, for the rest of the Texas Medicaid population or using national references to contextualize some of the changes observed pre- and post-HTW Demonstration.

The summative report will include additional years of data (through 2024) which will allow for the assessment of measures requiring long measurement periods, such as compliance with cervical cancer screening and birth spacing. Researchers

will also continue to refine methods related to the DID model to ensure results reflect the most rigorous and unbiased estimates possible in light of data availability and PHE-related policies that may impact the comparability of the 2018 and 2021 birth cohorts. Additionally, evaluating years beyond the PHE, which ended on May 2023,[32] will enable the assessment of the postulated hypotheses in a context that resembles more that of the pre-demonstration period. This will also allow for the assessment of whether the identified associations and trends change after the end of the PHE. Finally, qualitative data analysis will be available for the summative report. This information will hopefully allow for better interpretation and understanding of the findings from the quantitative analysis as well as shed light on the actual experiences from both clients and providers.

Appendix A: Methods

The following sections describe the methods used for the measurement and analysis of each specific hypothesis. For measures that strictly followed the CMS-approved Evaluation Design, we refer the reader to said document. However, several measures required small changes, such as additional exclusion criteria in the denominator or further analysis to better understand results. Additionally, in certain circumstances, the CMS-approved Evaluation Design suggested a series of statistical analyses and left it to the external evaluator to decide on the best approach. Details on these modifications, additions, and final statistical approaches can be found in the document below. They are grouped following the same organization as the body of the interim report, with an introduction detailing the methods shared across most if not all measures, followed by measure-specific clarifications. Aligned with this interim report, this section focusses on quantitative analyses of administrative data. Updates related to evaluation questions and hypotheses addressed through the provider and client surveys are provided in *Appendix C: Updates on Primary Data Collection and Qualitative Analyses*.

Design

The questions and hypotheses are being assessed through 31 measures covering access, utilization, health outcomes, cost, and the effect of provider eligibility criteria. In general, the analysis done for this interim report was based on an observational retrospective design, comparing before and after measures using administrative data. When possible, a comparison group was created and a difference-in-differences approach was used.

As explained in the CMS-approved Evaluation Design, the evaluation uses as baseline, or pre-HTW Demonstration years data form 2017 through 2019. The post Demonstration years run from 2020 through 2024. For the purposes of the analysis the start date assumed for the post-HTW Demonstration period is January 1st 2020, although the Demonstration was approved on January 22, 2020 and services did not begin until February of that year. For this interim report, the data analyzed ranged from January 2017 through December 2021, corresponding to two years post-implementation of the HTW Waiver.

Some measures under Hypothesis 3.2 use a truncated portion of the study period due to operationalization constraints or source-specific data lags. Details can be found in the CMS-approved Evaluation Design.

Data

UTHealth CHCD relied on the following data sources to calculate measures for the evaluation:

- Medicaid enrollment, encounters, and claims for medical and pharmacy services provided by HHSC (Calendar Year [CY] 2017-2021) for HTW and Medicaid clients, which serve as the control group for a limited set of measures.
- Provider-level enrollment files (CY 2017-2021).
- Mother-newborns crosswalk for mothers delivering under Medicaid (CY 2018 & 2021) prepared by HHSC.
- Pregnancy Risk Assessment Monitoring System (PRAMS) data for Medicaid recipients (2017-2021) received from DSHS.
- Medical and Pharmacy Network Adequacy reports (CY 2020-2021).
- Budget Neutrality estimations for (Demonstration Years [DY] 1-3) and total enrollment and spending reports (CY 2017-2019) obtained from HHSC.
- Primary Data collected from surveying clients and providers.

Population

The target population for the HTW evaluation includes all clients enrolled in the HTW Demonstration. In general, no additional inclusion or exclusion criteria have been applied. The target population is conceptually consistent with an intent-to-treat framework. All women who transitioned to or self-enrolled in the HTW Demonstration are considered part of the intervention group, regardless of whether they actively receive services. For the purposes of the evaluation, we excluded clients 15 to 17 years old from the pre-HTW Demonstration baseline to match the clients' age range in the HTW Demonstration. The PHE modified re-enrollment requirements, which had an effect on the age of individuals enrolled in the HTW program, allowing for women who would have traditionally aged out of HTW to remain. For the purpose of the interim report analysis, HTW enrollees who turned 45 during a measurement year and were still HTW clients were grouped into the 40-44 category. Women 45 or older at the beginning of the year (January 1st) were excluded as women would not be normally eligible for HTW program.

The HTW evaluation also assesses other populations, including that of providers serving HTW clients, and for the assessment of Measure 3.2.1 (Unintended Pregnancies) survey information for women identified as “Medicaid,” which could

have included both Medicaid and HTW clients available through the Pregnancy Risk Assessment Monitoring System (PRAMS). Additionally, measures under Hypothesis 3 rely on Medicaid-paid births from 2018 and 2021. Mothers who were not enrolled in HTW the year prior to the birth were used as control groups and are therefore part of the population studied.

Lastly, population-level data (rather than a sample) has been used for most measures to assess processes and outcomes. Measures relating to clients and providers have been stratified into key demographic subgroups such as age, race/ethnicity, region, or provider type, where applicable.

Quantitative Analysis

The quantitative analysis has been approached through three quasi-experimental methods: one group pre-posttest design, one group post-test only, and a nonequivalent comparison group pretest-posttest design. Most measures are being tested through a one-group pre-posttest design due to the longstanding nature of the HTW program and the absence of a suitable comparison group. Quantitative analytics methods used include:

Descriptive analysis assessing measures of central tendency and dispersion. Statistical differences using Chi-Square (age group, race/ethnicity, region, and receipt of HTW services), Kruskal-Wallis test (median enrolled months), and ANOVA (mean enrolled months). For Pre/Post-HTW Demonstration periods, comparisons were done using Wilcoxon rank sum tests (median enrolled months) and t-tests (mean enrolled months). All measures described were also created and stratified by age categories, race/ethnicity categories, and regions. A total of 5 age categories were created. Race and ethnicity were categorized as White non-Hispanic, Black, Hispanic (all races), and other. The "Other" category included clients recorded in enrollment files as Asian, American Indian or Alaskan, Other or Unknown. Regions were created using the Department State Health Services Public Health Regions (PHR).[33] Box plots, bar graphs, and line graphs were used as well.

Pre-post and sub-group comparisons using inferential statistics was done when appropriate. Pre- and post-HTW Demonstration annual averages were estimated as the sum of counts or rates for the years in each period (pre-Demonstration: 2017-2018-2019 and post-HTW Demonstration: 2020 and 2021) divided by the number of years in each period. Point changes are estimated by subtracting the value of the measurement from the pre-Demonstration period from the value of the post-HTW Demonstration period. Percentage changes reflect the percentage changes calculated by dividing the measure difference between pre- and post-HTW

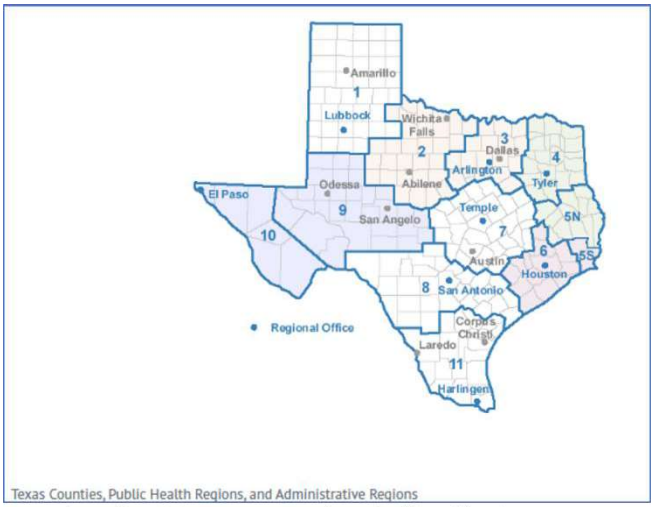
Demonstration periods by the value of the measure at the pre-HTW Demonstration period. Statistical methods used include the Chi-square test, Wilcoxon rank sum test, t-tests, Kruskal-Wallis, and ANOVA. When possible, a comparison with other benchmark information or peer review publications was performed to evaluate differences.

Descriptive trend analysis was used when pre- and post-HTW Demonstration data was available, plotting and analyzing time series data and testing for the presence of a trend through regression modeling when possible. For several measures, reported only as annual rates, the years of follow-up provided little power to test for trends appropriately. We describe the trajectory and evaluate differences between pre-and post-period averages to assess changes further.

Difference-in-differences (DID) models were used to assess all measures under hypothesis 3.2 as a comparison group was available for the pre-and post-HTW Demonstration period. To balance group characteristics of the pre-and post-intervention and control groups, a propensity score weighting approach recommended for use in DID modeling for policy evaluations was used.[36]

Additionally, all descriptive statistics and analysis are stratified by age, race/ethnicity, and region if feasible. The regional analysis was based out of Texas Public Health Regions. The map and counties included in each region are shown in a map (Figure 4). The summative report will include analysis using Managed Care Service Areas, per the request of Texas HHSC.

Figure 23: Texas Public Health Regions



Center for Health Statistics Texas County Numbers and Public Health Regions. https://www.dshs.texas.gov/center-health-statistics/center-health-statistics-texas-county-numbers-public-health-regions

Evaluation Question #1: Access to family planning, family planning-related, and preconception care services

Measure 1.1.1. Unique count of women enrolled in HTW

Measurement of unique client counts followed the specifications under the CMS-approved Evaluation Design. In addition to unique client counts, we examined the number of new enrollees (clients who had not been enrolled at least one month the prior year) and the number of retained clients (clients who had been enrolled anytime the prior year) to better understand changes in enrollment patterns. The year 2017 was used as the baseline year and therefore not classified by retained and newly enrolled clients. Additionally, we measured the number of member/months in the program per calendar year (number of individuals participating in HTW program each month, from January through December) and report this as member years (MY) which reflects the total number of member months in a year divided by 12. We used this to compare changes in unique counts of members and changes in counts of MY. Growth in MY, unaccompanied by a similar growth in unique clients counts, translates in longer enrollment periods. It should be noted, clients in HTW were enrolled for 12 months periods that could begin anytime during the year. However, this changed after the PHE begun, as clients were no longer subject to re-enrollment. To better understand the growth in MY observed, which was considerably large than the growth in unique client counts, we assessed the number of continuously enrolled months for each individual during a calendar year.

Measure 1.1.2. Proportion of Clients who received any HTW service

Measurement of the proportion of clients who received any HTW services was assessed as described by the CMS-approved Evaluation Design. Clients with at least one paid claim (medical or pharmacy) in a year were counted as having received an HTW-paid service during that given year.

Measure 1.1.3. Unique Counts of Providers Billing for any HTW Service

As specified in the CMS-approved Evaluation Design, this measure shows the number of unique billing and prescribing providers with at least one paid HTW medical or pharmacy claim in a given year. Additionally, the unique number of

performing providers in a given year is also summarized. We report this measure for "Billing Providers" (those identified in the billing provider field in the claims, "Performing Providers" (those identified in the performing provider line level variable in the paid claim), and "Prescribing Providers" (providers who appear as prescribing providers in a paid prescription claim). A performing provider can be a prescribing provider, as well as a billing provider. This is particularly true in cases of single practices, for example. Often billing providers represent organizations that group several performing providers, such as Federally Qualified Health Centers or physician group practices. Last, to create a composite measure we report the total number of unique providers across all possible fields. Totals do not add up because a unique provider could belong to more than one category. We evaluated the number of claims each provider had (stratified by provider category) and assess the distribution of paid claims. Additionally, we display the cumulative frequency of claims by unique providers ordered from providers with the largest number of claims to the lowest, and stratified by year.

Measure 1.1.4. Percentage of HTW Clients within prescribed Network Adequacy standards

This measure was assessed following instructions in the CMS-approved Evaluation Design and using reports on Network Adequacy created by HHSC during the years 2020 and 2021.

Evaluation Question #2: Utilization of Family Planning Services Among HTW Clients

Measure 2.1.1. Provision of Most Effective/Moderately Effective Contraceptive Methods and Measure and 2.1.2. Provision of Long-Acting Reversible Contraceptives (LARCs)

Both these measures were calculated following the CMS-approved Evaluation Design which specified the use of measure "CCW-AD: Contraceptive Care-All Women ages 21-44" from the Core Set of Adult's Health Care Quality Measures for Medicaid.[14] Specific codes for inclusion, exclusion criteria as well as for identification of drugs and procedures involved in this measure can be found in the Technical Specification of said document.

Measure 2.1.3. Test for any sexually transmitted infection (STI)

Several STI-related measures were analyzed. The first measure aligned with the CMS-approved Evaluation Design which asked for the assessment of the total number of unduplicated clients with at least one test for any sexually transmitted infection (STI) during a year over the total number of unduplicated clients during that year. We assessed the provision of at least any of the following screenings using Current Procedural Terminology (CPT) codes and HCPCS (Healthcare Common Procedure Coding System) codes: Gonorrhea, Hepatitis B, HIV, Syphilis, and Trichomoniasis, as well as codes for comprehensive (panel).

In addition to the simple measure specified in the CMS-approved Evaluation Design, two additional measures on STI testing were examined: 1) testing for chlamydia among sexually active women, and 2) tests for gonorrhea or other STIs among women who screened positive for chlamydia. The Medicaid Core Set of Adult Health Care Quality Measures[14] suggests monitoring testing for sexually transmitted infections (STIs) across Medicaid programs through "Testing for Chlamydia" among sexually active women ages 21 to 24. This measure is also employed by HHSC to evaluate testing for STIs among its Managed Care Organization (MCO) plans.[18] Additionally, this measure is reported by commercial plans under their Healthcare Effectiveness Data and Information Set (HEDIS) reporting.[19] To allow for comparisons and benchmarking with other standard measure reporting related to STI testing, we applied this measure to the HTW population as specified in the Medicaid Core Set of Adult Health Care Quality Measures (including directions for identifying sexually active women and continuous enrollment criteria). For a list of codes used for inclusion and exclusion criteria, as well as for identification of STI testing, please refer to CMS-approved Evaluation Design. Additionally, because of recommendations by the Center for Disease Control[10] and the US Preventive Services Task Force (USPSTF),[11] among those women screened for chlamydia, we assessed those who were also screened for gonorrhea.

Measure 2.2.1. Compliance with Cervical Cancer Screening (CCS)

For this measure, specifications align with the Medicaid Core Set of Adult's Health Care Quality Measures, as specified in the CMS-approved Evaluation Design.

Full measure reporting required five years of data, making comparison of pre- and post-HTW Demonstration rates unfeasible. We therefore report total and proportion of eligible women who met the criteria for cervix cytology in the past three years,

as well as women who had an hrHPV test within those three years for 2019, 2020 and 2021. Additionally, we measured adherence to CCS in 2021 using the full specification recommended by Medicaid's Core Set of measures and benchmark it against reports of the same measure for other populations.

Evaluation Question #3: Health Outcomes

Measure 3.1.1 through 3.1.3 Hypertension, Hypercholesterolemia and Diabetes medication adherence

To evaluate adherence to hypertension, diabetes, and hypercholesterolemia treatment, we used the proportion of days covered measures specified in the CMS-approved Evaluation Design, and developed by the Pharmacy Quality Alliance.[34] Among those individuals with two or more prescriptions for these conditions, these measures assess the percentage that filled their prescription often enough to cover 80 percent or more days during the period they are supposed to be taking the medication in the calendar year (Proportion of Days Covered).

The rate of PDC for each drug by year is reported by calculating the number of member-months of HTW clients with a proportion of days covered (PDC) at 80 percent or higher for measures 3.1.1-3.1.3 during the measurement period (numerator) divided by the number of member-months of HTW clients with at least two said medication fills on unique dates of service during the measurement period (denominator). P-values are reported to compare adherence rates between pre- and post-demonstration periods using rate=exp ($\beta 0 + \beta 1$*pre/post).

Additionally, we repeated measurement and testing limiting the analysis to individuals who had 12 months of continuous enrollment during a calendar year and tested using weighted Chi-square test.

Measure 3.1.4. Antidepressant medication management

To evaluate antidepressant medication management, we relied on measures developed and specified under Adults Health Care Quality Measures for Medicaid,[14] a National Committee for Quality Assurance measure as specified in the CMS-approved Evaluation design. . This measure assesses two rates, acute-phase phase treatment, which reports the percentage of individuals who remain on antidepressant medication for at least 12 weeks after the index prescription start date; and continuation phase treatment, which reports the percentage of individuals who remained on antidepressant medication for at least 6 months after the index prescription start date.

Measure 3.2.1. Unintended Pregnancies

Unintended pregnancies (3.2.1) were assessed using data from the PRAMS survey specific to Texas. This is a surveillance system designed to monitor maternal attitudes and behaviors before, during, and after pregnancy. Conducted in partnership with the Center for Disease Control and Prevention (CDC) and the Texas DSHS, Texas PRAMS is a statewide population-based assessment that monitors the health and behaviors of new mothers in Texas. Approximately half of the births in the PRAMS sample are paid by Medicaid, and the survey allows for stratification by payer type. However, it is not specific to HTW clients, so results are reported for the overall Medicaid population. PRAMS data include a two-year lag from the birth year. Therefore, the interim report includes PRAMS data on unintended pregnancies from 2017 through 2021.

The assessment of pregnancy intention is done using the following question and answer classification:

"Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?". The potential answers are classified as "I wanted to be pregnant later" (unintended), "I wanted to be pregnant then or sooner" (intended), "I didn't want to become pregnant then or any time in the future" (unintended); "I wasn't sure what I wanted" (not sure).

We performed descriptive trend analysis and compared Medicaid rates to that of the overall state of Texas.

Measure 3.2.2-3.2.5: Birth Spacing, Pregnancy Complication, Severe Maternal Morbidity and Adverse Birth Outcomes

The remaining four measures under Hypothesis 3.2 used claims data pulled from the cohort of mothers identified and linked to newborns for Medicaid-paid births during 2018 and 2021 by a crosswalk developed by HHSC. This crosswalk was then used to pull all medical and pharmacy claims of identified mother-infant dyads before and after the delivery index date. All Medicaid deliveries that were under a program other than STAR Medicaid, such as Emergency Medicaid or other Medicaid programs (STAR Health, STAR+PLUS, STAR KIDS, CHIP, CHIP-Perinate) were excluded to allow for better comparisons. This was done to exclude women who would not have been eligible for HTW prior to delivery, for example, due to immigration status or eligibility for other Medicaid coverage.

Mothers were then classified based on their HTW enrollment the year before the delivery (2017 and 2020), allowing for the creation of a group of women who had been enrolled in HTW pre-pregnancy and a comparison group who had not. The resulting comparison group could have been prior to their pregnancy uninsured, commercially insured, or Medicaid STAR if they had recently been pregnant and not transitioned out.

In order to adjust outcome analysis for potential confounding we measured, age, race/ethnicity, geographic region and all co-morbidities included in the Maternal Comorbidity Index (MCI).[35] These comorbidities were categorized and used in models to adjust (see table 27). For measures 3.2.3 (Gestational Diabetes, Gestational Hypertension) we excluded the conditions related from the Obstetric category and overall MCI. A similar approach was used in the analysis of measure 3.2.5 (SMM) when the condition in the MCI overlapped with conditions listed in SMM.

Table 27: Maternal Comorbidities

Maternal Comorbidities	
Obstetrics-related	Placenta previa
	Previous cesarean delivery
	Multiple gestation
	Gestational hypertension (maternal hypertension)
	Gestational diabetes mellitus (maternal)
	Mild preeclampsia or preeclampsia
	Severe preeclampsia
General Health	Preexisting hypertension
	Preexisting diabetes mellitus
	Obesity
	Asthma
Renal-related	Chronic renal disease
Cardio-related	Pulmonary hypertension
	Cardiac valvular disease
	Chronic congestive heart failure
	Chronic ischemic heart
	Congenital heart disease
Autoimmune-related	Systemic lupus erythematosus
	Human immunodeficiency (HIV)
	Cystic fibrosis
	Sickle cell disease
Substance Abuse-related	Substance use disorder
	Alcohol abuse
	Tobacco use

Measure 3.2.2: Birth Spacing

This measure was evaluated following the CMS-approved Evaluation Design, which proposed measuring the percentage of HTW clients with a subsequent Medicaid-paid live birth, who had a second or greater number of Medicaid-paid births within 27 months based on their HTW enrollment the year prior to the index delivery. This was designed to compare women with index deliveries in 2018 and 2021, classified them based on their HTW enrollment the year prior (2017 and 2020), and follow them for 27 months.

For the interim report, we could not fully assess this measure as only data through 2021 was available, therefore making the assessment of the post-HTW Demonstration group not feasible. We report though the birth spacing rates for year 2018 based on HTW enrollment. The descriptive table for this sub-cohort can be found in *Appendix B: Additional Results*.

For the purpose of this interim report we first ran the analysis comparing women based on their HTW enrollment before the index (2018) delivery, which meant looking at their enrollment in 2017. Additionally, we ran the analysis looking at their enrollment status in HTW post their delivery, which in this case meant 2019.

Crude Risk Ratio and Adjusted Risk Ratio comparing those with HTW vs. non-HTW enrollment and accounting for age, race, ethnicity, and (MCI) were created using Modified Poisson regression.

Measure 3.2.3-3.2.5: Pregnancy complications, Severe Maternal Morbidity and Adverse Birth Outcomes

Pregnancy complications were defined as the presence of a diagnosis code for any of the following conditions during pregnancy or delivery: gestational diabetes, gestational hypertension, or preeclampsia. We used International Classification Disease codes (ICD-10) previously validated to identify these conditions.[35] Due to measurement errors and potential confounding, we excluded mothers with historical hypertension and diabetes from the pregnancy complications assessment. This meant 16,155 women (6%) were not included in the analysis of this measure. This exclusion did not affect group balance and no specific demographic group suffered a higher proportion of exclusions than others.

Table 28: Clients Included in the Analysis Before and After Exclusion by Category

	Clients Before Exclusion		Clients After Exclusion	
	N	%	N	%
HTW, pre	27,188	10.97	24,992	10.79
HTW, post	21,143	8.53	19,791	8.55
No HTW, pre	122,948	49.63	114,747	49.55
No HTW, post	76,460	30.86	72,054	31.11
Total	247,739	100	231,584	100

Notes: HTW: Healthy Texas Women. Pre and Post: Pre-HTW Demonstration and Post-HTW Demonstration. N: counts of unique clients.

Severe maternal morbidity (SMM) was assessed as the presence of any of the 21 conditions identified by CDC[26] and further classified and studied by the Alliance for Innovation on Maternal Health (AIM).[27] Recent recommendations and studies have suggested excluding the receipt of blood transfusion from the SMM definition.[26] We follow the same approach in this report and only include non-transfusion indicators in the SMM rates used for analysis.

Adverse birth outcomes assessed were preterm births (PT) and low birth weight (LBW) newborns. LBW was defined as births below 2,500 grams and identified based on flags created by HHSC in provided files that rely on ICD-10 codes. Pre term births was defined as births less than 37 weeks and identified following the same approach.[28] The information on these outcomes was provided by HHSC in the Mother-Newborn crosswalk.

Statistical Analysis

We relied on Difference-in-differences (DID) analysis for these three measures. This allowed for the assessment and subsequent adjustment of our measures by demographics and maternal comorbidities. Traditional DID models rely on linear regression, which assumes a linear relationship between normally distributed independent and dependent variables. Although several measures under Hypothesis 3.2 are based on dichotomous variables, because of known challenges involved in the application and interpretation of non-linear DID models, especially regarding interaction terms,[36] linear models are often used to preserve interpretability of the treatment effect coefficient.

A frequent concern with DID models in policy evaluation application is that the program and intervention groups may differ in ways that are related to their trends

over time, or their compositions may change over time.[d] To address this concern, we conducted DID analysis using propensity score weighted linear regression model suggested by Stuart et al.[23] We applied propensity score methods in the context of DID models. There are four groups defined by time and intervention status: treatment pre-HTW Demonstration (Group 1), treatment post-HTW Demonstration (Group 2), comparison pre-HTW Demonstration (Group 3), and comparison post-HTW Demonstration (Group 4). This propensity score weighting strategy defines the propensity score as the probability of being in Group 1 (versus Groups 2, 3, or 4) and weights the four groups to be balanced on a set of characteristics. To estimate the propensity scores, we fitted a multinomial logistic regression predicting Group as a function of a set of observed covariates *X* including age, race/ethnicity, and maternal comorbidities. Each individual will have four resulting propensity scores, $e_k(X_i)$: the probability of being in Group *k*, for *k*=1 to 4. The weights are then created in such a way that each of the four groups is weighted to be similar to Group 1, the treatment group in the pre-period. The weight for individual *i* was calculated as:

$$w_i = \frac{e_1(X_i)}{e_g(X_i)}$$

where *g* refers to the group that individual *i* was actually in. Thus, individuals in Group 1 will receive a weight of 1, while individuals in other groups receive a weight that is proportional to the probability of their being in Group 1 relative to the probability of their being in the group, they were actually in.

As mentioned previously, not all MCI comorbidities could be included in each of the three analysis, as some co morbidities overlapped with pregnancy complications and others with SMM. We therefore run separate models for each measure analysis and created weights specific to each measure. Tables below describe means and proportions for each group as well as the resulting propensity score weighted standardized mean differences for each measure analysis.

[d] If selection bias between the intervention and comparison groups is not consistent over time, bias may be introduced into the DID model. To help account for potential selection threats, the evaluator may choose to employ balancing techniques such as PSM prior to conducting DID analyses. Implementing PSM during the sample identification phase may help reduce potential bias originating from differences in observed characteristics between the intervention and comparison groups.

Table 29: Mean and Propensity Score Weighted Standardized Mean Difference Across Groups for Pregnancy-Related Complications Comparisons

	Mean				Propensity Score Weighted Standardized Mean Difference		
	HTW, pre (1)	HTW, post (2)	No HTW, pre (3)	No HTW, post (4)	2 vs 1	3 vs 1	4 vs 1
Maternal Age (mean)	26.5	26.9	25.7	26.1	0.03	0.01	0.02
Race/ Ethnicity (%)							
NH White	19.5	19.3	24.4	22.9	0.00	0.00	0.00
NH Black	21.5	20.7	16.5	16.8	0.00	0.00	0.00
Hispanic	55.0	56.2	53.2	54.5	-0.01	0.00	0.00
NH Other	4.0	3.8	5.9	5.8	0.00	0.00	0.00
Maternal Comorbidities (%)							
Obstetrics	38.5	40.6	34.6	36.3	0.00	0.00	0.01
General Health	33.0	29.3	30.2	28.1	-0.01	0.00	0.00
Substance Use	10.7	7.3	8.8	6.3	0.00	0.00	0.00
Autoimmune	1.1	1.1	0.8	0.9	0.00	0.00	0.00
Cardio	0.3	0.4	0.3	0.3	0.00	0.00	0.00
Renal	0.1	0.1	0.1	0.1	0.00	0.00	0.00

Table 30: Mean and Propensity Score Weighted Standardized Mean Difference Across Groups for Severe Maternal Morbidity Comparisons

	Mean				Propensity Score Weighted Standardized Mean Difference		
	HTW, pre (1)	HTW, post (2)	No HTW, pre (3)	No HTW, post (4)	2 vs 1	3 vs 1	4 vs 1
Maternal Age (mean)	26.7	27.1	25.9	26.2	0.03	0.01	0.02
Race/ Ethnicity (%)							
NH White	19.4	19.3	24.3	22.8	0.00	0.00	0.00
NH Black	22.4	21.3	17.2	17.4	0.00	0.00	0.00
Hispanic	54.1	55.6	52.5	54.0	-0.01	0.00	0.00
NH Other	4.1	3.8	6.0	5.8	0.00	0.00	0.00
Maternal Comorbidities (%)							
Obstetrics	40.5	42.0	36.5	37.8	0.00	0.00	0.01
General Health	38.4	33.9	34.8	32.3	-0.01	0.00	0.00
Substance Use	11.6	7.6	9.6	6.6	-0.01	0.00	0.00
Autoimmune	1.3	1.1	0.9	0.9	0.00	0.00	0.00
Cardio	0.4	0.4	0.4	0.4	0.00	0.00	0.00
Renal	0.2	0.2	0.2	0.2	0.00	0.00	0.00

Table 31: Mean and Propensity Score Weighted Standardized Mean Difference Across Groups for Low Weight and Preterm Births

	Mean				Propensity Score Weighted Standardized Mean Difference		
	HTW, pre (1)	HTW, post (2)	No HTW, pre (3)	No HTW, post (4)	2 vs 1	3 vs 1	4 vs 1
Maternal Age, (mean)	26.7	27.1	25.9	26.2	0.03	0.01	0.02
Race/ Ethnicity, %							
NH White	19.4	19.3	24.3	22.8	0.00	0.00	0.00
NH Black	22.4	21.3	17.2	17.4	0.00	0.00	0.00
Hispanic	54.1	55.6	52.5	54.0	-0.01	0.00	0.00
NH Other	4.1	3.8	6.0	5.8	0.00	0.00	0.00
Maternal Comorbidities (%)							
Obstetrics	40.5	42.0	36.5	37.8	0.00	0.00	0.01
General Health	38.4	33.9	34.8	32.3	-0.01	0.00	0.00
Substance Use	11.6	7.6	9.6	6.6	-0.01	0.00	0.00
Autoimmune	1.3	1.1	0.9	0.9	0.00	0.00	0.00
Cardio	0.4	0.4	0.4	0.4	0.00	0.00	0.00
Renal	0.2	0.2	0.2	0.2	0.00	0.00	0.00

These weights are then incorporated to the traditional DID model that was run for each one of the measures (3.2.3-3.2.5). Results were displayed as proportion of the population meeting the outcome criteria. Additionally, we plotted proportions for each, HTW and control groups, pre- and post-HTW Demonstration Periods.

Evaluation Question #4: Costs

Measurement of Demonstration costs followed the specifications under the CMS-approved Evaluation Design.

Evaluation Question #5: Provider Eligibility Criteria

The evaluation of measure 5.1.1 followed the CMS-approved Evaluation Design. The identification of providers billing for family planning services was done using the list of Current Procedural Terminology (CPT) codes and logic provided by Texas HHSC.

Appendix B: Additional Results

Evaluation Question #1: Access to family planning, family planning-related, and preconception care services

Table 32: Clients Characteristics, Enrollment, and Use of Services (Measures 1.1.1 and 1.1.2)

	Total N (%)	Pre-HTW Demonstration N (%)	Post-HTW Demonstration N (%)	p-value
No. of HTW Enrollees	2,176,982	1,287,121	889,861	
Age Group				
18-24	643,567 (29.6)	412,231 (32.0)	231,336 (26.0)	<0.001
25-29	577,546 (26.5)	352,159 (27.4)	225,387 (25.3)	
30-34	445,379 (20.5)	252,378 (19.6)	193,001 (21.7)	
35-39	311,593 (14.3)	170,476 (13.2)	141,117 (15.9)	
40-44	198,897 (9.1)	99,877 (7.8)	99,020 (11.1)	
Race/Ethnicity				
NH White	486,618 (22.4)	292,974 (22.8)	193,644 (21.8)	<0.001
NH Black	516,188 (23.7)	307,321 (23.9)	208,867 (23.5)	
Hispanic	1,039,231 (47.7)	621,358 (48.3)	417,873 (47.0)	
Asian	27,585 (1.3)	16,843 (1.3)	10,742 (1.2)	
American Indian or Alaskan	5,986 (0.3)	3,575 (0.3)	2,411 (0.3)	
Other/Unknown	101,374 (4.7)	45,050 (3.5)	56,324 (6.3)	
Texas Public Health Region				
1	76,476 (3.5)	46,702 (3.6)	29,774 (3.3)	<0.001
2	41,266 (1.9)	25,412 (2.0)	15,854 (1.8)	
3	451,039 (20.7)	267,571 (20.8)	183,468 (20.6)	
4	98,712 (4.5)	59,646 (4.6)	39,066 (4.4)	
5	76,583 (3.5)	47,100 (3.7)	29,483 (3.3)	

	Total N (%)	Pre-HTW Demonstration N (%)	Post-HTW Demonstration N (%)	p-value
6	539,259 (24.8)	321,745 (25.0)	217,514 (24.4)	
7	199,344 (9.2)	120,210 (9.3)	79,134 (8.9)	
8	244,552 (11.2)	147,789 (11.5)	96,763 (10.9)	
9	54,387 (2.5)	32,784 (2.5)	21,603 (2.4)	
10	84,656 (3.9)	52,468 (4.1)	32,188 (3.6)	
11	264,271 (12.1)	158,825 (12.3)	105,446 (11.8)	
Unknown	46,437 (2.1)	6,869 (0.5)	39,568 (4.4)	
No. of Enrolled Months				
Median (IQR)	9 (5-12)	7 (4-10)	12 (8-12)	<0.001
Mean (SD)	8.1 (3.9)	7.0 (3.7)	9.6 (3.6)	<0.001
Receipt of HTW service				
Prescription/Drug	277,860 (12.8)	171,915 (13.4)	105,945 (11.9)	<0.001
Medical	770,561 (35.4)	435,683 (33.8)	334,878 (37.6)	<0.001
Any	838,166 (38.5)	479,899 (37.3)	358,267 (40.3)	<0.001

Notes. All numbers indicate the number of HTW clients and percentage except for No. of enrolled months. P-values are reported for statistical differences between pre- and post-Demonstration periods using Chi-square (age group, race/ethnicity, region, and receipt of HTW service), Wilcoxon rank sum (median enrolled months), and t-tests (mean enrolled months).

Table 33: Clients Characteristics, Enrollment, and Use of Services (Measures 1.1.1 and 1.1.2): By Year

	Total, N (%)	2017, N (%)	2018, N (%)	2019, N (%)	2020, N (%)	2021, N (%)	p-value
No. of HTW Enrollees	2,176,982	344,920	445,094	497,107	436,545	453,316	
Age Group							
18-24	643,567 (29.6)	114,447 (33.2)	140,875 (31.7)	156,909 (31.6)	124,613 (28.5)	106,723 (23.5)	<0.001
25-29	577,546 (26.5)	94,028 (27.3)	121,737 (27.4)	136,394 (27.4)	115,285 (26.4)	110,102 (24.3)	
30-34	445,379 (20.5)	65,988 (19.1)	87,467 (19.7)	98,923 (19.9)	91,918 (21.1)	101,083 (22.3)	
35-39	311,593 (14.3)	44,145 (12.8)	59,798 (13.4)	66,533 (13.4)	64,299 (14.7)	76,818 (16.9)	
40-44	198,897 (9.1)	26,312 (7.6)	35,217 (7.9)	38,348 (7.7)	40,430 (9.3)	58,590 (12.9)	
Race/Ethnicity							
NH White	486,618 (22.4)	79,111 (22.9)	102,040 (22.9)	111,823 (22.5)	97,162 (22.3)	96,482 (21.3)	<0.001
NH Black	516,188 (23.7)	82,751 (24.0)	107,198 (24.1)	117,372 (23.6)	104,372 (23.9)	104,495 (23.1)	
Hispanic	1,039,231 (47.7)	166,202 (48.2)	212,915 (47.8)	242,241 (48.7)	212,857 (48.8)	205,016 (45.2)	
Asian	27,585 (1.3)	4,480 (1.3)	5,900 (1.3)	6,463 (1.3)	5,346 (1.2)	5,396 (1.2)	
American Indian or Alaskan	5,986 (0.3)	962 (0.3)	1,278 (0.3)	1,335 (0.3)	1,220 (0.3)	1,191 (0.3)	
Other/Unknown	101,374 (4.7)	11,414 (3.3)	15,763 (3.5)	17,873 (3.6)	15,588 (3.6)	40,736 (9.0)	
Texas Public Health Region							
1	76,476 (3.5)	12,924 (3.7)	15,923 (3.6)	17,855 (3.6)	15,203 (3.5)	14,571 (3.2)	<0.001
2	41,266 (1.9)	7,072 (2.1)	8,590 (1.9)	9,750 (2.0)	8,171 (1.9)	7,683 (1.7)	
3	451,039 (20.7)	68,931 (20.0)	92,087 (20.7)	106,553 (21.4)	93,668 (21.5)	89,800 (19.8)	
4	98,712 (4.5)	16,098 (4.7)	20,470 (4.6)	23,078 (4.6)	19,982 (4.6)	19,084 (4.2)	
5	76,583 (3.5)	12,944 (3.8)	16,587 (3.7)	17,569 (3.5)	15,107 (3.5)	14,376 (3.2)	
6	539,259 (24.8)	84,646 (24.5)	114,581 (25.7)	122,518 (24.6)	109,631 (25.1)	107,883 (23.8)	
7	199,344 (9.2)	32,970 (9.6)	41,042 (9.2)	46,198 (9.3)	40,292 (9.2)	38,842 (8.6)	
8	244,552 (11.2)	40,164 (11.6)	50,328 (11.3)	57,297 (11.5)	50,288 (11.5)	46,475 (10.3)	
9	54,387 (2.5)	9,022 (2.6)	11,055 (2.5)	12,707 (2.6)	11,117 (2.5)	10,486 (2.3)	
10	84,656 (3.9)	14,845 (4.3)	18,002 (4.0)	19,621 (3.9)	16,754 (3.8)	15,434 (3.4)	
11	264,271 (12.1)	43,581 (12.6)	54,009 (12.1)	61,235 (12.3)	54,039 (12.4)	51,407 (11.3)	

	Total, N (%)	2017, N (%)	2018, N (%)	2019, N (%)	2020, N (%)	2021, N (%)	p-value
Unknown	46,437 (2.1)	1,723 (0.5)	2,420 (0.5)	2,726 (0.5)	2,293 (0.5)	37,275 (8.2)	
No. of Enrolled Months							
Median (IQR)	9 (5-12)	7 (4-11)	7 (4-10)	7 (4-10)	12 (6-12)	12 (10-12)	<0.001
Mean (SD)	8.1 (3.9)	7.1 (3.7)	6.8 (3.7)	7.0 (3.6)	9.0 (3.9)	10.2 (3.3)	<0.001
Receipt of HTW service							
Prescription/Drug	277,860 (12.8)	49,797 (14.4)	58,852 (13.2)	63,266 (12.7)	58,128 (13.3)	47,817 (10.5)	<0.001
Medical	770,561 (35.4)	119,753 (34.7)	147,694 (33.2)	168,236 (33.8)	164,488 (37.7)	170,390 (37.6)	<0.001
Any	838,166 (38.5)	132,922 (38.5)	162,852 (36.6)	184,125 (37.0)	177,642 (40.7)	180,625 (39.8)	<0.001

Notes. All numbers indicate the number of HTW clients and percentage except for No. of enrolled months. P-values are reported for statistical differences between across years using Chi-square (age group, race/ethnicity, region and receipt of HTW service), Kruskal-Wallis (median enrolled months), and ANOVA (mean enrolled months).

Table 34: Unique Clients, Retained vs. New and Member Years by Age Category

Age	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
18-24	2017	N/A	114,447	114,447	65,979
	2018	74,804	66,071	140,875	77,616
	2019	89,942	66,967	156,909	89,059
	2020	90,150	34,463	124,613	92,994
	2021	87,016	19,707	106,723	89,026
	Annual Pre-HTW Demonstration Average (2017-2019)	82,373	66,519	137,410	77,551
	Annual Post-HTW Demonstration Average (2020-2021)	88,583	27,085	115,668	91,010
	Pre/Post Diff.	6,210	-39,434	-21,742	13,459
	% Change	*7.5%*	*-59.3%*	*-15.8%*	*17.4%*

Age	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
25-29	2017	N/A	94,028	94,028	55,651
	2018	72,321	49,416	121,737	69,254
	2019	90,926	45,468	136,394	79,866
	2020	91,617	23,668	115,285	87,023
	2021	96,173	13,929	110,102	93,880
	Annual Pre-HTW Demonstration Average (2017-2019)	81,624	47,442	117,386	68,257
	Annual Post-HTW Demonstration Average (2020-2021)	93,895	18,799	112,694	90,452
	Pre/Post Diff.	12,272	-28,644	-4,693	22,195
	% Change	*15.0%*	*-60.4%*	*-4.0%*	*32.5%*
30-34	2017	N/A	65,988	65,988	39,850
	2018	52,867	34,600	87,467	50,828
	2019	66,998	31,925	98,923	59,096
	2020	72,133	19,785	91,918	69,970
	2021	86,827	14,256	101,083	86,545
	Annual Pre-HTW Demonstration Average (2017-2019)	59,933	33,263	84,126	49,925
	Post	79,480	17,021	96,501	78,257
	Pre/Post Diff.	19,548	-16,242	12,375	28,333
	% Change	*32.6%*	*-48.8%*	*14.7%*	*56.8%*

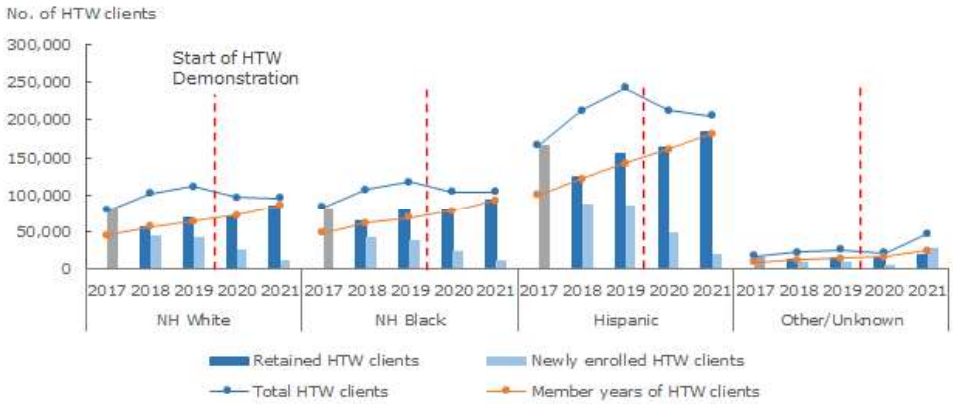
Age	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
35-39	2017	N/A	44,145	44,145	26,827
	2018	35,989	23,809	59,798	35,287
	2019	44,617	21,916	66,533	40,210
	2020	48,590	15,709	64,299	49,089
	2021	63,394	13,424	76,818	65,645
	Annual Pre-HTW Demonstration Average (2017-2019)	40,303	22,863	56,825	34,108
	Post	55,992	14,567	70,559	57,367
	Pre/Post Diff.	15,689	-8,296	13,733	23,259
	% Change	*38.9%*	*-36.3%*	*24.2%*	*68.2%*
40-44	2017	N/A	26,312	26,312	15,355
	2018	21,598	13,619	35,217	20,088
	2019	25,847	12,501	38,348	22,101
	2020	29,166	11,264	40,430	30,143
	2021	46,960	11,630	58,590	50,090
	Annual Pre-HTW Demonstration Average (2017-2019)	23,723	13,060	33,292	19,181
	Post	38,063	11,447	49,510	40,117
	Pre/Post Diff.	14,341	-1,613	16,218	20,935
	% Change	*60.5%*	*-12.4%*	*48.7%*	*109.1%*

Table 35: Unique Clients, Retained vs. New and Member Years by Race and Ethnicity

Race/ Ethnicity	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
NH White	2017	N/A	79,111	79,111	45,967
	2018	57,039	45,001	102,040	56,797
	2019	69,068	42,755	111,823	63,953
	2020	71,429	25,733	97,162	72,516
	2021	84,375	12,107	96,482	85,613
	Annual Pre-HTW Demonstration Average (2017-2019)	63,054	43,878	97,658	55,572
	Annual Post-HTW Demonstration Average (2020-2021)	77,902	18,920	96,822	79,065
	Pre/Post Diff.	14,849	-24,958	-836	23,492
	% Change	*23.5%*	*-56.9%*	*-0.9%*	*42.3%*
NH Black	2017	N/A	82,751	82,751	48,795
	2018	63,718	43,480	107,198	61,859
	2019	78,099	39,273	117,372	69,249
	2020	80,097	24,275	104,372	78,807
	2021	92,653	11,842	104,495	92,494
	Annual Pre-HTW Demonstration Average (2017-2019)	70,909	41,377	102,440	59,968
	Annual Post-HTW Demonstration Average (2020-2021)	86,375	18,059	104,434	85,651
	Pre/Post Diff.	15,467	-23,318	1,993	25,683
	% Change	*21.8%*	*-56.4%*	*1.9%*	*42.8%*

Race/ Ethnicity	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
Hispanic	2017	N/A	166,202	166,202	99,300
	2018	124,630	88,285	212,915	121,784
	2019	156,021	86,220	242,241	142,585
	2020	164,596	48,261	212,857	161,478
	2021	184,048	20,968	205,016	181,898
	Annual Pre-HTW Demonstration Average (2017-2019)	140,326	87,253	207,119	121,223
	Annual Post-HTW Demonstration Average (2020-2021)	174,322	34,615	208,937	171,688
	Pre/Post Diff.	33,997	-52,638	1,817	50,465
	% Change	*24.2%*	*-60.3%*	*0.9%*	*41.6%*
Other/ Unknown	2017	N/A	16,856	16,856	9,600
	2018	12,192	10,749	22,941	12,633
	2019	15,142	10,529	25,671	14,545
	2020	15,534	6,620	22,154	16,418
	2021	19,294	28,029	47,323	25,182
	Annual Pre-HTW Demonstration Average (2017-2019)	13,667	10,639	21,823	12,259
	Annual Post-HTW Demonstration Average (2020-2021)	17,414	17,325	34,739	20,800
	Pre/Post Diff.	3,747	6,686	12,916	8,541
	% Change	*27.4%*	*62.8%*	*59.2%*	*69.7%*

Figure 24: Trends in Unique Clients, Retained vs. New and Member Years by Race and Ethnicity



Notes. Dark blue bars represent HTW clients retained from the prior year, while light blue bars represent those newly enrolled. Since 2017 is the first year of data, the grey bar indicates HTW clients enrolled in 2017 regardless of their previous enrollment.

Table 36: Unique Clients, Retained vs. New and Member Years by Texas Public Health Region

Public Health Region	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
1	2017	N/A	12,924	12,924	7,589
	2018	9,210	6,713	15,923	9,106
	2019	11,498	6,357	17,855	10,353
	2020	11,895	3,308	15,203	11,502
	2021	12,924	1,647	14,571	12,997
	Annual Pre-HTW Demonstration Average (2017-2019)	10,354	6,535	15,567	9,016
	Annual Post-HTW Demonstration average (2020-2021)	12,410	2,478	14,887	12,249
	Pre/Post Diff.	2,056	-4,058	-680	3,233
	% Change	*19.9%*	*-62.1%*	*-4.4%*	*35.9%*
2	2017		7,072	7,072	4,126
	2018	4,900	3,690	8,590	4,753
	2019	6,067	3,683	9,750	5,566
	2020	6,322	1,849	8,171	6,153
	2021	6,775	908	7,683	6,874
	Annual Pre-HTW Demonstration average (2017-2019)	5,484	3,687	8,471	4,815
	Annual Post-HTW Demonstration average (2020-2021)	6,549	1,379	7,927	6,513
	Pre/Post Diff.	1,065	-2,308	-544	1,698
	% Change	*19.4%*	*-62.6%*	*-6.4%*	*35.3%*

Public Health Region	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
3	2017	N/A	68,931	68,931	39,545
	2018	50,420	41,667	92,087	52,049
	2019	65,849	40,704	106,553	61,677
	2020	69,530	24,138	93,668	70,257
	2021	78,428	11,372	89,800	80,363
	Annual Pre-HTW Demonstration average (2017-2019)	58,135	41,186	89,190	51,091
	Annual Post-HTW Demonstration average (2020-2021)	73,979	17,755	91,734	75,310
	Pre/Post Diff.	15,845	-23,431	2,544	24,220
	% Change	*27.3%*	*-56.9%*	*2.9%*	*47.4%*
4	2017	N/A	16,098	16,098	9,456
	2018	11,744	8,726	20,470	11,827
	2019	14,825	8,253	23,078	13,528
	2020	15,330	4,652	19,982	15,139
	2021	16,798	2,286	19,084	17,064
	Annual Pre-HTW Demonstration average (2017-2019)	13,285	8,490	19,882	11,604
	Annual Post-HTW Demonstration average (2020-2021)	16,064	3,469	19,533	16,102
	Pre/Post Diff.	2,780	-5,021	-349	4,498
	% Change	*20.9%*	*-59.1%*	*-1.8%*	*38.8%*

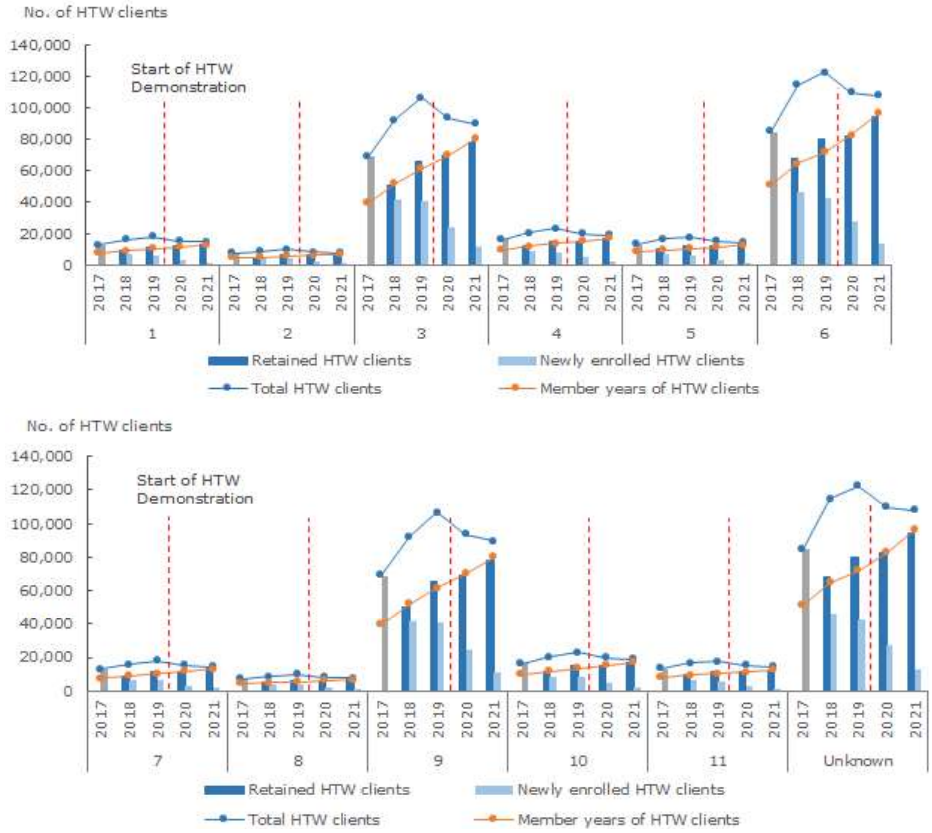
Public Health Region	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
5	2017	N/A	12,944	12,944	7,885
	2018	9,986	6,601	16,587	9,448
	2019	11,720	5,849	17,569	10,391
	2020	11,807	3,300	15,107	11,467
	2021	12,810	1,566	14,376	12,809
	Annual Pre-HTW Demonstration average (2017-2019)	10,853	6,225	15,700	9,241
	Annual Post-HTW Demonstration average (2020-2021)	12,309	2,433	14,742	12,138
	Pre/Post Diff.	1,456	-3,792	-959	2,897
	% Change	*13.4%*	*-60.9%*	*-6.1%*	*31.3%*
6	2017	N/A	84,646	84,646	50,862
	2018	68,154	46,427	114,581	64,840
	2019	79,763	42,755	122,518	72,026
	2020	82,386	27,245	109,631	82,700
	2021	94,644	13,239	107,883	96,433
	Annual Pre-HTW Demonstration average (2017-2019)	73,959	44,591	107,248	62,576
	Annual Post-HTW Demonstration average (2020-2021)	88,515	20,242	108,757	89,567
	Pre/Post Diff.	14,557	-24,349	1,509	26,990
	% Change	*19.7%*	*-54.6%*	*1.4%*	*43.1%*

Public Health Region	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
7	2017	N/A	32,970	32,970	19,247
	2018	23,421	17,621	41,042	23,409
	2019	29,214	16,984	46,198	26,668
	2020	30,352	9,940	40,292	30,585
	2021	34,272	4,570	38,842	35,022
	Annual Pre-HTW Demonstration average (2017-2019)	26,318	17,303	40,070	23,108
	Annual Post-HTW Demonstration average (2020-2021)	32,312	7,255	39,567	32,804
	Pre/Post Diff.	5,995	-10,048	-503	9,695
	% Change	*22.8%*	*-58.1%*	*-1.3%*	*42.0%*
8	2017	N/A	40,164	40,164	23,611
	2018	28,876	21,452	50,328	28,711
	2019	36,719	20,578	57,297	33,508
	2020	38,806	11,482	50,288	38,120
	2021	41,595	4,880	46,475	41,862
	Annual Pre-HTW Demonstration average (2017-2019)	32,798	21,015	49,263	28,610
	Annual Post-HTW Demonstration average (2020-2021)	40,201	8,181	48,382	39,991
	Pre/Post Diff.	7,403	-12,834	-882	11,381
	% Change	*22.6%*	*-61.1%*	*-1.8%*	*39.8%*

Public Health Region	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
9	2017	N/A	9,022	9,022	5,303
	2018	6,234	4,821	11,055	6,073
	2019	7,748	4,959	12,707	7,266
	2020	8,208	2,909	11,117	8,226
	2021	9,245	1,241	10,486	9,317
	Annual Pre-HTW Demonstration average (2017-2019)	6,991	4,890	10,928	6,214
	Annual Post-HTW Demonstration average (2020-2021)	8,727	2,075	10,802	8,772
	Pre/Post Diff.	1,736	-2,815	-127	2,557
	% Change	*24.8%*	*-57.6%*	*-1.2%*	*41.2%*
10	2017	N/A	14,845	14,845	8,937
	2018	10,816	7,186	18,002	10,743
	2019	13,068	6,553	19,621	11,781
	2020	13,124	3,630	16,754	12,904
	2021	13,968	1,466	15,434	14,017
	Annual Pre-HTW Demonstration average (2017-2019)	11,942	6,870	17,489	10,487
	Annual Post-HTW Demonstration average (2020-2021)	13,546	2,548	16,094	13,460
	Pre/Post Diff.	1,604	-4,322	-1,395	2,974
	% Change	*13.4%*	*-62.9%*	*-8.0%*	*28.4%*

Public Health Region	Year	Retained HTW Clients	Newly Enrolled HTW Clients	Total HTW Clients	Member Years of HTW Clients
11	2017	N/A	43,581	43,581	26,356
	2018	32,544	21,465	54,009	31,151
	2019	40,316	20,919	61,235	36,448
	2020	42,172	11,867	54,039	40,924
	2021	45,911	5,496	51,407	45,803
	Annual Pre-HTW Demonstration average (2017-2019)	36,430	21,192	52,942	31,318
	Annual Post-HTW Demonstration average (2020-2021)	44,042	8,682	52,723	43,363
	Pre/Post Diff.	7,612	-12,511	-219	12,045
	% Change	*20.9%*	*-59.0%*	*-0.4%*	*38.5%*
Unknown	2017	N/A	1,723	1,723	743
	2018	1,274	1,146	2,420	962
	2019	1,543	1,183	2,726	1,120
	2020	1,724	569	2,293	1,243
	2021	13,000	24,275	37,275	12,625
	Annual Pre-HTW Demonstration average (2017-2019)	1,409	1,165	2,290	942
	Annual Post-HTW Demonstration average (2020-2021)	7,362	12,422	19,784	6,934
	Pre/Post Diff.	5,954	11,258	17,494	5,992
	% Change	*422.7%*	*966.7%*	*764.1%*	*636.2%*

Figure 25: Trends in Unique Clients, Retained vs. New and Member Years by Texas Public Health Region



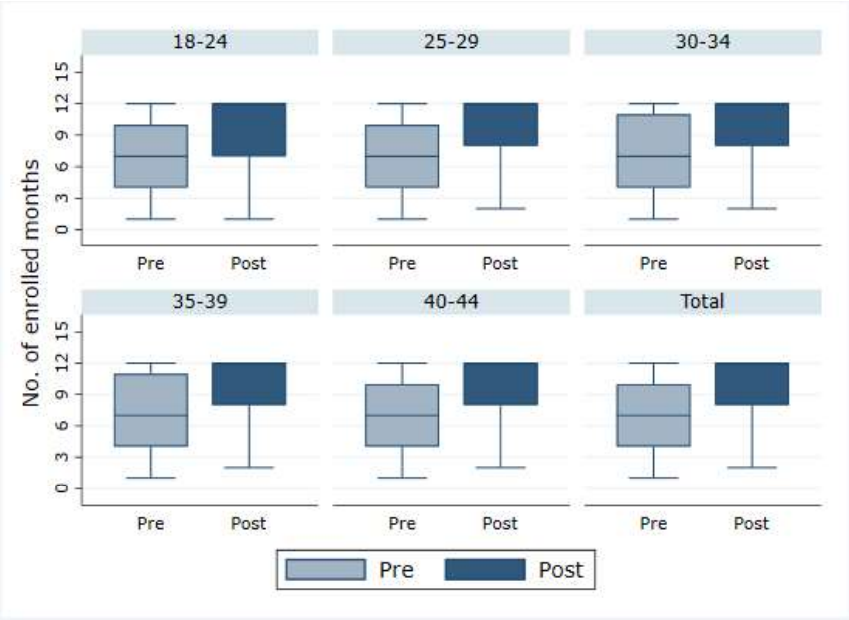
Notes. Dark blue bars represent HTW clients retained from the prior year, while light blue bars represent those newly enrolled. Since 2017 is the first year of data, the grey bar indicates HTW clients enrolled in 2017 regardless of their previous enrollment.

Table 37: Enrollment Months per Year per Client

	Median (IQR)[1]			Mean (SD)[2]		
Subgroup	**Pre**	**Post**	**p-value[3]**	**Pre**	**Post**	**p-value[3]**
All	7 (4-10)	12 (8-12)	<0.001	7.0 (3.7)	9.6 (3.6)	<0.001
Age Group						
18-24	7 (4-10)	12 (7-12)	<0.001	6.8 (3.6)	9.4 (3.7)	<0.001
25-29	7 (4-10)	12 (8-12)	<0.001	7.0 (3.7)	9.6 (3.7)	<0.001
30-34	7 (4-11)	12 (8-12)	<0.001	7.1 (3.7)	9.7 (3.6)	<0.001
35-39	7 (4-11)	12 (8-12)	<0.001	7.2 (3.7)	9.8 (3.6)	<0.001
40-44	7 (4-10)	12 (8-12)	<0.001	6.9 (3.7)	9.7 (3.6)	<0.001
Race/ Ethnicity						
NH White	7 (4-10)	12 (8-12)	<0.001	6.8 (3.6)	9.8 (3.5)	<0.001
NH Black	7 (4-10)	12 (8-12)	<0.001	7.0 (3.7)	9.8 (3.5)	<0.001
Hispanic	7 (4-10)	12 (9-12)	<0.001	7.0 (3.7)	9.9 (3.5)	<0.001
Other/ Unknown	7 (4-10)	7 (3-12)	<0.001	6.7 (3.6)	7.2 (4.5)	<0.001
Texas Public Health Region						
1	7 (4-10)	12 (8-12)	<0.001	7.0 (3.6)	9.9 (3.5)	<0.001
2	7 (4-10)	12 (8-12)	<0.001	6.8 (3.6)	9.9 (3.5)	<0.001
3	7 (4-10)	12 (9-12)	<0.001	6.9 (3.6)	9.9 (3.5)	<0.001
4	7 (4-10)	12 (9-12)	<0.001	7.0 (3.7)	9.9 (3.4)	<0.001
5	7 (4-11)	12 (9-12)	<0.001	7.1 (3.7)	9.9 (3.5)	<0.001
6	7 (4-11)	12 (9-12)	<0.001	7.0 (3.7)	9.9 (3.4)	<0.001
7	7 (4-10)	12 (9-12)	<0.001	6.9 (3.6)	9.9 (3.4)	<0.001
8	7 (4-10)	12 (9-12)	<0.001	7.0 (3.7)	9.9 (3.4)	<0.001
9	7 (4-10)	12 (8-12)	<0.001	6.8 (3.6)	9.7 (3.5)	<0.001
10	7 (4-11)	12 (9-12)	<0.001	7.2 (3.7)	10.0 (3.4)	<0.001
11	7 (4-11)	12 (9-12)	<0.001	7.1 (3.7)	9.9 (3.5)	<0.001
Unknown	4 (3-7)	3 (2-4)	<0.001	4.9 (2.9)	4.2 (3.5)	<0.001

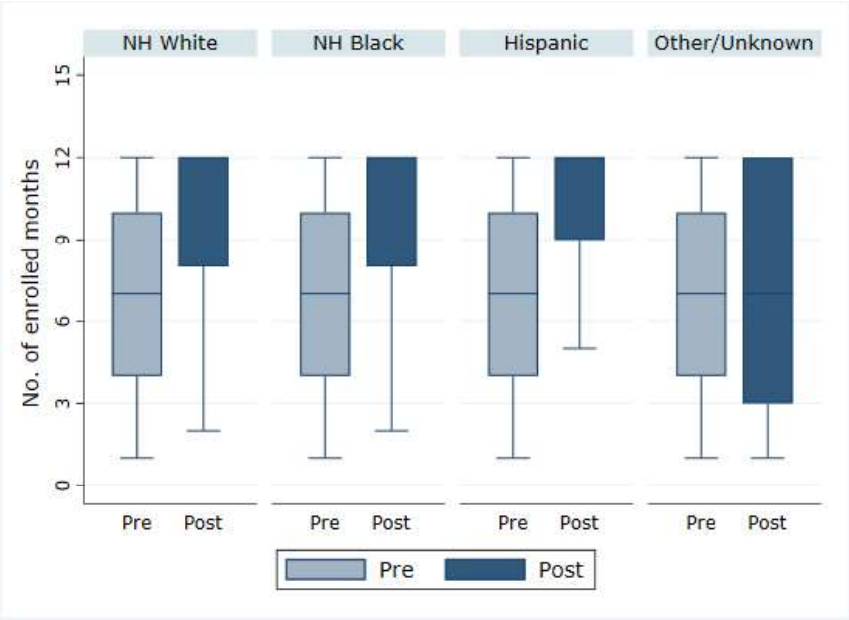
Notes. [1] IQR, interquartile range. [2] Standard deviation. [3] P-values are reported for significant differences between pre-and post-Demonstration periods using Wilcoxon rank sum for median enrolled months and t-tests for mean enrolled months.

Figure 26: Enrolled Months for HTW Clients: Box Plots of Median, Interquartile Range, and Extreme Values Pre- and Post-HTW Demonstration by Age



Notes. Horizontal lines inside the boxes denote medians. Bottom and top borders of the boxes denote IQR. Whiskers denote range of values.

Figure 27: Enrolled Months for HTW Clients: Box Plots of Median, Interquartile Range, and Extreme Values Pre- and Post-HTW Demonstration by Race and Ethnicity



Notes. Horizontal lines inside the boxes denote medians. Bottom and top borders of the boxes denote IQR. Whiskers denote range of values.

Table 38: Annual Proportion of HTW Clients Receiving Any Services, Medical and Prescription Services by Age Category

Age	Year	Any HTW Service	Medical Service	Prescription
18-24	2017	41.1	37.0	15.9
	2018	39.8	36.0	15.0
	2019	40.8	37.2	14.5
	2020	45.8	42.3	15.5
	2021	43.4	40.9	12.2
	Annual Pre-HTW Demonstration Average (2017-2019)	40.5	36.8	15.1
	Annual Post-HTW Demonstration Average (2020-2021)	44.7	41.7	14.0
	Point change	*4.1*	*4.9*	*-1.1*
	% Change[1]	*10.2*	*13.3*	*-7.0*
	p-values[2]	<0.001	<0.001	<0.001
25-29	2017	39.2	35.1	15.8
	2018	36.9	33.2	14.4
	2019	36.8	33.4	13.6
	2020	41.0	37.8	14.5
	2021	41.2	38.9	11.7
	Annual Pre-HTW Demonstration Average (2017-2019)	37.5	33.8	14.5
	Annual Post-HTW Demonstration Average (2020-2021)	41.1	38.3	13.1
	Point change	*3.6*	*4.5*	*-1.4*
	% Change[1]	*9.7*	*13.4*	*-9.4*
	p-values[2]	<0.001	<0.001	<0.001

Age	Year	Any HTW Service	Medical Service	Prescription
30-34	2017	36.9	33.1	13.9
	2018	34.7	31.3	12.6
	2019	35.0	31.9	12.2
	2020	38.5	35.6	12.7
	2021	39.0	36.7	10.3
	Annual Pre-HTW Demonstration Average (2017-2019)	35.4	32.0	12.8
	Annual Post-HTW Demonstration Average (2020-2021)	38.8	36.2	11.4
	Point change	*3.3*	*4.2*	*-1.4*
	% Change[1]	*9.4*	*13.1*	*-10.8*
	p-values[2]	<0.001	<0.001	<0.001
35-39	2017	35.6	32.3	11.7
	2018	33.3	30.4	10.6
	2019	33.4	30.9	10.0
	2020	36.3	33.7	10.6
	2021	36.6	34.5	9.0
	Annual Pre-HTW Demonstration Average (2017-2019)	33.9	31.1	10.7
	Annual Post-HTW Demonstration Average (2020-2021)	36.4	34.1	9.8
	Point change	*2.5*	*3.1*	*-0.9*
	% Change[1]	*7.4*	*9.8*	*-8.7*
	p-values[2]	<0.001	<0.001	<0.001

Age	Year	Any HTW Service	Medical Service	Prescription
40-44	2017	34.0	31.5	9.2
	2018	33.1	31.2	8.2
	2019	33.8	31.9	8.3
	2020	36.2	34.3	9.0
	2021	36.5	34.7	7.9
	Annual Pre-HTW Demonstration Average (2017-2019)	33.6	31.5	8.5
	Annual Post-HTW Demonstration Average (2020-2021)	36.4	34.5	8.4
	Point change	*2.8*	*3.0*	*-0.1*
	% Change[1]	*8.2*	*9.5*	*-1.5*
	p-values[2]	<0.001	<0.001	0.29

Notes. [1] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [2] P-values are reported from Chi-square tests.

Figure 28: Annual Trends in Proportion of HTW Clients Receiving Any Services, Medical and Prescription Services by Age Groups

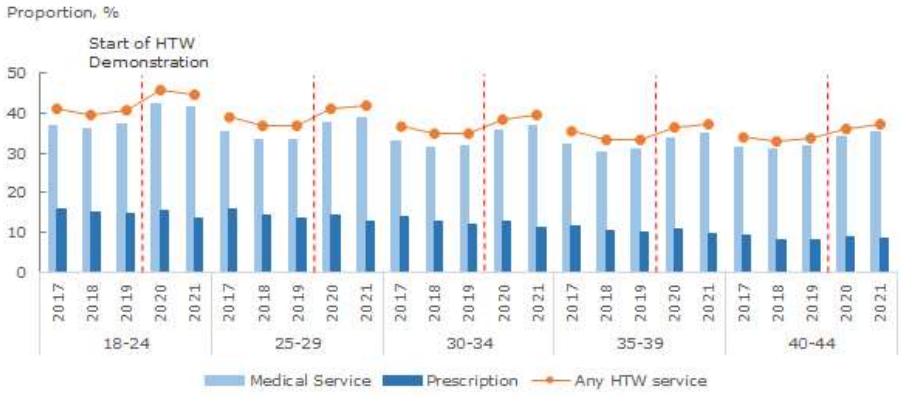


Table 39: Annual Proportion of HTW Clients Receiving Any Services, Medical and Prescription Services by Race and Ethnicity

Age	Year	Any HTW Service	Medical Service	Prescription
NH White	2017	35.5	30.8	14.5
	2018	33.4	29.1	13.0
	2019	33.2	29.1	12.5
	2020	36.5	32.7	12.8
	2021	36.6	34.0	9.7
	Annual Pre-HTW Demonstration Average (2017-2019)	33.9	29.6	13.2
	Annual Post-HTW Demonstration Average (2020-2021)	36.6	33.4	11.3
	Point change	*2.7*	*3.8*	*-1.9*
	% Change[1]	*7.9*	*12.8*	*-14.6*
	p-values[2]	<0.001	<0.001	<0.001
NH Black	2017	41.2	38.0	16.0
	2018	39.0	36.1	14.7
	2019	39.2	36.4	14.1
	2020	42.6	40.0	14.7
	2021	44.0	41.9	12.2
	Annual Pre-HTW Demonstration Average (2017-2019)	39.7	36.7	14.8
	Annual Post-HTW Demonstration Average (2020-2021)	43.3	41.0	13.4
	Point change	*3.6*	*4.2*	*-1.4*
	% Change[1]	*9.2*	*11.5*	*-9.4*
	p-values[2]	<0.001	<0.001	<0.001

Age	Year	Any HTW Service	Medical Service	Prescription
Hispanic	2017	38.9	35.2	13.8
	2018	37.2	34.0	12.8
	2019	38.1	35.1	12.4
	2020	42.0	39.1	13.0
	2021	42.7	40.4	11.2
	Annual Pre-HTW Demonstration Average (2017-2019)	38.0	34.7	12.9
	Annual Post-HTW Demonstration Average (2020-2021)	42.4	39.8	12.1
	Point change	*4.4*	*5.0*	*-0.7*
	% Change[1]	*11.5*	*14.5*	*-5.8*
	p-values[2]	<0.001	<0.001	<0.001
Other/ Unknown	2017	36.4	32.4	13.3
	2018	33.4	30.1	11.5
	2019	34.0	30.8	11.1
	2020	37.2	34.3	12.0
	2021	24.7	23.2	5.8
	Annual Pre-HTW Demonstration Average (2017-2019)	34.4	31.0	11.8
	Annual Post-HTW Demonstration Average (2020-2021)	28.7	26.7	7.8
	Point change	*-5.7*	*-4.3*	*-4.0*
	% Change[1]	*-16.6*	*-13.7*	*-34.3*
	p-values[2]	<0.001	<0.001	<0.001

Notes. [1] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [2] P-values are reported from Chi-square tests.

Figure 29: Annual Trends in Proportion of HTW Clients Receiving Any Services, Medical Services, and Prescription Services by Race and Ethnicity

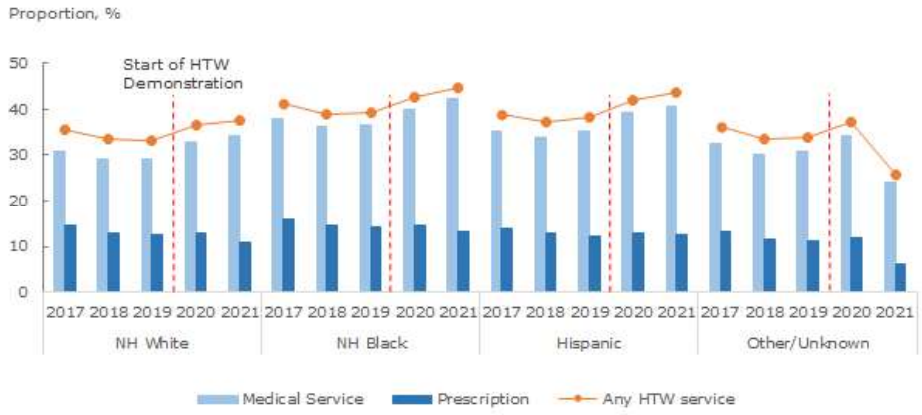


Table 40: Statewide Summary of PCP Network Adequacy

	Number of Members for Whom Access Based on Distance was Calculated	Distance Standard from Two PCPs (County Type Specific)	Performance Standard Percentage	Estimated Percent of Members Within Distance Standard from Two PCPs	Variation from Standard	Absolute Change (2020-2019)
Baseline (DY 1) Statewide Summary	262,690	---	90	87	-3	
Metro	220,709	10 Miles	90	87.5	-2.5	
Micro	16,735	20 Miles	90	72.7	-17.3	
Rural	25,246	30 Miles	90	92.1	2.1	
DY 2 Statewide Summary	334,271	---	90	89.3	-0.7	2.3
Metro	286,824	10 Miles	90	90	0	2.5
Micro	20,053	20 Miles	90	75	-15	2.3
Rural	27,394	30 Miles	90	92.2	2.2	0.1

Table 41: Detailed Comparison of 2019 vs 2020 for PCP Network Adequacy Standards (By Medicaid Managed Care Service Area and County type)

Medicaid MC Service Area / County Type	Baseline (DY 1) from Standard	DY 2 Variation from Standard	Absolute Change from Baseline to DY 2
Bexar	-0.4	1.7	2.1
Metro	-0.7	1.6	2.3
Micro	-9.2	-7.1	2
Rural	8.2	8.2	0.1
Dallas	-1.6	0.5	2
Metro	-1.5	0.5	2.1
Micro	N/A	N/A	N/A
Rural	-6.6	-7	-0.4
El Paso	4.3	2.9	-1.4
Metro	4.5	2.9	-1.6
Micro	N/A	N/A	N/A
Rural	-47.1	-90	-42.9
Harris	3.1	2.2	-0.9
Metro	2.9	2.1	-0.8
Micro	10	-10.8	-20.8
Rural	10	10	0
Hidalgo	-0.4	1.9	2.3
Metro	2.9	6.4	3.5
Micro	-40.2	-62.8	-22.6
Rural	-13.5	-23.2	-9.6
Jefferson	-2.3	91.2	3.6
Metro	-0.6	7	7.6
Micro	0.9	2.6	1.8
Rural	-11.7	-19.4	-7.8

Medicaid MC Service Area / County Type	Baseline (DY 1) from Standard	DY 2 Variation from Standard	Absolute Change from Baseline to DY 2
Lubbock	5.3	5.7	0.5
Metro	4.9	5.8	0.9
Micro	N/A	N/A	N/A
Rural	6.8	5.5	-1.3
MRSA Central Texas	-11.1	3.8	14.9
Metro	-15.9	4.3	20.2
Micro	-34	-5.7	28.3
Rural	3.9	4.8	0.9
MRSA Northeast Texas	-23.9	-23.4	0.4
Metro	-34	-34.1	-0.1
Micro	-24.7	-20.3	4.4
Rural	4.6	-0.7	-5.3
MRSA West Texas	-0.2	1.5	1.7
Metro	5.7	4.9	-0.8
Micro	-13.4	-12.1	1.3
Rural	-1.9	2	3.9
Nueces	-7.8	-2.7	5.1
Metro	-11.5	-4.9	6.6
Micro	-22.4	-14.4	7.9
Rural	8.7	9.7	1
Tarrant	-11.9	-6.9	5.1
Metro	-11.9	-6.7	5.3
Micro	-11.6	-19.7	-8.1
Rural	N/A	N/A	N/A
Travis	-3.5	-0.9	2.5
Metro	-5.9	-2.7	3.2
Micro	9.4	10	0.6
Rural	10	10	0

Notes. N/A indicates "Not Applicable" due to low client enrollment numbers.

Table 42: Pharmacy Network Adequacy Standards, Proportion of HTW Clients Meeting Standards and Changes Pre- and Post-HTW Demonstration

Medicaid MC Service Area / County Type	Number of Members for Whom Access Based on Distance was Calculated	Number of Members Within Distance Standard from a Pharmacy	Distance Standard from a Pharmacy (County Type Specific)	Performance Standard Percentage	Estimated Percent of Members Within Distance Standard from a Pharmacy	Variation from Standard
Baseline (DY 1) Statewide Summary	**262,690**	**228,991**	---	---	**87.2**	---
Metro	220,709	192,493	2 Miles	80	87.2	7.2
Micro	16,735	12,637	5 Miles	75	75.5	0.5
Rural	25,246	23,861	15 Miles	90	94.5	4.5
DY 2 Statewide Summary	**334,271**	**293,033**	---	---	**87.7**	---
Metro	286,824	249,433	2 Miles	80	87	7
Micro	20,053	17,206	5 Miles	75	85.8	10.8
Rural	27,394	26,394	15 Miles	90	96.3	6.3

Table 43: Detailed Comparison of Baseline vs. DY 1 for Pharmacy Network Adequacy Standards (By Medicaid Managed Care Service Area and County Type)

Medicaid MC Service Area / County Type	Baseline (DY 1) Variation from Standard	DY 2 Variation from Standard	Change from Baseline to DY 1
Bexar			
Metro	9.7	9.7	0
Micro	-15.8	-14.7	1.1
Rural	9.7	9.5	-0.2
Dallas			
Metro	8.6	8.4	-0.2
Micro			0
Rural	9.4	8.3	-1.1
El Paso			
Metro	5.1	4.6	-0.5
Micro			0
Rural	-90	10	100
Harris			
Metro	12.6	11.8	-0.9
Micro	5.4	-0.8	-6.2
Rural	9.2	8.8	-0.4
Hidalgo			
Metro	-2.8	-2.5	0.2
Micro	9.3	8.9	-0.5
Rural	-6.9	6.8	13.7

Medicaid MC Service Area / County Type	Baseline (DY 1) Variation from Standard	DY 2 Variation from Standard	Change from Baseline to DY 1
Jefferson			
Metro	4.3	2.9	-1.4
Micro	-3.9	-4.5	-0.5
Rural	6.9	6.8	-0.2
Lubbock			
Metro	10.8	10	-0.8
Micro			0
Rural	8.8	-0.4	-9.2
MRSA Central Texas			
Metro	7	5.3	-1.7
Micro	30.9	31.8	0.9
Rural	8	7.7	-0.4
MRSA Northeast Texas			
Metro	-2.8	-5.2	-2.4
Micro	17.6	45	27.4
Rural	6.2	5.6	-0.7
MRSA West Texas			
Metro	6.5	5.2	-1.3
Micro	34	34.8	0.7
Rural	-2.1	4.7	6.8
Nueces			
Metro	8.4	9.7	1.2
Micro	17	18.6	1.6
Rural	8.4	9.3	0.9

Medicaid MC Service Area / County Type	Baseline (DY 1) Variation from Standard	DY 2 Variation from Standard	Change from Baseline to DY 1
Tarrant			
Metro	9.4	9.2	-0.2
Micro	-9.4	-15	-5.5
Rural			
Travis			
Metro	1.6	3	1.4
Micro	-21.4	-22.1	-0.7
Rural	4.1	6.5	2.4

Evaluation Question #2: Utilization of Family Planning Services Among HTW Clients

Table 44: Most Effective/ Moderately Effective Contraceptives (MEME) and LARC Rates by Age Groups, Pre and Post-Demonstration Averages and Changes

Age	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
18-24	2017	20,383	5,420	26.6%	810	4.0%
	2018	21,070	6,013	28.5%	914	4.3%
	2019	22,697	7,828	34.5%	1,351	6.0%
	2020	62,053	15,933	25.7%	2,807	4.5%
	2021	72,646	14,748	20.3%	2,316	3.2%
	Annual Pre-HTW Demonstration Average (2017-2019)	21,383	6,420	29.9%	1,025	4.8%
	Annual Post-HTW Demonstration Average (2020-2021)	67,350	15,341	23.0%	2,562	3.9%
	Pre/Post Diff.	45,966	8,920	-6.9%	1,537	-0.9%
	% Change[2]	---	---	*-23.0%*	---	*-18.9%*
	p-value[3]	---	---	<0.001	---	<0.001
25-29	2017	18,257	4,786	26.2%	736	4.0%
	2018	21,864	5,684	26.0%	876	4.0%
	2019	24,011	6,790	28.3%	1,175	4.9%
	2020	60,233	11,881	19.7%	2,283	3.8%
	2021	78,473	12,061	15.4%	2,287	2.9%

Age	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	Annual Pre-HTW Demonstration Average (2017-2019)	21,377	5,753	26.8%	929	4.3%
	Annual Post-HTW Demonstration Average (2020-2021)	69,353	11,971	17.5%	2,285	3.4%
	Pre/Post Diff.	47,976	6,218	-9.3%	1,356	-1.0%
	% Change[2]	---	---	*-34.6%*	---	*-22.2%*
	p-value[3]	---	---	<0.001	---	<0.001
30-34	2017	13,881	3,164	22.8%	387	2.8%
	2018	17,519	3,764	21.5%	517	3.0%
	2019	19,385	4,643	24.0%	690	3.6%
	2020	49,199	8,169	16.6%	1,473	3.0%
	2021	72,482	9,317	12.9%	1,801	2.5%
	Annual Pre-HTW Demonstration Average (2017-2019)	16,928	3,857	22.7%	531	3.1%
	Annual Post-HTW Demonstration Average (2020-2021)	60,841	8,743	14.7%	1,637	2.7%
	Pre/Post Diff.	43,912	4,886	-8.0%	1,106	-0.4%
	% Change[2]	---	---	*-35.2%*	---	*-11.6%*
	p-value[3]	---	---	<0.001	---	<0.001

Age	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
35-39	2017	9,573	1,757	18.4%	178	1.9%
	2018	12,301	1,987	16.2%	252	2.0%
	2019	13,763	2,505	18.2%	322	2.3%
	2020	34,407	4,475	13.0%	730	2.1%
	2021	54,826	5,554	10.1%	959	1.7%
	Annual Pre-HTW Demonstration Average (2017-2019)	11,879	2,083	17.6%	251	2.1%
	Annual Post-HTW Demonstration Average (2020-2021)	44,617	5,015	11.6%	845	1.9%
	Pre/Post Diff.	32,738	2,932	-6.0%	594	-0.1%
	% Change[2]	---	---	*-34.2%*	---	*-7.1%*
	p-value[3]	---	---	<0.001	---	0.012
40-44	2017	4,812	594	12.3%	54	1.1%
	2018	6,207	717	11.6%	90	1.4%
	2019	6,745	898	13.3%	118	1.7%
	2020	17,980	1,739	9.7%	260	1.4%
	2021	32,418	2,478	7.6%	403	1.2%
	Annual Pre-HTW Demonstration Average (2017-2019)	5,921	736	12.4%	87	1.4%
	Annual Post-HTW Demonstration Average (2020-2021)	25,199	2,109	8.7%	332	1.3%
	Pre/Post Diff.	19,278	1,372	-3.7%	244	-0.1%

Age	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	% Change[2]	---	---	*-30.2%*	---	*-6.7%*
	p-value[3]	---	---	<0.001	---	<0.001

Notes. [1] HTW clients age 18 to 44 at end of the demonstration year (DY) and continuously enrolled who were not pregnant during DY, pregnant during DY but whose pregnancy ended in first 10 months, or pregnant during DY but whose pregnancy ended in ectopic pregnancy, stillbirth, miscarriage, or induced abortion are included. HTW clients who were infertile, had live birth in last 2 months of DY, or were still pregnant at end of DY are excluded. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 45: MEME and LARC Rates by Race and Ethnicity Groups, Pre and Post-Demonstration Averages and Changes

Race/ Ethnicity	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
NH White	2017	13,952	3,450	24.7%	410	2.9%
	2018	16,359	3,971	24.3%	549	3.4%
	2019	17,656	4,669	26.4%	756	4.3%
	2020	48,574	8,406	17.3%	1,463	3.0%
	2021	69,655	8,613	12.4%	1,480	2.1%
	Annual Pre-HTW Demonstration Average (2017-2019)	15,989	4,030	25.1%	572	3.5%
	Annual Post-HTW Demonstration Average (2020-2021)	59,115	8,510	14.8%	1,472	2.6%
	Pre/Post Diff.	43,126	4,480	-10.3%	900	-1.0%

Race/ Ethnicity	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	% Change[2]	---	---	*-41.0%*	---	*-27.1%*
	p-value[3]	---	---	<0.001	---	<0.001
NH Black	2017	16,857	3,766	22.3%	432	2.6%
	2018	20,358	4,268	21.0%	464	2.3%
	2019	21,878	5,341	24.4%	636	2.9%
	2020	53,588	9,468	17.7%	1,298	2.4%
	2021	75,396	9,815	13.0%	1,310	1.7%
	Annual Pre-HTW Demonstration Average (2017-2019)	19,698	4,458	22.6%	511	2.6%
	Annual Post-HTW Demonstration Average (2020-2021)	64,492	9,642	15.3%	1,304	2.1%
	Pre/Post Diff.	44,794	5,183	-7.2%	793	-0.5%
	% Change[2]	---	---	*-32.0%*	---	*-19.5%*
	p-value[3]	---	---	<0.001	---	<0.001
Hispanic	2017	33,039	7,835	23.7%	1,226	3.7%
	2018	38,801	9,197	23.7%	1,531	3.9%
	2019	43,216	11,775	27.2%	2,143	5.0%
	2020	110,890	22,553	20.3%	4,467	4.0%
	2021	149,835	23,808	15.9%	4,663	3.1%
	Annual Pre-HTW Demonstration Average (2017-2019)	38,352	9,602	24.9%	1,633	4.2%

Race/ Ethnicity	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	Annual Post-HTW Demonstration Average (2020-2021)	130,363	23,181	18.1%	4,565	3.6%
	Pre/Post Diff.	92,011	13,578	-6.8%	2,932	-0.6%
	% Change[2]	---	---	*-27.2%*	---	*-15.1%*
	p-value[3]	---	---	<0.001	---	<0.001
Other/ Unknown	2017	3,058	670	21.9%	97	3.2%
	2018	3,443	729	21.2%	105	3.0%
	2019	3,851	879	22.8%	121	3.1%
	2020	10,820	1,770	16.4%	325	3.0%
	2021	15,959	1,922	12.0%	313	2.0%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,451	759	22.0%	108	3.1%
	Annual Post-HTW Demonstration Average (2020-2021)	13,390	1,846	14.2%	319	2.5%
	Pre/Post Diff.	9,939	1,087	-7.8%	211	-0.6%
	% Change[2]	---	---	*-35.4%*	---	*-20.5%*
	p-value[3]	---	---	<0.001	---	<0.001

Notes. [1] HTW clients age 18 to 44 at end of the demonstration year (DY) and continuously enrolled who were not pregnant during DY, pregnant during DY but whose pregnancy ended in first 10 months, or pregnant during DY but whose pregnancy ended in ectopic pregnancy, stillbirth, miscarriage, or induced abortion are included. HTW clients who were infertile, had live birth in last 2 months of DY, or were still pregnant at end of DY are excluded. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Figure 30: Trends in Rates of MEME and LARC Rates by Race and Ethnicity Groups, Pre- and Post-HTW Demonstration

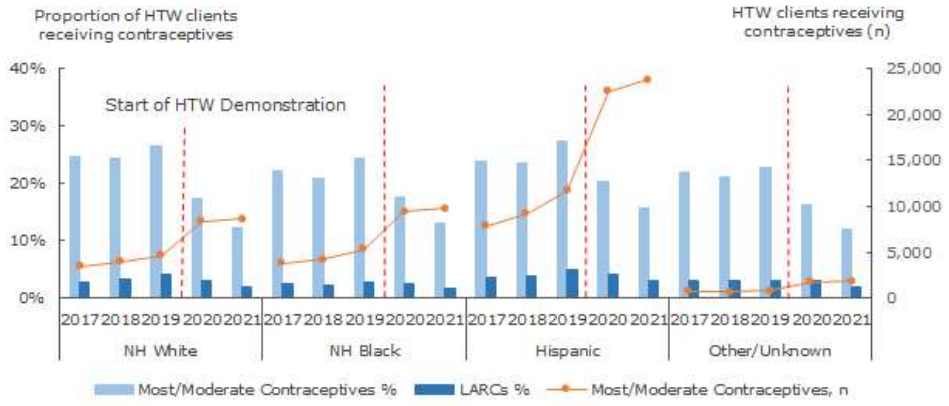


Table 46: MEME and LARC Rates by Public Health Regions (PHR), Pre- and Post-Demonstration Averages and Changes

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
1	2017	2,057	519	25.2%	65	3.2%
	2018	2,799	650	23.2%	87	3.1%
	2019	3,033	881	29.0%	119	3.9%
	2020	7,972	1,738	21.8%	297	3.7%
	2021	10,632	1,680	15.8%	274	2.6%
	Annual Pre-HTW Demonstration Average (2017-2019)	2,630	683	25.8%	90	3.4%
	Annual Post-HTW Demonstration Average (2020-2021)	9,302	1,709	18.8%	286	3.2%
	Pre/Post Diff.	6,672	1,026	-7.0%	195	-0.2%
	% Change[2]	---	---	*-27.2%*	---	*-7.2%*
	p-value[3]	---	---	<0.001	---	0.121
2	2017	1,101	274	24.9%	25	2.3%
	2018	1,337	281	21.0%	38	2.8%
	2019	1,497	409	27.3%	56	3.7%
	2020	4,260	787	18.5%	131	3.1%
	2021	5,626	777	13.8%	120	2.1%
	Annual Pre-HTW Demonstration Average (2017-2019)	1,312	321	24.4%	40	3.0%

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	Annual Post-HTW Demonstration Average (2020-2021)	4,943	782	16.1%	126	2.6%
	Pre/Post Diff.	3,631	461	-8.3%	86	-0.3%
	% Change[2]	---	---	*-33.9%*	---	*-11.8%*
	p-value[3]	---	---	<0.001	---	0.111
3	2017	10,369	2,331	22.5%	363	3.5%
	2018	15,368	3,009	19.6%	529	3.4%
	2019	17,416	3,864	22.2%	708	4.1%
	2020	47,385	7,599	16.0%	1,443	3.0%
	2021	65,933	7,191	10.9%	1,324	2.0%
	Annual Pre-HTW Demonstration Average (2017-2019)	14,384	3,068	21.4%	533	3.7%
	Annual Post-HTW Demonstration Average (2020-2021)	56,659	7,395	13.5%	1,384	2.5%
	Pre/Post Diff.	42,275	4,327	-7.9%	850	-1.1%
	% Change[2]	---	---	*-37.1%*	---	*-31.1%*
	p-value[3]	---	---	<0.001	---	<0.001

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
4	2017	2,785	964	34.6%	94	3.4%
	2018	3,837	1,212	31.6%	129	3.4%
	2019	4,233	1,342	31.7%	169	4.0%
	2020	10,503	2,215	21.1%	324	3.1%
	2021	14,000	2,022	14.4%	285	2.0%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,618	1,173	32.6%	131	3.6%
	Annual Post-HTW Demonstration Average (2020-2021)	12,252	2,119	17.8%	305	2.6%
	Pre/Post Diff.	8,633	946	-14.9%	174	-1.0%
	% Change	---	---	*-45.6%*	---	*-28.4%*
	p-value	---	---	<0.001	---	<0.001
5	2017	3,210	762	23.7%	58	1.8%
	2018	3,220	788	24.5%	68	2.1%
	2019	3,339	947	28.4%	94	2.8%
	2020	7,899	1,520	19.2%	197	2.5%
	2021	10,442	1,404	13.4%	180	1.7%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,256	832	25.5%	73	2.2%

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	Annual Post-HTW Demonstration Average (2020-2021)	9,171	1,462	16.3%	189	2.1%
	Pre/Post Diff.	5,914	630	-9.2%	115	-0.1%
	% Change[2]	---	---	*-36.0%*	---	*-6.0%*
	p-value[3]	---	---	<0.001	---	0.277
6	2017	21,431	4,417	20.6%	639	3.0%
	2018	20,906	4,602	22.0%	638	3.1%
	2019	22,073	5,521	25.0%	855	3.9%
	2020	55,565	9,751	17.5%	1,712	3.1%
	2021	79,152	10,282	13.0%	1,773	2.2%
	Annual Pre-HTW Demonstration Average (2017-2019)	21,470	4,847	22.5%		3.3%
	Annual Post-HTW Demonstration Average (2020-2021)	67,359	10,017	15.3%		2.7%
	Pre/Post Diff.	45,889	5,170	-7.3%		-0.6%
	% Change[2]	---	---	*-32.3%*	---	*-19.4%*
	p-value[3]	---	---	<0.001	---	<0.001

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
7	2017	5,471	1,392	25.4%	171	3.1%
	2018	6,868	1,561	22.7%	217	3.2%
	2019	7,509	1,856	24.7%	272	3.6%
	2020	20,919	3,464	16.6%	696	3.3%
	2021	28,954	3,351	11.6%	666	2.3%
	Annual Pre-HTW Demonstration Average (2017-2019)	6,616	1,603	24.3%	220	3.3%
	Annual Post-HTW Demonstration Average (2020-2021)	24,937	3,408	14.1%	681	2.8%
	Pre/Post Diff.	18,321	1,805	-10.2%	461	-0.5%
	% Change[2]	---	---	*-42.1%*	---	*-14.8%*
	p-value[3]	---	---	<0.001	---	<0.001
8	2017	6,754	1,942	28.8%	359	5.3%
	2018	8,907	2,397	26.9%	453	5.1%
	2019	10,157	2,782	27.4%	580	5.7%
	2020	26,299	4,922	18.7%	1,027	3.9%
	2021	34,504	4,657	13.5%	954	2.8%
	Annual Pre-HTW Demonstration Average (2017-2019)	8,606	2,374	27.7%	464	5.4%

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	Annual Post-HTW Demonstration Average (2020-2021)	30,402	4,790	16.1%	991	3.3%
	Pre/Post Diff.	21,796	2,416	-11.6%	527	-2.0%
	% Change[2]	---	---	*-41.8%*	---	*-37.9%*
	p-value[3]	---	---	<0.001	---	<0.001
9	2017	1,344	334	24.9%	31	2.3%
	2018	1,685	396	23.5%	39	2.3%
	2019	1,914	462	24.1%	58	3.0%
	2020	5,451	910	16.7%	192	3.5%
	2021	7,632	1,002	13.1%	206	2.7%
	Annual Pre-HTW Demonstration Average (2017-2019)	1,648	397	24.2%	43	2.6%
	Annual Post-HTW Demonstration Average (2020-2021)	6,542	956	14.9%	199	3.1%
	Pre/Post Diff.	4,894	559	-9.3%	156	0.6%
	% Change[2]	---	---	*-38.3%*	---	*22.0%*
	p-value[3]	---	---	<0.001	---	0.107

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
10	2017	2,855	1,033	36.2%	157	5.5%
	2018	3,749	1,258	33.6%	215	5.7%
	2019	4,045	1,327	32.8%	325	8.0%
	2020	9,145	1,988	21.7%	455	5.0%
	2021	11,819	1,931	16.3%	451	3.8%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,550	1,206	34.2%	232	6.4%
	Annual Post-HTW Demonstration Average (2020-2021)	10,482	1,960	19.0%	453	4.4%
	Pre/Post Diff.	6,932	754	-15.1%	221	-2.0%
	% Change[2]	---	---	*-44.3%*	---	*-31.6%*
	p-value[3]	---	---	<0.001	---	<0.001
11	2017	9,474	1,741	18.4%	201	2.1%
	2018	10,241	1,999	19.5%	236	2.3%
	2019	11,350	3,267	28.8%	418	3.7%
	2020	28,200	7,280	25.8%	1,074	3.8%
	2021	37,728	7,656	20.3%	1,110	2.9%
	Annual Pre-HTW Demonstration Average (2017-2019)	10,355	2,336	22.2%	285	2.7%

Public Health Region	Year	Eligible Population[1]	Most Effective/ Moderately Effective Contraceptives	% Most Effective/ Moderately Effective Contraceptives	Long-acting Reversible Contraceptives	% Long-acting Reversible Contraceptives
	Annual Post-HTW Demonstration Average (2020-2021)	32,964	7,468	23.1%	1,092	3.4%
	Pre/Post Diff.	22,609	5,132	0.8%	807	0.7%
	% Change[2]	---	---	*3.7%*	---	*24.9%*
	p-value[3]	---	---	0.731	---	<0.001
Unknown	2017	55	12	21.8%	2	3.6%
	2018	44	12	27.3%	0	0.0%
	2019	35	6	17.1%	2	5.7%
	2020	274	23	8.4%	5	1.8%
	2021	4,423	2,205	49.9%	423	9.6%
	Annual Pre-HTW Demonstration Average (2017-2019)	45	10	22.1%	1	3.1%
	Annual Post-HTW Demonstration Average (2020-2021)	2,349	1,114	29.1%	214	5.7%
	Pre/Post Diff.	2,304	1,104	7.0%	213	2.6%
	% Change[2]	---	---	*31.9%*	---	*82.7%*
	p-value[3]	---	---	<0.001	---	0.014

Notes. [1] HTW clients age 18 to 44 at end of the demonstration year (DY) and continuously enrolled who were not pregnant during DY, pregnant during DY but whose pregnancy ended in first 10 months, or pregnant during DY but whose pregnancy ended in ectopic pregnancy, stillbirth, miscarriage, or induced abortion are included. HTW clients who were infertile, had live birth in last 2 months of DY, or were still pregnant at end of DY are excluded. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 47: Chlamydia Screening Rates by Age

Age	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
20	2017	2,994	2,110	70.5%
	2018	3,212	2,238	69.7%
	2019	3,588	2,505	69.8%
	2020	4,932	3,180	64.5%
	2021	4,476	2,981	66.6%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,265	2,284	70.0%
	Annual Post-HTW Demonstration Average (2020-2021)	4,704	3,081	65.5%
	Pre/Post Diff.	1,439	796	-4.5%
	% Change[2]	---	---	*-6.4%*
	p-value[3]	---	---	<0.001
21	2017	4,744	3,193	67.3%
	2018	5,247	3,490	66.5%
	2019	5,497	3,628	66.0%
	2020	6,499	4,261	65.6%
	2021	5,700	3,855	67.6%
	Annual Pre-HTW Demonstration Average (2017-2019)	5,163	3,437	66.6%
	Annual Post-HTW Demonstration Average (2020-2021)	6,100	4,058	66.6%
	Pre/Post Diff.	937	621	0.0%
	% Change[2]	---	---	*0.0%*
	p-value[3]	---	---	0.938

Age	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
22	2017	4,691	3,206	68.3%
	2018	4,977	3,313	66.6%
	2019	5,521	3,700	67.0%
	2020	6,436	4,159	64.6%
	2021	5,720	3,830	67.0%
	Annual Pre-HTW Demonstration Average (2017-2019)	5,063	3,406	67.3%
	Annual Post-HTW Demonstration Average (2020-2021)	6,078	3,995	65.8%
	Pre/Post Diff.	1,015	588	-1.5%
	% Change[2]	---	---	*-2.3%*
	p-value[3]	---	---	0.007
23	2017	4,852	3,296	67.9%
	2018	4,992	3,319	66.5%
	2019	5,287	3,467	65.6%
	2020	6,343	4,050	63.8%
	2021	5,397	3,606	66.8%
	Annual Pre-HTW Demonstration Average (2017-2019)	5,044	3,361	66.7%
	Annual Post-HTW Demonstration Average (2020-2021)	5,870	3,828	65.3%
	Pre/Post Diff.	826	467	-1.3%
	% Change[2]	---	---	*-2.0%*
	p-value[3]	---	---	0.015

Age	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
24	2017	1,438	879	61.1%
	2018	1,499	890	59.4%
	2019	1,522	895	58.8%
	2020	1,101	745	67.7%
	2021	713	470	65.9%
	Annual Pre-HTW Demonstration Average (2017-2019)	1,486	888	59.8%
	Annual Post-HTW Demonstration Average (2020-2021)	907	608	66.8%
	Pre/Post Diff.	-579	-281	7.0%
	% Change[2]	---	---	*11.8%*
	p-value[3]	---	---	<0.001

Notes. [1] HTW clients age 21-24 at end of the demonstration year (DY) and continuously enrolled are included. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period for compliance rate only. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 48: Chlamydia Screening Rates by Race and Ethnicity Groups

Race/ Ethnicity	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
NH White	2017	3,147	1,825	58.0%
	2018	3,357	1,981	59.0%
	2019	3,555	2,066	58.1%
	2020	4,099	2,305	56.2%
	2021	3,231	1,930	59.7%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,353	1,957	58.4%
	Annual Post-HTW Demonstration Average (2020-2021)	3,665	2,118	58.0%
	Pre/Post Diff.	312	160	-0.4%
	% Change[2]	---	---	*-0.7%*
	p-value[3]	---	---	0.429
NH Black	2017	4,800	3,457	72.0%
	2018	4,926	3,427	69.6%
	2019	5,035	3,479	69.1%
	2020	6,164	4,219	68.4%
	2021	5,416	3,762	69.5%
	Annual Pre-HTW Demonstration Average (2017-2019)	4,920	3,454	70.2%
	Annual Post-HTW Demonstration Average (2020-2021)	5,790	3,991	69.0%
	Pre/Post Diff.	870	536	-1.3%
	% Change[2]	---	---	*-1.8%*
	p-value[3]	---	---	0.024

Race/ Ethnicity	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
Hispanic	2017	9,970	6,877	69.0%
	2018	10,784	7,295	67.6%
	2019	11,842	8,013	67.7%
	2020	13,877	9,106	65.6%
	2021	11,842	8,035	67.9%
	Annual Pre-HTW Demonstration Average (2017-2019)	10,865	7,395	68.1%
	Annual Post-HTW Demonstration Average (2020-2021)	12,860	8,571	66.7%
	Pre/Post Diff.	1,994	1,176	-1.4%
	% Change[2]	---	---	*-2.0%*
	p-value[3]	---	---	<0.001
Other/Unknown	2017	803	526	65.5%
	2018	860	547	63.6%
	2019	984	638	64.8%
	2020	1,171	765	65.3%
	2021	1,517	1,015	66.9%
	Annual Pre-HTW Demonstration Average (2017-2019)	882	570	64.6%
	Annual Post-HTW Demonstration Average (2020-2021)	1,344	890	66.1%
	Pre/Post Diff.	462	320	1.5%
	% Change[2]	---	---	*2.3%*
	p-value[3]	---	---	0.225

Notes. [1] HTW clients age 21-24 at end of the demonstration year (DY) and continuously enrolled are included. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period for compliance rate only. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 49: Chlamydia Screening Rates by Texas Public Health Region (PHR)

PHR	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
1	2017	594	356	59.9%
	2018	713	447	62.7%
	2019	807	513	63.6%
	2020	925	534	57.7%
	2021	814	484	59.5%
	Annual Pre-HTW Demonstration Average (2017-2019)	705	439	62.1%
	Annual Post-HTW Demonstration Average (2020-2021)	870	509	58.6%
	Pre/Post Diff.	165	70	-3.5%
	% Change[2]	---	---	*-5.6%*
	p-value[3]	---	---	0.019
2	2017	330	100	30.3%
	2018	396	189	47.7%
	2019	389	195	50.1%
	2020	441	226	51.2%
	2021	326	177	54.3%
	Annual Pre-HTW Demonstration Average (2017-2019)	372	161	42.7%
	Annual Post-HTW Demonstration Average (2020-2021)	384	202	52.8%
	Pre/Post Diff.	12	40	10.1%
	% Change[2]	---	---	*23.5%*
	p-value[3]	---	---	<0.001

PHR	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
3	2017	3,020	1,498	49.6%
	2018	3,472	1,754	50.5%
	2019	3,866	2,058	53.2%
	2020	4,577	2,307	50.4%
	2021	3,554	1,746	49.1%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,453	1,770	51.1%
	Annual Post-HTW Demonstration Average (2020-2021)	4,066	2,027	49.8%
	Pre/Post Diff.	613	257	-1.4%
	% Change[2]	---	---	*-2.6%*
	p-value[3]	---	---	0.056
4	2017	850	541	63.6%
	2018	935	596	63.7%
	2019	1,015	614	60.5%
	2020	1,256	805	64.1%
	2021	849	593	69.8%
	Annual Pre-HTW Demonstration Average (2017-2019)	933	584	62.6%
	Annual Post-HTW Demonstration Average (2020-2021)	1,053	699	67.0%
	Pre/Post Diff.	119	115	4.3%
	% Change[2]	---	---	*6.9%*
	p-value[3]	---	---	0.005

PHR	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
5	2017	752	535	71.1%
	2018	781	541	69.3%
	2019	765	533	69.7%
	2020	810	520	64.2%
	2021	665	452	68.0%
	Annual Pre-HTW Demonstration Average (2017-2019)	766	536	70.0%
	Annual Post-HTW Demonstration Average (2020-2021)	738	486	66.1%
	Pre/Post Diff.	-29	-50	-3.9%
	% Change[2]	---	---	*-5.6%*
	p-value[3]	---	---	0.008
6	2017	5,382	4,065	75.5%
	2018	5,045	3,561	70.6%
	2019	5,282	3,717	70.4%
	2020	6,421	4,454	69.4%
	2021	5,689	4,134	72.7%
	Annual Pre-HTW Demonstration Average (2017-2019)	5,236	3,781	72.2%
	Annual Post-HTW Demonstration Average (2020-2021)	6,055	4,294	71.0%
	Pre/Post Diff.	819	513	-1.1%
	% Change[2]	---	---	*-1.6%*
	p-value[3]	---	---	0.018

PHR	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
7	2017	1,417	927	65.4%
	2018	1,512	1,004	66.4%
	2019	1,589	995	62.6%
	2020	2,147	1,341	62.5%
	2021	1,660	1,016	61.2%
	Annual Pre-HTW Demonstration Average (2017-2019)	1,506	975	64.8%
	Annual Post-HTW Demonstration Average (2020-2021)	1,904	1,179	61.8%
	Pre/Post Diff.	398	203	-3.0%
	% Change[2]	---	---	*-4.6%*
	p-value[3]	---	---	0.007
8	2017	1,697	1,066	62.8%
	2018	2,072	1,345	64.9%
	2019	2,171	1,402	64.6%
	2020	2,523	1,646	65.2%
	2021	1,844	1,220	66.2%
	Annual Pre-HTW Demonstration Average (2017-2019)	1,980	1,271	64.1%
	Annual Post-HTW Demonstration Average (2020-2021)	2,184	1,433	65.7%
	Pre/Post Diff.	204	162	1.6%
	% Change[2]	---	---	*2.5%*
	p-value[3]	---	---	0.131

PHR	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
9	2017	346	181	52.3%
	2018	362	215	59.4%
	2019	478	253	52.9%
	2020	510	274	53.7%
	2021	435	255	58.6%
	Annual Pre-HTW Demonstration Average (2017-2019)	395	216	54.9%
	Annual Post-HTW Demonstration Average (2020-2021)	473	265	56.2%
	Pre/Post Diff.	77	48	1.3%
	% Change[2]	---	---	*2.4%*
	p-value[3]	---	---	0.562
10	2017	900	616	68.4%
	2018	962	659	68.5%
	2019	967	677	70.0%
	2020	1,008	713	70.7%
	2021	668	473	70.8%
	Annual Pre-HTW Demonstration Average (2017-2019)	943	651	69.0%
	Annual Post-HTW Demonstration Average (2020-2021)	838	593	70.8%
	Pre/Post Diff.	-105	-58	1.8%
	% Change[2]	---	---	*2.6%*
	p-value[3]	---	---	0.213

PHR	Year	Eligible Population[1]	Chlamydia Screening (N)	Chlamydia Screening (%)
11	2017	3,415	2,790	81.7%
	2018	3,645	2,917	80.0%
	2019	4,061	3,229	79.5%
	2020	4,675	3,565	76.3%
	2021	4,224	3,288	77.8%
	Annual Pre-HTW Demonstration Average (2017-2019)	3,707	2,979	80.4%
	Annual Post-HTW Demonstration Average (2020-2021)	4,450	3,427	77.0%
	Pre/Post Diff.	743	448	-3.4%
	% Change[2]	---	---	*-4.2%*
	p-value[3]	---	---	<0.001
Unknown	2017	17	10	58.8%
	2018	32	22	68.8%
	2019	26	10	38.5%
	2020	18	10	55.6%
	2021	1,278	904	70.7%
	Annual Pre-HTW Demonstration Average (2017-2019)	25	14	55.3%
	Annual Post-HTW Demonstration Average (2020-2021)	648	457	63.1%
	Pre/Post Diff.	623	443	7.8%
	% Change[2]	---	---	*14.1%*
	p-value[3]	---	---	0.008

Notes. [1] HTW clients age 21-24 at end of the demonstration year (DY) and continuously enrolled are included. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period for compliance rate only. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 50: Screening for Other Sexually Transmitted Infections: Comprehensive, Gonorrhea, and Hepatitis B

Year	Eligible Population[1]	Comprehensive Screening (N)	Comprehensive Screening (%)	Gonorrhea Screening (N)	Gonorrhea Screening (%)	Hepatitis B Screening (N)	Hepatitis B Screening (%)
2017	12,685	1,366	11%	12,636	99.6%	1,759	13.9%
2018	13,250	1,672	13%	13,214	99.7%	1,949	14.7%
2019	14,196	1,960	14%	14,176	99.9%	2,200	15.5%
2020	16,395	2,690	16%	16,359	99.8%	2,704	16.5%
2021	14,742	2,247	15%	14,714	99.8%	2,474	16.8%
Annual Pre-HTW Demonstration Average (2017-2019)	13,377	1,666	12.4%	13,342	99.7%	1,969	14.7%
Annual Post-HTW Demonstration Average (2020-2021)	15,569	2,469	15.8%	15,537	99.8%	2,589	16.6%
Pre/Post Diff.	2,192	803	3.4%	2,195	0.1%	620	1.9%
% Change[2]	---	---	*27.6%*	---	*0.1%*	---	*13.2%*
p-value[3]	---	---	<0.001	---	0.127	---	<0.001

Notes. [1] HTW clients who were also tested for chlamydia. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period for compliance rate only. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 51: Screening for Other Sexually Transmitted Infections: HIV and Syphilis

Year	Eligible Population[1]	HIV Screening (N)	HIV Screening (%)	Syphilis Screening (N)	Syphilis Screening (%)
2017	12,685	4,519	35.6%	5,342	42.1%
2018	13,250	4,901	37.0%	5,560	42.0%
2019	14,196	6,037	42.5%	6,059	42.7%
2020	16,395	7,712	47.0%	6,803	41.5%
2021	14,742	7,180	48.7%	6,539	44.4%
Annual Pre-HTW Demonstration Average (2017-2019)	13,377	5,152	38.4%	5,654	42.3%
Annual Post-HTW Demonstration Average (2020-2021)	15,569	7,446	47.9%	6,671	42.9%
Pre/Post Diff.	2,192	2,294	9.5%	1,017	0.7%
% Change[2]	---	---	*24.7%*	---	*1.6%*
p-value[3]	---	---	<0.001	---	0.117

Notes. [1] HTW clients who were also tested for chlamydia. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period for compliance rate only. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 52: Screening for Other Sexually Transmitted Infections: Trichomoniasis and Any Comprehensive STI Screening

Year	Eligible Population[1]	Trichomoniasis Screening (N)	Trichomoniasis Screening (%)	Any Comprehensive STI Screening (N)	Any Comprehensive STI Screening (%)
2017	12,685	2,663	21.0%	1,921	15.1%
2018	13,250	3,431	25.9%	2,354	17.8%
2019	14,196	4,227	29.8%	2,823	19.9%
2020	16,395	5,152	31.4%	3,612	22.0%
2021	14,742	4,921	33.4%	3,167	21.5%
Annual Pre-HTW Demonstration Average (2017-2019)	13,377	3,440	25.6%	2,366	17.6%
Annual Post-HTW Demonstration Average (2020-2021)	15,569	5,037	32.4%	3,390	21.8%
Pre/Post Diff.	2,192	1,596	6.8%	1,024	4.2%
% Change[2]	---	---	*26.8%*	---	*23.6%*
p-value[3]	---	---	<0.001	---	<0.001

Notes. [1] HTW clients who were also tested for chlamydia. [2] % Change indicates the percentage change calculated by dividing the measure difference between pre- and post-Demonstration periods by the value of the measure at the pre-Demonstration period for compliance rate only. [3] P-values were reported for statistical testing using Chi-square to compare compliance rates between pre- and post-Demonstration periods.

Table 53: Compliance with Cervical Cancer Screening Recommendations (three-year measure: 2019-2021), Subgroup Information

	Eligible Population[1]	HPV or Cervix Cytology Lab (N)	HPV or Cervix Cytology Lab (%)	p-value[2]
No. of HTW enrollees	152,553	65,817	43.1%	<0.001
Calendar Year				
2019	22,321	11,969	53.6%	<0.001
2020	40,269	19,557	48.6%	
2021	89,963	34,291	38.1%	
Age Group				
21-24	17,175	7,066	41.1%	<0.001
25-29	49,574	21,205	42.8%	
30-34	41,882	18,734	44.7%	
35-39	27,596	11,960	43.3%	
40-44	15,373	6,494	42.2%	
45+	953	358	37.6%	
Race/ Ethnicity				
NH White	19,812	11,800	59.6%	<0.001
NH Black	20,098	16,158	80.4%	
Hispanic	42,204	35,414	83.9%	
Other/ Unknown	4,622	2,445	52.9%	

	Eligible Population[1]	HPV or Cervix Cytology Lab (N)	HPV or Cervix Cytology Lab (%)	p-value[2]
Public Health Region				
1	5,035	1,542	30.6%	<0.001
2	2,676	1,019	38.1%	
3	30,557	9,987	32.7%	
4	7,575	3,825	50.5%	
5	5,826	2,598	44.6%	
6	38,778	16,479	42.5%	
7	12,700	4,941	38.9%	
8	17,608	8,361	47.5%	
9	3,571	1,350	37.8%	
10	7,197	3,974	55.2%	
11	19,324	10,639	55.1%	
Unknown	1,706	1,102	64.6%	

Notes. [1] HTW clients age 21 or older at end of the demonstration year (DY) and continuously enrolled during past 3 years including DY are included. HTW clients who had one or more gaps in HTW enrollment lasting more than 45 days (or more than one month if enrollment is determined monthly), received hospice care or had hysterectomy any time during the client's history through the end of DY are excluded. [2] P-values are reported for statistical differences across categories using Chi-Square tests.

Table 54: Compliance with Cervical Cancer Screening Recommendations (five-year measure: 2021), by Subgroup

	Eligible Population[1]	HPV or Cervix Cytology Lab, N	HPV or Cervix Cytology Lab, %	p-value[2]
No. of HTW enrollees	11,299	6,820	60.4%	
Age Group				
25-29	875	497	56.8%	0.005
30-34	4,579	2,726	59.5%	
35-39	3,439	2,153	62.6%	
40-44	2,186	1,320	60.4%	
45+	220	124	56.4%	
Race/ Ethnicity				
NH White	2,248	1,236	55.0%	<0.001
NH Black	2,844	1,687	59.3%	
Hispanic	5,642	3,629	64.3%	
Other/ Unknown	565	268	47.4%	
Public Health Region				
1	353	174	49.3%	<0.001
2	178	102	57.3%	
3	1,960	926	47.2%	
4	622	398	64.0%	
5	488	314	64.3%	
6	2,845	1,692	59.5%	
7	869	481	55.4%	
8	1,299	831	64.0%	
9	234	132	56.4%	
10	593	431	72.7%	
11	1,524	1,096	71.9%	
Unknown	334	243	72.8%	

Notes. [1] HTW clients age 21 or older at end of the demonstration year (DY) and continuously enrolled during past 5 years including DY are included. HTW clients who had one or more gaps in HTW enrollment lasting more than 45 days (or more than one month if enrollment is determined monthly), received hospice care or had hysterectomy any time during the client's history through the end of DY are excluded. [2] P-values are reported for statistical differences across categories using Chi-Square tests.

Evaluation Question #3: Health Outcomes

Table 55: Hypertension (HTN) Treatment Medication Adherence among Women Enrolled in HTW with Antihypertension Medication Prescription

Year	HTW Clients with HTN Medication	HTW Clients with HTN Medication Adherence	MY for HTW Clients with HTN Medication	MY for HTW Clients with HTN Medication Adherence	Rate of HTN Medication Adherence
2017	1,104	459	600	151	25.2%
2018	1,182	537	607	169	27.9%
2019	1,111	528	566	171	30.3%
2020	813	284	571	134	23.5%
2021	891	260	695	142	20.5%
Annual Pre-HTW Demonstration Average (2017-2019)	1,132	508	591	164	27.7%
Annual Post -HTW Demonstration Average (2020-2021)	852	272	633	138	21.9%
Pre/Post Diff.	-280	-236	42	-25	-5.9%
% Change	*-24.8*	*-46.5*	*7.1*	*-15.6*	*-21.1%*
p-value	---	---	---	---	0.002

Notes. HTN, hypertension. HTW clients are only included if the first fill of their HTN medication occurs at least 91 days before the end of the enrollment period. Adherence was defined as filling prescription often enough to cover 80% or more days within calendar year. Rates were calculated as MY for HTW clients divided by MY for HTW with adherence. P-values are reported for statistical significance of the rate difference using Poisson regression.

Table 56: Diabetes Treatment Medication Adherence among Women Enrolled in HTW with Non-insulin Medication Prescription

Year	HTW Clients with Diabetes Medication	HTW Clients with Diabetes Medication Adherence	MY for HTW Clients with Diabetes Medication	MY for HTW Clients with Diabetes Medication Adherence	Rate of Diabetes Medication Adherence
2017	1,260	471	680	144	21.2%
2018	1,850	776	965	222	23.0%
2019	1,840	751	991	245	24.7%
2020	1,299	431	916	193	21.0%
2021	1,386	432	1,047	207	19.7%
Annual Pre-HTW Demonstration Average (2017-2019)	1,650	666	879	204	23.2%
Annual Post -HTW Demonstration Average (2020-2021)	1,343	432	982	200	20.3%
Pre/Post Diff.	-308	-235	103	-4	-2.8%
% Change	*-18.6*	*-35.2*	*11.7*	*-2.0*	*-12.3%*
p-value	---	---	---	---	0.042

Notes. HTW clients are only included if the first fill of their Diabetes medication occurs at least 91 days before the end of the enrollment period. Adherence was defined as filling prescription often enough to cover 80% or more days within calendar year. Rates were calculated as MY for HTW clients divided by MY for HTW with adherence. P-values are reported for statistical significance of the rate difference using Poisson regression.

Table 57: Hypercholesterolemia (HCL) Treatment Medication Adherence among Women Enrolled in HTW with Cholesterol Medication Prescription

Year	HTW Clients with HCL Medication	HTW Clients with HCL Medication Adherence	MY for HTW Clients with HCL Medication	MY for HTW Clients with HCL Medication Adherence	Rate of HCL Medication Adherence
2017	387	154	208	46	22.2%
2018	528	228	273	65	23.9%
2019	531	228	287	72	25.1%
2020	496	146	383	75	19.6%
2021	658	185	526	94	17.8%
Annual Pre-HTW Demonstration Average (2017-2019)	482	203	256	61	23.9%
Annual Post -HTW Demonstration Average (2020-2021)	577	166	454	84	18.6%
Pre/Post Diff.	95	-38	198	23	-5.3%
% Change	*19.7*	*-18.6*	*77.4*	*37.9*	*-22.2%*
p-value	---	---	---	---	0.018

Notes. HCL, hypercholesterolemia. HTW clients are only included if the first fill of their HCL medication occurs at least 91 days before the end of the enrollment period. Adherence was defined as filling prescription often enough to cover 80% or more days within calendar year. Rates were calculated as MY for HTW clients divided by MY for HTW with adherence. P-values are reported for statistical significance of the rate difference using Poisson regression.

Table 58: Medication Adherence among Women Enrolled in HTW for 12 Continuous Months (Hypertension, Diabetes and Hypercholesterolemia Medication)

Year	Hypertension		Diabetes		Hypercholesterolemia	
	HTW Clients treated with Medication	**Medication Adherence (%)**	**HTW Clients treated with Medication**	**Medication Adherence (%)**	**HTW Clients treated with Medication**	**Medication Adherence (%)**
2017	225	17.3%	238	14.3%	78	7.7%
2018	229	20.5%	365	12.6%	107	9.3%
2019	200	19.0%	369	15.4%	120	16.7%
2020	400	20.5%	634	16.4%	292	16.8%
2021	572	17.3%	842	14.7%	442	13.1%
Annual Pre-HTW Demonstration Average (2017-2019)	218	19.0%	324	14.1%	102	11.8%
Annual Post -HTW Demonstration Average (2020-2021)	486	18.6%	738	15.4%	367	14.6%
Pre/Post Diff.	---	-0.3%	---	1.4%	---	2.8%
% Change	---	*-1.8%*	---	*9.6%*	---	*23.5%*
p-value	---	0.86	---	0.36	---	0.237

Notes. HTW clients are only included if the first fill of their medication occurs at least 91 days before the end of the enrollment period and were continuously enrolled during the measurement year. Adherence was defined as filling prescription often enough to cover 80% or more days within calendar year. Rates were calculated as MY for HTW clients divided by MY for HTW with adherence. P-values are reported for statistical significance of the rate difference using Poisson regression.

Table 59: Antidepressant Medication Management: Effective Acute Phase Treatment

Year	HTW Clients with Antidepressant medication	HTW clients with Effective Acute Phase Treatment	MY for HTW clients with Antidepressant medication	MY for HTW clients with Effective Acute Phase Treatment	Rate of Effective Acute Phase Treatment
2017	131	50	118	47	39.4%
2018	338	148	318	141	44.5%
2019	456	188	421	180	42.6%
2020	853	372	830	362	43.6%
2021	619	334	616	333	54.0%
Annual Pre-HTW Demonstration Average (2017-2019)	308	129	286	122	42.9%
Annual Post -HTW Demonstration Average (2020-2021)	736	353	723	347	48.0%
Pre/Post Diff.	428	224	438	225	5.2%
% Change	*138.7*	*174.4*	*153.2*	*183.7*	*12.1%*
p-value	---	---	---	---	0.078

Notes. HTW clients are only included if they were treated with antidepressant medication, had a diagnosis of major depression, and had continuous enrollment 105 days prior to the earliest prescription dispensing date for antidepressant medication through 231 days. Adherence was defined as filling prescription often enough to cover 80% or more days within calendar year. Rates were calculated as MY for HTW clients divided by MY for HTW with adherence. P-values are reported for statistical significance of the rate difference using Poisson regression.

Table 60: Antidepressant Medication Management: Effective Continuation Phase Treatment

Year	HTW Clients with Antidepressant medication	HTW Clients with Effective Continuation Phase Treatment	MY for HTW Clients with Antidepressant medication	MY for HTW Clients with Effective Continuation Phase Treatment	Rate of Effective Continuation Phase Treatment
2017	131	11	118	11	8.9%
2018	338	71	318	68	21.4%
2019	456	83	421	80	19.0%
2020	853	174	830	171	20.5%
2021	619	174	616	174	28.2%
Annual Pre-HTW Demonstration Average (2017-2019)	308	55	286	53	18.5%
Annual Post -HTW Demonstration Average (2020-2021)	736	174	723	172	23.8%
Pre/Post Diff.	428	119	438	119	5.3%
% Change	*138.7*	*216.4*	*153.2*	*226.0*	*28.8%*
p-value	---	---	---	---	0.008

Notes. HTW clients are only included if they were treated with antidepressant medication, had a diagnosis of major depression, and had continuous enrollment 105 days prior to the earliest prescription dispensing date for antidepressant medication through 231 days. Adherence was defined as filling prescription often enough to cover 80% or more days within calendar year. Rates were calculated as MY for HTW clients divided by MY for HTW with adherence. P-values are reported for statistical significance of the rate difference using Poisson regression.

Table 61: Antidepressant Medication Management for Those Individuals with 12 months of Continuous Enrollment in a Given Year

Year	HTW clients treated with Antidepressant medication	Rate of Effective Acute Phase Treatment (%)	Rate of Effective Continuation Phase Treatment (%)
2017	75	44.0%	12.0%
2018	233	45.9%	21.0%
2019	308	45.5%	21.4%
2020	732	43.4%	21.3%
2021	602	54.3%	28.6%
Annual Pre-HTW Demonstration Average (2017-2019)	205	45.5%	20.1%
Annual Post -HTW Demonstration Average (2020-2021)	667	48.4%	24.6%
Pre/Post Diff.	462	2.9%	4.5%
% Change	*224.8*	*6.4%*	*22.1%*
p-value	---	0.23	0.03

Notes. HTW clients are only included if they were treated with antidepressant medication, had a diagnosis of major depression, had continuous enrollment 105 days prior to the earliest prescription dispensing date for antidepressant medication through 231 days, and had 12 months of continuous enrollment during the measurement year. Adherence was defined as filling prescription often enough to cover 80% or more days within calendar year. Rates were calculated as MY for HTW clients divided by MY for HTW with adherence. P-values are reported for statistical significance of the rate difference using Poisson regression.

Table 62: Birth Spacing Measure Cohort Characteristics

	Total	HTW after initial delivery in 2018[1]	No HTW after initial delivery in 2018	p-value[2]
Number of deliveries	150,136	80,572	69,564	
Maternal age, median (IQR)[3]	25 (22-29)	25 (22-29)	25 (22-30)	0.008
Race/Ethnicity				
NH White	35,114 (23.4)	18,236 (22.6)	16,878 (24.3)	<0.001
NH Black	27,264 (18.2)	14,551 (18.1)	12,713 (18.3)	
Hispanic	79,288 (52.8)	43,291 (53.7)	35,997 (51.7)	
NH Other	8,470 (5.6)	4,494 (5.6)	3,976 (5.7)	
Public Health Region				
1	5,358 (3.6)	2,736 (3.4)	2,622 (3.8)	<0.001
2	3,335 (2.2)	1,649 (2.0)	1,686 (2.4)	
3	33,871 (22.6)	18,718 (23.2)	15,153 (21.8)	
4	7,150 (4.8)	3,852 (4.8)	3,298 (4.7)	
5	5,122 (3.4)	2,653 (3.3)	2,469 (3.5)	
6	35,679 (23.8)	19,123 (23.7)	16,556 (23.8)	
7	12,341 (8.2)	6,525 (8.1)	5,816 (8.4)	
8	17,800 (11.9)	9,072 (11.3)	8,728 (12.5)	
9	5,119 (3.4)	2,665 (3.3)	2,454 (3.5)	
10	5,686 (3.8)	3,333 (4.1)	2,353 (3.4)	
11	18,675 (12.4)	10,246 (12.7)	8,429 (12.1)	

	Total	HTW after initial delivery in 2018[1]	No HTW after initial delivery in 2018	p-value[2]
Maternal Comorbidities				
Any	89,233 (59.4)	47,665 (59.2)	41,568 (59.8)	0.019
Obstetrics	55,943 (37.3)	30,011 (37.2)	25,932 (37.3)	0.90
General health	53,252 (35.5)	28,117 (34.9)	25,135 (36.1)	<0.001
Substance use	14,955 (10.0)	7,579 (9.4)	7,376 (10.6)	<0.001
Autoimmune	1,499 (1.0)	768 (1.0)	731 (1.1)	0.058
Cardio	625 (0.4)	322 (0.4)	303 (0.4)	0.28
Renal	278 (0.2)	119 (0.1)	159 (0.2)	<0.001
Inadequate birth spacing[4]	26,241 (17.5)	13,818 (17.1)	12,423 (17.9)	<0.001
Pregnancy complications				
Any	26,778 (17.8)	14,405 (17.9)	12,373 (17.8)	0.64
High blood pressure	10,303 (6.9)	5,532 (6.9)	4,771 (6.9)	0.95
Gestational diabetes	11,048 (7.4)	6,009 (7.5)	5,039 (7.2)	0.11
Preeclampsia	9,475 (6.3)	5,028 (6.2)	4,447 (6.4)	0.23
Adverse birth outcomes				
LBW	11,790 (7.9)	6,129 (7.6)	5,661 (8.1)	<0.001
Preterm	15,801 (10.5)	8,094 (10.0)	7,707 (11.1)	<0.001
SMM[5]	2,021 (1.3)	1,080 (1.3)	941 (1.4)	0.84

Notes. Women who had a Medicaid funded live birth in 2018 are included. All numbers indicate the number of women and percentage of them except for maternal age. [1] HTW enrollment at any time point during the year after the index delivery in HTW. [2] P-values are reported for statistical differences between women who were enrolled in HTW vs those not enrolled using Chi-square tests for categorical variables and Wilcoxon rank sum test for median maternal age. [3] IQR, interquartile range. [4] Inadequate birth spacing is defined as having any subsequent births within 27 months of the initial birth. [5] SMM, severe maternal morbidity.

Appendix C: Updates on Primary Data Collection and Qualitative Analyses

Beneficiary Primary Data Collection

Overview

The beneficiary survey data collection, processing, and weighting ran from May 18 to July 27, 2023. A total of 1,612 beneficiary responses were collected through online and telephone collection methods.

The provider survey data collection, processing, and weighting ran from May 10 to August 30, 2023. A total of 181 HTW provider locations responded to the survey, through online and paper collection methods.

The survey sought to collect data for 2 evaluation hypotheses and 10 evaluation measures, as follows:

- Evaluation Hypothesis 1: Did the HTW Demonstration increase access to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas?
  - 1.2.1 Motivating factors for HTW enrollment and renewal
  - 1.2.2 Understanding of eligibility requirements
  - 1.2.3 Understanding of HTW benefits
  - 1.2.4 Awareness of how to obtain services
  - 1.2.5 Effectiveness of outreach channels
  - 1.2.6 Effectiveness of HTW Demonstration resources
- Evaluation Hypothesis 5: How does implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services?
  - 5.1.2 Appointment wait times
  - 5.1.3 Barriers to receiving care
  - 5.1.4 Providers accepting new clients
  - 5.1.5 Barriers to providing care

Questionnaire Design

The questionnaire was collaboratively developed by UTHealth CHCD researchers and a third-party, a full-service survey and market research firm with expertise in research designs and implementation, SRSS AUS Marketing Research Systems, Inc. (SSRS), to address research questions and hypotheses for evaluation of the HTW program. To ensure respondent comprehension and assess questionnaire length, a live pre-test of the questionnaire was conducted by telephone on February 7, 2023. In total, 14 pre-test interviews were completed. Based on the pre-test, some questions were removed due to issues with length. Other adjustments were made to ease respondent comprehension and assist with interviewer administration. Table 1 below shows the list of evaluation measures that guided questionnaire design and their corresponding, finalized survey questions. The final survey consisted of 55 total questions. Table 63 shows how each of the questions addressed the components of the CMS-approved Evaluation Design. Items assessing current health status, health history, and demographic information were also included in the final survey.

The questionnaire was then formatted and translated into Spanish so respondents could complete the survey in English or Spanish. Before the field period, SSRS programmed the study into Confirmit Computer Assisted Telephone and Web Interviewing (CATI/CAWI) software. Extensive program checking was conducted to ensure that skip patterns and sample splits followed the questionnaire design.

Table 63: Methods and Survey Questions for Beneficiary Primary Data Collection

Evaluation Hypothesis	Corresponding Measures	Corresponding Survey Questions[1]
Evaluation Question 1: Did the HTW Demonstration increase access to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas?	1.2.1 Motivating factors for HTW enrollment and renewal	Q1. How did you enroll in the Healthy Texas Women program? Q22. Did you have to switch from your usual health care provider to a provider who participates in the Healthy Texas women program to receive services? Q23. How easy or difficult would you say it was to enroll in the program? Q24. If you are eligible next year, how likely are you to re-enroll in the Healthy Texas Women program? Q25. What was the most difficult part of enrolling in the Healthy Texas Women program? Q26. How important were each of the following factors in your decision to enroll in the Healthy Texas Women program? Q27. What specific conditions, question, or service did you want to see a doctor or health care provider about that was a factor in your decision to enroll in the Healthy Texas Women Program? Q28. Now thinking about the Healthy Texas Women program overall, how would you rate each of the following? [Health care received/communication/etc.]
	1.2.2 Understanding of eligibility requirements	Q9. As far as you know, are there restrictions based on gender, age, health insurance coverage status, income and pregnancy status for someone to enroll in the Healthy Texas Women program?
	1.2.3 Understanding of HTW benefits	Q10. As far as you know, which of the following services are covered by the Healthy Texas Women program? Q36. The last time you had each of the following services, was it covered under the Health Texas Women program?

Evaluation Hypothesis	Corresponding Measures	Corresponding Survey Questions[1]
	1.2.4 Awareness of how to obtain services	Q11. Have you received any services from a primary care provider paid for in part or entirely by the HTW program in the past 12 months? Q12. Have you ever received services from a primary care provider through the HTW program? Q13. Have you received any services from a specialist provider through the HTW program in the past 12 months? Q14. Have you ever received any services from a specialist provider through the HTW program? Q15. Have you received a prescription medication covered by the Healthy Texas Women program in the last 12 months? Q16. Have you ever received a prescription medication covered by the Healthy Texas Women program?
	1.2.5 Effectiveness of outreach channels 1.2.6 Effectiveness of HTW Demonstration resources	Q2. Have you ever heard, read, or seen information about the Healthy Texas Women program from any of these other sources? Q5. Have you ever done any of the following to get more information about the HTW program? Q6. Was the information provided about HTW program by each of the following helpful [scale]? Q7. How easy or difficult was it to use each of the following sources for information about the HTW program? Q8. What was the most difficult part about using [insert item] for information about the HTW program? Q30. If you needed to find out the following types of information about a provider that participated in the Healthy Texas Women program how confident are you that you could find the information?

Evaluation Hypothesis	Corresponding Measures	Corresponding Survey Questions[1]
Evaluation Question 5. How does implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services?	5.1.2 Appointment wait times 5.1.3 Barriers to receiving care	Q17. In the last 12 months, have you had to miss a scheduled appointment with a Healthy Texas Women program provider? Q18. Are each of the following a reason you had to miss an appointment with a Healthy Texas Women provider? Q19. Are there any other reasons you had to miss an appointment with a Healthy Texas Women provider? Q20. Did any of the following factors keep you from using Healthy Texas Women services [, or not]? Q21. How (easy) or (difficult) was it for you to do each of the following? [Travel to appointment/Get an appointment/etc.] Q29. How (easy) or (difficult) was it for you to (INSERT ITEM) that participated in the Healthy Texas Women program? [Find providers/travel/schedule/etc.] Q31. The last time you wanted an appointment with a provider who participates in Healthy Texas Women, how long did you have to wait to get an appointment? Were you able to get an appointment: Q32. How satisfied, if at all, were you with how long you had to wait to get an appointment? Q.33 Now thinking about all your visits with health care providers who participate in the Healthy Texas Women program, how often did they (INSERT ITEM)? [Explain things/listen/show respect/etc.]

Notes. [1] Some of these questions were double-barreled or a sub-question depending on answers to previous questions.

Beneficiary Primary Data Collection Updates

The beneficiary survey sample was based on a file received from the Texas HHSC with names and contact information for all individuals enrolled in HTW during November 2022, who were enrolled in HTW for at least six months. This file also included a flag for whether the respondent received a service covered by the HTW program in the prior 12 months. From this list, SSRS pulled a stratified random sample designed to reach a minimum of 120 respondents in each Texas Public Health Region[33] and an additional 1,000 respondents who had received a service covered by HTW (see Tables 64 and 65). SSRS identified a total of 19,433 beneficiaries for the final survey sample. A total of 1,612 surveys were completed by program beneficiaries online or by phone, giving a response rate of 8.3%. In total, 28 respondents completed the survey in Spanish.

Table 64. Proposed Sampling Strategy for Beneficiary Primary Data Collection

Method of Primary Data Collection	Study Population (N)	Sampling Technique	Target Analytic Sample[1,2]	Actual Sample
Print and/or online beneficiary survey	HTW clients (340,095)[3]	Stratified random sample of all HTW clients based on key demographic subgroups (e.g., region, age, race/ethnicity)	1,600	1,612

Notes. [1] Target analytic samples for the beneficiary and provider surveys meet conventional criteria for statistical power (0.80) at α = 0.05. [2] The external evaluator will apply survey weights to ensure survey samples are representative of all HTW clients and providers. [3] Reflects the number of beneficiaries in the data file we received from HHSC in December 2022.

Table 65. Key Demographic Targets and Sample Sizes for Beneficiary Primary Data Collection

	Target Analytic Sample	Actual Sample
Total	1,600	1,612
Service Use		
Previous Service	1,000	1,248
No Previous Service	--	346
Texas Public Health Regions		
Lubbock	137	123
Temple	160	150
San Antonio	194	201
Harlingen	205	244
Arlington	314	272
Houston	314	332
South Tyler	137	153
El Paso	137	137

	Target Analytic Sample	Actual Sample
Urbanicity		
Urban	720	694
Suburban	592	614
Rural	288	304

Survey Administration

Procedure and Timeline

The field period for the beneficiary survey was May 18 through July 27, 2023. The web program went 'live' with the first mailing on May 18, 2023. On that date, SSRS designated interviewers in its phone rooms, during business hours (9:00 AM – 5:00 PM ET, Monday through Friday; 10:00 AM – 6:00 PM ET, Saturday; 11:00 AM – 8:00 PM ET, Sunday) to interview respondents who preferred completing the questionnaire by phone in English or Spanish. After hours, respondents could leave their information on a dedicated voicemail, and interviewers would call them to complete the survey later in the field period. Respondents could choose a language for hearing the voicemail greeting and leaving their message.

Recruitment to the survey occurred through the following multi-step procedure:

1. All sampled beneficiaries were sent an invitation letter via USPS first class mail. The letter introduced the survey and asked respondents to go to a study specific URL (htwsurvey.org) or call a toll-free number to take part in the survey. Respondents were provided a unique passcode they would enter on the survey's landing page or tell the interviewers if they chose to call in. The letters were mailed first class with the larger batches being presorted. Prospective respondents were offered a non-contingent incentive and the letters also provided prospective respondents with information about an additional $10 incentive contingent on completing the survey.
2. On the survey's landing page, respondents were welcomed to the survey and provided with information about the survey, assurance that their responses were confidential, contact information for questions, and a prompt to enter their passcode. Respondents could also select their preferred language to complete the survey.
3. Approximately one week after the initial mailing, all sampled beneficiaries received a reminder postcard in the mail with the same information as the initial mailing asking them to complete the survey online or by calling a toll-free number.

4. Approximately two weeks after the initial invitation letter, respondents received a final reminder letter with an additional non-contingent incentive.
5. Shortly after the final reminder email was sent, SSRS began outbound calls to any sampled beneficiaries who had not yet completed online or by calling in.

Recruitment was conducted in two waves. Wave 1 was mailed on May 18, 2023 with 6,933 records. After about two weeks in field, the results from wave 1 were used to make slight adjustments to the wave 2 design to ensure study-specific targets sizes for subgroups of interest were met. Wave 2 was mailed on June 27, 2023 with 12,500 records. Table 66 presents the dates for letter and postcard notifications for both wave 1 and wave 2.

Table 66. Contact Schedule for Beneficiary Primary Data Collection

Notification Type	Wave 1	Wave 2
Initial Invitation Letter	05/18/2023	06/27/2023
Reminder Postcard	05/23/2023	07/05/2023
First Reminder Letter	05/31/2023	07/12/2023
Outbound Dialing	06/05/2023	07/13/2023
Field Close	07/27/2023	07/27/2023

Online Data Collection

The website's landing page included a brief description of the survey and information about the post-incentive for those qualifying and completing the survey. From the landing page, respondents could also link to a page with FAQs about the study. Respondents were prompted to select a language to complete the study in, then to enter the unique passcode that appeared in their invitation mailing. Once they entered the passcode, respondents were asked first to confirm that they were the person named on the invitation letter who is enrolled in the HTW program. They were then directed to the questionnaire itself.

Respondents could suspend the survey at any point and resume later from the point where they suspended. At the end of the survey respondents were asked to provide a mailing address to receive the additional $10 incentive by mail.

Telephone Data Collection

Telephone interviewers received written materials about the survey instrument and formal training. The written materials were provided prior to the live pretest, and again, at the beginning of the field period. Training materials included an annotated

questionnaire that contained information about the goals of the study, eligibility criteria, the meaning and pronunciation of key terms, potential obstacles to be overcome in getting good answers to questions, and respondent problems that could be anticipated ahead of time, as well as strategies for addressing the potential problems. Call center supervisors and interviewers were given instructions to help them maximize response rates and ensure accurate data collection.

For outbound calls, SSRS enacted the following procedures during the field period:

- Up to three follow-up attempts were made to contact non-responsive numbers (e.g., no answer, busy, answering machine).
- Non-responsive numbers were contacted at varying the times of day, and the days of the week that call-backs were placed using a programmed differential call rule.
- Interviewers explained the purpose of the study and its importance.
- Respondents were offered the option of scheduling a call-back at their convenience.
- Respondents were reminded of the $10 post-incentive.

Quality Control and Data Cleaning

SSRS project managers and research directors monitored the progress of the study on a daily basis. Quality measures involved data-checking along with feedback provided by call center supervisors to interviewers and to the project team. For the web component, the SSRS team enacted the following measures:

- Extensive program checking: Prior to fielding, project management staff tested the web program extensively to ensure that skip patterns were working correctly, and the program can be used efficiently by respondents and interviewers using laptops, smartphones, and tablets.
- Unique passcodes: to avoid duplication, respondents had to log on to the survey using a unique passcode provided to them in the mailing materials. This ensured there was no duplication of respondents, and that people could not complete the survey unless they were specifically invited to do so.
- Data quality checks: Cases were flagged for review if they met any of the following criteria. If two or more of these criteria were met, they would have been removed. No cases in the final data met this criterion.
    - Length less than 25% of the average by mode

- Refused or skipped more than 30% of questions asked
- Straight-lined (i.e. gave the same response for every item) the majority of grid questions asked (web only)

Prior to processing the final data files, the data was thoroughly cleaned with a computer validation program that establishes editing parameters in order to locate any errors including data that do not follow skip patterns, out of range values, and errors in data field locations.

Weighting Procedures

Weighting is generally used in survey analysis to compensate for sample designs and patterns of non-response that might bias results. The weighting ensures that the demographic profile of the sample matches the profile of the target population.

The sample was weighted in stages. The first stage of the weighting was the application of a base weight to account for different selection probabilities and response rates across sample strata. In the second stage sample demographics were post-stratified to match population parameters. These parameters included age, race, Texas region, and urbanicity (Table 67).

Table 67. Weighting Benchmarks for Beneficiary Primary Data

	Parameter	Unweighted	Weighted
Age			
18-24	15.9%	10.9%	15.5%
25-29	21.3%	19.3%	21.2%
30-34	23.8%	22.8%	23.7%
35-39	19.4%	21.9%	19.6%
40-45	15.3%	19.6%	15.5%
45+[1]			
Race/Ethnicity			
White, non-Hispanic	23.1%	19.9%	22.4%
Black, non-Hispanic	24.5%	21.8%	24.7%
Hispanic	46.7%	53.3%	47.1%
Asian, non-Hispanic	1.4%	1.3%	1.4%
Indian, non-Hispanic	0.3%	0.3%	0.3%
Other, non-Hispanic	4.0%	3.3%	4.1%
Texas Health Regions			
Lubbock	3.4%	7.6%	3.4%
Temple	10.7%	9.3%	10.1%
San Antonio	11.6%	12.5%	11.7%
Harlingen	11.5%	15.1%	11.6%
Arlington	24.1%	16.9%	23.9%
Houston	26.7%	20.6%	27.0%
South Tyler	6.1%	9.5%	6.2%
El Paso	6.0%	8.5%	6.0%
Urbanicity			
Urban	45.7%	43.1%	46.2%
Suburban	36.0%	38.1%	36.1%
Rural	18.3%	18.9%	17.7%

Notes. [1] Women aged 45 and older are not eligible for the HTW but their eligibility was maintained in this instance due to the Public Health Emergency declaration.

Provider Primary Data Collection

Questionnaire Design

The questionnaire was collaboratively developed by UTHealth CHCD researchers and a third-party, full-service survey and market research firm with expertise in research designs and implementation, SRSS AUS Marketing Research Systems, Inc. (SSRS), to address research questions and hypotheses for evaluation of the HTW program. To ensure respondent comprehension and assess questionnaire length, a live pretest of the questionnaire was conducted from March 15, 2023 through April 28, 2023. Pre-testing for the provider survey involved testing the recruitment process for finding clinic administrators and receiving feedback on the survey itself.

Through phone calls, 15 administrators were found who were the most knowledgeable in the clinic on the HTW program and who agreed to participate in an interview. After multiple attempts at reaching out by email and phone, no providers could participate in this sample. Three administrators were able to complete an online version of the survey that was edited to include open-ended questions for feedback. Interviews were then conducted using contacts identified through provider files.

The primary issue administrators cited during pre-testing was finding time to complete the 30-minute in-depth interview. Some language was added to the online survey home page to present the survey in as little of a burden as possible, highlighting that the self-administered survey should only take 15 minutes. Some providers also raised confidentiality concerns, and language was added to assure them of confidentiality.

Table 68 lists the evaluation measures that guided questionnaire design and their corresponding, finalized survey questions. Items assessing provider background and clinic characteristics were also included in the final survey. There was a total of 37 questions.

Table 68. Methods and Survey Questions for Provider Primary Data Collection

Evaluation Hypothesis	Corresponding Measures	Corresponding Survey Questions[1]
Evaluation Question 1: Did the HTW Demonstration increase access to family planning, family planning-related, preconception care, and postpartum services for low-income women in Texas?	1.2.1 Motivating factors for HTW enrollment and renewal	Q8. How easy or difficult would you say it was to enroll your practice in HTW? Q9. What was the most difficult part of enrolling in the program? [open ended] Q10. How important were each of the following factors in your decision to enroll in the HTW program? Q11. What other factors, if any, were important in your decision to enroll in the HTW program? Q12. How likely is your clinic likely to renew their practice's enrollment in the HTW program? Q17. How much of a challenge has each of the following been for your clinic in providing care to HTW patients? [Filing claims, patient qualification, reimbursements, etc.]
	1.2.2 Understanding of eligibility requirements	Q5. As far as you know, which of the following conditions are a requirement for health care providers or clinics to be eligible for the Healthy Texas Women program? Q6. As far as you know, how often do providers need to renew their certification for the Healthy Texas Women program and attest that they do not perform or promote elective abortions or affiliate with individuals or entities that perform or promote elective abortions?
	1.2.3 Understanding of HTW benefits	Q3. Before being invited to participate in this survey, did you know you or your clinic was a part of the Healthy Texas Women program? Q7. As far as you know, which of the following services are covered by Healthy Texas Women? (Please select all that apply)
	1.2.5 Effectiveness of outreach channels 1.2.6 Effectiveness of HTW Demonstration resources	Q13. How helpful has information about the Healthy Texas Women program from the following sources been? Q.14 To your knowledge, have you or anyone at the clinic ever sought out information about the Healthy Texas Women program from any of the following sources? Q15. How helpful, if at all, was the information provided from each of the following sources?

Evaluation Hypothesis	Corresponding Measures	Corresponding Survey Questions[1]
Evaluation Question 5. How does implementation of the HTW provider eligibility criteria outlined in Goal 5 of the HTW Demonstration affect access to and utilization of women's health and family planning services?	5.1.4 Providers accepting new clients	Q16. In a typical month, about how many patients does your clinic see overall? Q16B. And among all the patients your clinic sees, about what percent are enrolled in Healthy Texas women? Q18. Is your clinic currently accepting new patients who are covered by HTW? Q19. Are each of the following a reason your clinic is not currently accepting new patients covered by HTW?
	5.1.5 Barriers to providing care	Q20. How much of a problem are each of the following for your clinic in providing care for HTW patients? Q21. How easy or difficult would you say finding specialists who accept referrals for Healthy Texas Women patients is: Q22. Overall, would you say HTW covers all, most, or just some of the costs to deliver health care service? Q23. Now thinking about the patients at your clinic who are enrolled in the HTW program, for about how many of your HTW patients does your clinic provide each of the following: Q23B. And continuing to think about the patients at your clinic who are enrolled in the HTW program, for about how many of your HTW patients does your clinic provide each of the following: Q25. In general, do you think the providers at your clinic are able to spend enough time in visits with patients enrolled in HTW? Q26. Now continuing to think about your specific clinic or practice, in a typical month… [physicians enrolled in HTW/specialists enrolled in HTW in clinic]

Notes. [1] Some of these questions were double-barreled or a sub-question depending on answers to previous questions.

Provider Primary Data Collection Updates

The provider sample was based on a file received from HHSC with names and contact information for all program providers. These providers included HTW contracted providers as of December 2022, Medicaid providers who completed the HTW attestation as of December 2022, and active HTW providers (e.g., performing and billing providers) between June and November 2022 (the most recent month of data available as of December 2022). Certain providers were excluded, including laboratories, anesthesiology, radiology, ambulance services, and medical supply companies. From the provided list, SSRS pulled a random sample of 950 providers.

The target analytic sample for the provider survey changed to 200 from the original 300 proposed in the CMS-approved Evaluation Design (see Table 69). This was due mainly to a shift from surveying individual providers, to actually aiming to include provider administrators that often represent several providers working under one organization, such as a physician group or clinic or an FQHC. Additionally, HHSC confirmed providers could not be offered incentives for completing the survey and, therefore, we adjusted response expectations.

SSRS recruited over the phone for approximately a week before each wave to identify the clinic administrators that would best be able to answer the survey and address the survey invitation directly to them. Approximately 100 invitations were sent out in each wave to these specifically named individuals (approximately 200 total). The rest of the 950-provider sample was a random of clinics that were sent invitation letters.

Table 69. Proposed Sampling Strategy for Provider Primary Data Collection

Method of Primary Data Collection	Study Population (N)	Sampling Technique	Target Analytic Sample[1,2]	Wave 1 Mailings	Wave 2 Mailings
Print and/or online beneficiary survey	HTW active billing providers (1,726)[4]	Stratified random sample of all HTW providers based on key demographic subgroups (e.g., region, provider type) or convenience sample[5]	200	300	650

Notes. [1] Target analytic samples for the beneficiary and provider surveys meet conventional criteria for statistical power (0.80) at α = 0.05. [2] The external evaluator will apply survey weights to ensure survey samples are representative of all HTW clients and providers. [4] Reflects 1,726 unique, finalized locations from the data file sent by HHSC. Certain providers were excluded, including anesthesiology, radiology, ambulance services, and medical supply companies. [5] Clinics will first be screened by phone to identify the appropriate administrator to address the survey notices to.

Survey Administration

A pre-recruitment process was used in attempt to increase response rates. From May 10 through May 30, 2023, SSRS interviewers made multiple attempts to call each of the clinics in this sample to reach the person within the clinic or facility most knowledgeable about the HTW program. Interviewers collected the name and position of this staff member and confirmed their mailing address. The interviewer also told the respondent they should receive a FedEx packet in the mail in the coming months with a formal invitation to take part in the study.

Recruitment to the survey occurred through the following multi-step procedure:

1. HHSC sent out announcement emails to contractors of Women's Health and Education Services that subscribe to alerts, and anyone interested in subscribing to HTW alerts on their email listserv to let them know that a survey was going to be sent out and for clinics to respond if they received an invitation.
2. All sampled clinics were sent a FedEx packet addressed to the person reached through the pre-recruitment process or addresses generically to the 'Clinic Administrator'. The packet included an invitation letter that introduced the survey and asked the respondent to go to a study specific URL (htwprovidersurvey.org) or fill-in the enclosed paper survey and return it in the provided prepaid envelope. The letter also included a phone number and email address that respondents could use to contact SSRS project staff with questions or concerns.

   On the survey's landing page, respondents were welcomed to the survey and provided with information about the survey, assurance that their responses were confidential, contact information for questions, and a prompt to enter the unique passcode on their intervention letter.
3. Approximately one week after the initial mailing, all sampled clinics received a reminder letter vis USPS with the same information as the initial mailing asking them to complete either the paper copy they were previously sent or the online survey.
4. Approximately two weeks after the initial invitation letter, respondents received a final reminder letter and another paper version of the survey.

Recruitment was conducted in two waves. Wave 1 was mailed on May 31, 2023 with 303 records. After about two weeks in field, the results from wave 1 were used

to make slight adjustments to the wave 2 design to ensure study-specific targets sizes for subgroups of interest were met. Wave 2 was mailed on July 30, 2023 with 647 records. Table 70 presents the dates for initial invitation and reminder notifications for both wave 1 and wave 2.

Table 70. Contact Schedule for Provider Primary Data Collection

Notification Type	Wave 1	Wave 2
HHSC Announcement Email	05/30/2023	07/19/2023
Invitation Letter	05/31/2023	07/20/2023
First Reminder Letter	06/07/2023	07/25/2023
Second Reminder Letter	06/15/2023	08/04/2023
Field Close	8/30/2023	08/30/2023

Quality Control and Data Cleaning

SSRS project managers and research directors monitored the progress of the study on a daily basis. For the web component, the SSRS team enacted the following measures:

- Extensive program checking: Prior to fielding, project management staff tested the web program extensively to ensure that skip patterns were working correctly, and the program can be used efficiently by respondents and interviewers using laptops, smartphones, and tablets.
- Unique passcodes: to avoid duplication, respondents had to log on to the survey using a unique passcode provided to them in the mailing materials. This ensured there was no duplication of respondents, and that people could not complete the survey unless they were specifically invited to do so.

Paper surveys were scanned and the hardcopy data were combined with data from the web surveys. There were 5 cases where the same clinic or facility location completed the surveys online and by mailing in a paper survey. In these cases, data from the web survey were preferred over the paper survey.

Weighting Procedures

Weighting is generally used in survey analysis to compensate for sample designs and patterns of non-response that might bias results. The weighting ensures that the demographic profile of the sample matches the profile of the target population.

The sample was weighed in stages. The first stage of the weighting was the application of a base weight to account for different selection probabilities and

response rates across sample strata. In the second stage sample demographics were post-stratified to match population parameters. These parameters included age, race, Texas region, and urbanicity (Table 71).

Table 71: Weighting Benchmarks for Beneficiary Primary Data

	Parameter	Unweighted	Weighted
Texas Public Health Regions			
Lubbock	4.7%	4.4%	4.7%
Temple	9.8%	4.4%	9.2%
San Antonio	10.1%	9.4%	10.2%
Harlingen	12.3%	16.0%	12.4%
Arlington	24.5%	17.1%	24.7%
Houston	24.6%	27.6%	24.8%
South Tyler	7.7%	9.9%	7.7%
El Paso	6.4%	11.0%	6.4%
Urbanicity			
Urban	43.4%	28.7%	43.0%
Suburban	45.0%	49.2%	45.2%
Rural	11.6%	22.1%	11.7%
Number of Associated Providers			
1	69.7%	74.6%	69.9%
2 or more	30.3%	25.4%	30.1%

Appendix D: References

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CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11 -W-00326/6

TITLE: Healthy Texas Women

AWARDEE: Texas Health and Human Services Commission

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Texas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from ~~January 22, 2020 through December 31, 2024~~ January 1, 2025, through December 31, 2029, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Healthy Texas Women demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. **Healthy Texas Women.** Effective through December 31, 2029~~4~~, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children's Health Insurance Program (CHIP), ages 18 through 44 with income at or below 20~~40~~.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their ~~60-day~~ postpartum coverage period.

2. **Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment**
   Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:
   - Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: 11 -W-00326/6

TITLE: Healthy Texas Women

AWARDEE: Texas Health and Human Services Commission

Title XIX Waivers

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. **Methods of Administration: Transportation** **Section1902(a)(4)(A)** ~~**insofar as it incorporates 42 CFR 431.53**~~

   To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. **Amount, Duration, and Scope of Services (Comparability)** **Section 1902(a)(10)(B)**

   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

3. **Retroactive Coverage** **Section 1902(a)(34)**

   To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section1902(a)(43)(A)**

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. **Freedom of Choice** **Section1902(a)(23)(A)**

To the extent necessary to enable the state to limit freedom of choice of provider in accordance with state law as described in the STCs. To the extent necessary, to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services.

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Ms. Linda Austin
Chief Operations Officer
Ysleta Del Sur Pueblo
119 S. Old Pueblo Road
El Paso, Texas 79907

Dear Ms. Austin:

The purpose of this letter is to notify members of the Ysleta Del Sur Pueblo that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
- Increase access to women's health and family planning services by enhancing continuity of care for women transitioning among Texas' managed care programs - STAR, the Children's Health Insurance Program (CHIP), and HTW throughout a woman's lifecycle. This includes young women transitioning from adolescent to well woman care, pregnant women transitioning from well woman to obstetric care, and postpartum women transitioning back to well woman care.

Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. **Methods of Administration: Transportation Section 1902(a)(4)**

   To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. **Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)**

   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

3. **Retroactive Coverage Section 1902(a)(34)**

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. Freedom of Choice Section 1902(a)(23)(A)

To the extent necessary to enable the state to limit freedom of choice of provider in accordance with state law as described in the STCs. To the extent necessary, to enable the state to restrict freedom of choice of providers through the use of mandatory enrollment in managed care plans for the receipt of covered services.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. Healthy Texas Women

Effective through December 31, 2029, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children’s Health Insurance Program (CHIP), ages 18 through 44 with income at or below 204.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their postpartum coverage period.

Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

Financial Analysis

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact - is approximately $17.5 Million with a General Revenue (GR) cost of approximately $4.8 Million (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9 Million AF and $8.8 Million GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to

twelve months after the extension period begins). This transition may influence measures related to access, quality, and cost. As a result, the evaluation for the HTW demonstration extension will focus on the impacts of this service delivery change. HHSC will also add new evaluation components, where necessary, to ensure the evaluation provides a comprehensive assessment of HTW services delivered under managed care.

Enrollment, Cost Sharing and Service Delivery
There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

Location and times of Public Hearings
HHSC will host two meetings to provide information about the demonstration extension as well as an opportunity for the public to provide comments. Locations, dates and times are as follows:

On February 22, 2024 at 1pm, HHSC will hold a hybrid public hearing with both virtual and in-person options. The public hearing will be held in conjunction with the quarterly State Medicaid Managed Care Advisory Committee (SMMCAC) meeting and will be located at the Texas Department of State Health Services, Moreton Building, Room M100, First Floor, 1100 West 49th Street, Austin, Texas 78756. Members of the public must pre-register to provide oral comments virtually during the meeting and written comments by completing a Public Comment Registration form at https://texashhsmeetings.org/SMMCAC_PCReg_Feb2024 no later than 5pm on Tuesday, February 20, 2024.

On March 5, 2024 at 10:30 a.m., HHSC will hold a public hearing at 801 S. State Highway 161, 2nd Floor, Lone Star Conference Room #200, Grand Prairie, TX 75051. This is an in-person hearing. Public comments will be accepted at this meeting. Members of the public may provide oral comments during the hearing at the hearing location either by pre-registering using the Public Comment Registration form at https://texashhsmeetings.org/HTW_PCReg_Mar2024 or without pre-registering by completing a form at the entrance to the hearing room. The Public Comment Registration form must be completed no later than 5pm on March 1, 2024.

A link to the webcast and virtual registration for commenters wishing to provide testimony during the hybrid public hearing on February 22, 2024, will be included in the agenda posted in the Texas Register and on the HHSC's website.

Feedback from Tribal Governments

CMS requires the State to seek advice from the tribal governments regarding any changes to the State's waivers that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. To allow sufficient time for consideration of the tribal government's comments or questions, HHSC requests your feedback by March 11, 2024.

To obtain a free copy of the proposed waiver extension, provide comments, ask questions, or request additional information regarding this extension request, please contact Nicole Hotchkiss by March 11, 2024 by phone at (512) 438-5035, by mail at Texas Health and Human Services Commission, 701 W. 51st Street, Mail Code H310, Austin, TX 78751, or by e-mail at TX_Medicaid_Waivers@hhs.texas.gov

Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Cecilia Flores
Tribal Council Chairwomen
Alabama-Coushatta Tribe of Texas
571 State Park Road, #56
Livingston, Texas 77351

Dear Ms. Flores:

The purpose of this letter is to notify members of the Alabama-Coushatta Tribe of Texas that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
- Increase access to women's health and family planning services by enhancing continuity of care for women transitioning among Texas' managed care programs - STAR, the Children's Health Insurance Program (CHIP), and HTW throughout a woman's lifecycle. This includes young women transitioning from adolescent to well woman care, pregnant women transitioning from well woman to obstetric care, and postpartum women transitioning back to well woman care.

Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. **Methods of Administration: Transportation Section 1902(a)(4)**

   To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. **Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)**

   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

3. **Retroactive Coverage Section 1902(a)(34)**

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. Freedom of Choice Section 1902(a)(23)(A)

To the extent necessary to enable the state to limit freedom of choice of provider in accordance with state law as described in the STCs. To the extent necessary, to enable the state to restrict freedom of choice of providers through the use of mandatory enrollment in managed care plans for the receipt of covered services.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. Healthy Texas Women

Effective through December 31, 2029, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children’s Health Insurance Program (CHIP), ages 18 through 44 with income at or below 204.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their postpartum coverage period.

Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

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Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

Financial Analysis

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact - is approximately $17.5 Million with a General Revenue (GR) cost of approximately $4.8 Million (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9 Million AF and $8.8 Million GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to

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Enrollment, Cost Sharing and Service Delivery
There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

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Feedback from Tribal Governments

CMS requires the State to seek advice from the tribal governments regarding any changes to the State's waivers that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. To allow sufficient time for consideration of the tribal government's comments or questions, HHSC requests your feedback by March 11, 2024.

To obtain a free copy of the proposed waiver extension, provide comments, ask questions, or request additional information regarding this extension request, please contact Nicole Hotchkiss by March 11, 2024 by phone at (512) 438-5035, by mail at Texas Health and Human Services Commission, 701 W. 51st Street, Mail Code H310, Austin, TX 78751, or by e-mail at TX_Medicaid_Waivers@hhs.texas.gov

Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Gabriela Garza
Community Services Administrator
Kickapoo Traditional Tribe of Texas
2212 Rosita Valley Road
Eagle Pass, Texas 78852

Dear Ms. Garza:

The purpose of this letter is to notify members of the Kickapoo Traditional Tribe of Texas that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
- Increase access to women's health and family planning services by enhancing continuity of care for women transitioning among Texas' managed care programs - STAR, the Children's Health Insurance Program (CHIP), and HTW throughout a woman's lifecycle. This includes young women transitioning from adolescent to well woman care, pregnant women transitioning from well woman to obstetric care, and postpartum women transitioning back to well woman care.

Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. Methods of Administration: Transportation Section 1902(a)(4)

To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

3. Retroactive Coverage Section 1902(a)(34)

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. Freedom of Choice Section 1902(a)(23)(A)

To the extent necessary to enable the state to limit freedom of choice of provider in accordance with state law as described in the STCs. To the extent necessary, to enable the state to restrict freedom of choice of providers through the use of mandatory enrollment in managed care plans for the receipt of covered services.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. Healthy Texas Women

Effective through December 31, 2029, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children’s Health Insurance Program (CHIP), ages 18 through 44 with income at or below 204.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their postpartum coverage period.

Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

Financial Analysis

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact - is approximately $17.5 Million with a General Revenue (GR) cost of approximately $4.8 Million (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9 Million AF and $8.8 Million GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to

twelve months after the extension period begins). This transition may influence measures related to access, quality, and cost. As a result, the evaluation for the HTW demonstration extension will focus on the impacts of this service delivery change. HHSC will also add new evaluation components, where necessary, to ensure the evaluation provides a comprehensive assessment of HTW services delivered under managed care.

Enrollment, Cost Sharing and Service Delivery
There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

Location and times of Public Hearings
HHSC will host two meetings to provide information about the demonstration extension as well as an opportunity for the public to provide comments. Locations, dates and times are as follows:

On February 22, 2024 at 1pm, HHSC will hold a hybrid public hearing with both virtual and in-person options. The public hearing will be held in conjunction with the quarterly State Medicaid Managed Care Advisory Committee (SMMCAC) meeting and will be located at the Texas Department of State Health Services, Moreton Building, Room M100, First Floor, 1100 West 49th Street, Austin, Texas 78756. Members of the public must pre-register to provide oral comments virtually during the meeting and written comments by completing a Public Comment Registration form at https://texashhsmeetings.org/SMMCAC_PCReg_Feb2024 no later than 5pm on Tuesday, February 20, 2024.

On March 5, 2024 at 10:30 a.m., HHSC will hold a public hearing at 801 S. State Highway 161, 2nd Floor, Lone Star Conference Room #200, Grand Prairie, TX 75051. This is an in-person hearing. Public comments will be accepted at this meeting. Members of the public may provide oral comments during the hearing at the hearing location either by pre-registering using the Public Comment Registration form at https://texashhsmeetings.org/HTW_PCReg_Mar2024 or without pre-registering by completing a form at the entrance to the hearing room. The Public Comment Registration form must be completed no later than 5pm on March 1, 2024.

A link to the webcast and virtual registration for commenters wishing to provide testimony during the hybrid public hearing on February 22, 2024, will be included in the agenda posted in the Texas Register and on the HHSC's website.

Feedback from Tribal Governments

CMS requires the State to seek advice from the tribal governments regarding any changes to the State's waivers that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. To allow sufficient time for consideration of the tribal government's comments or questions, HHSC requests your feedback by March 11, 2024.

To obtain a free copy of the proposed waiver extension, provide comments, ask questions, or request additional information regarding this extension request, please contact Nicole Hotchkiss by March 11, 2024 by phone at (512) 438-5035, by mail at Texas Health and Human Services Commission, 701 W. 51st Street, Mail Code H310, Austin, TX 78751, or by e-mail at TX_Medicaid_Waivers@hhs.texas.gov

Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Brittany Lewis
Executive Assistant-Human Resources
Texas Native Health
1283 Record Crossing Road
Dallas, Texas 75235

Dear Ms. Lewis:

The purpose of this letter is to notify members of the Texas Native Health that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
- Increase access to women's health and family planning services by enhancing continuity of care for women transitioning among Texas' managed care programs - STAR, the Children's Health Insurance Program (CHIP), and HTW throughout a woman's lifecycle. This includes young women transitioning from adolescent to well woman care, pregnant women transitioning from well woman to obstetric care, and postpartum women transitioning back to well woman care.

Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. **Methods of Administration: Transportation Section 1902(a)(4)**

   To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. **Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)**

   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

3. **Retroactive Coverage Section 1902(a)(34)**

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. Freedom of Choice Section 1902(a)(23)(A)

To the extent necessary to enable the state to limit freedom of choice of provider in accordance with state law as described in the STCs. To the extent necessary, to enable the state to restrict freedom of choice of providers through the use of mandatory enrollment in managed care plans for the receipt of covered services.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. Healthy Texas Women

Effective through December 31, 2029, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children’s Health Insurance Program (CHIP), ages 18 through 44 with income at or below 204.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their postpartum coverage period.

Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

Financial Analysis

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact - is approximately $17.5 Million with a General Revenue (GR) cost of approximately $4.8 Million (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9 Million AF and $8.8 Million GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to

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Enrollment, Cost Sharing and Service Delivery
There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

Location and times of Public Hearings
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Feedback from Tribal Governments

CMS requires the State to seek advice from the tribal governments regarding any changes to the State's waivers that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. To allow sufficient time for consideration of the tribal government's comments or questions, HHSC requests your feedback by March 11, 2024.

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Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Martin Lopez
Health and Human Services Director
Ysleta Del Sur Pueblo
9314 Juanchido Lane
El Paso, Texas 79907

Dear Mr. Lopez:

The purpose of this letter is to notify members of the Ysleta Del Sur Pueblo that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
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Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

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All Medicaid requirements apply, except the following:

1. **Methods of Administration: Transportation Section 1902(a)(4)**

   To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

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   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

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To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

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Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Ledora McDougle
Kickapoo Community Health Center Director
Kickapoo Traditional Tribe of Texas
2192 Rosita Valley Road
Eagle Pass, TX 78852

Dear Ms. McDougle:

The purpose of this letter is to notify members of the Kickapoo Traditional Tribe of Texas that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

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- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

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- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
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Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

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Waiver and Expenditure Authorities

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To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

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The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

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2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

Financial Analysis

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact - is approximately $17.5 Million with a General Revenue (GR) cost of approximately $4.8 Million (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9 Million AF and $8.8 Million GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to

twelve months after the extension period begins). This transition may influence measures related to access, quality, and cost. As a result, the evaluation for the HTW demonstration extension will focus on the impacts of this service delivery change. HHSC will also add new evaluation components, where necessary, to ensure the evaluation provides a comprehensive assessment of HTW services delivered under managed care.

Enrollment, Cost Sharing and Service Delivery
There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

Location and times of Public Hearings
HHSC will host two meetings to provide information about the demonstration extension as well as an opportunity for the public to provide comments. Locations, dates and times are as follows:

On February 22, 2024 at 1pm, HHSC will hold a hybrid public hearing with both virtual and in-person options. The public hearing will be held in conjunction with the quarterly State Medicaid Managed Care Advisory Committee (SMMCAC) meeting and will be located at the Texas Department of State Health Services, Moreton Building, Room M100, First Floor, 1100 West 49th Street, Austin, Texas 78756. Members of the public must pre-register to provide oral comments virtually during the meeting and written comments by completing a Public Comment Registration form at https://texashhsmeetings.org/SMMCAC_PCReg_Feb2024 no later than 5pm on Tuesday, February 20, 2024.

On March 5, 2024 at 10:30 a.m., HHSC will hold a public hearing at 801 S. State Highway 161, 2nd Floor, Lone Star Conference Room #200, Grand Prairie, TX 75051. This is an in-person hearing. Public comments will be accepted at this meeting. Members of the public may provide oral comments during the hearing at the hearing location either by pre-registering using the Public Comment Registration form at https://texashhsmeetings.org/HTW_PCReg_Mar2024 or without pre-registering by completing a form at the entrance to the hearing room. The Public Comment Registration form must be completed no later than 5pm on March 1, 2024.

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Feedback from Tribal Governments

CMS requires the State to seek advice from the tribal governments regarding any changes to the State's waivers that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. To allow sufficient time for consideration of the tribal government's comments or questions, HHSC requests your feedback by March 11, 2024.

To obtain a free copy of the proposed waiver extension, provide comments, ask questions, or request additional information regarding this extension request, please contact Nicole Hotchkiss by March 11, 2024 by phone at (512) 438-5035, by mail at Texas Health and Human Services Commission, 701 W. 51st Street, Mail Code H310, Austin, TX 78751, or by e-mail at TX_Medicaid_Waivers@hhs.texas.gov

Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Elizabeth Palyu, LCSW
Director of Behavioral Health
Ysleta Del Sur Pueblo
9314 Juanchido Lane
El Paso, Texas 79907

Dear Ms. Palyu:

The purpose of this letter is to notify members of the Ysleta Del Sur Pueblo that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
- Increase access to women's health and family planning services by enhancing continuity of care for women transitioning among Texas' managed care programs - STAR, the Children's Health Insurance Program (CHIP), and HTW throughout a woman's lifecycle. This includes young women transitioning from adolescent to well woman care, pregnant women transitioning from well woman to obstetric care, and postpartum women transitioning back to well woman care.

Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. **Methods of Administration: Transportation Section 1902(a)(4)**

   To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. **Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)**

   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

3. **Retroactive Coverage Section 1902(a)(34)**

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

4. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Section1902(a)(43)(A)

To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations.

5. Freedom of Choice Section 1902(a)(23)(A)

To the extent necessary to enable the state to limit freedom of choice of provider in accordance with state law as described in the STCs. To the extent necessary, to enable the state to restrict freedom of choice of providers through the use of mandatory enrollment in managed care plans for the receipt of covered services.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. Healthy Texas Women

Effective through December 31, 2029, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children’s Health Insurance Program (CHIP), ages 18 through 44 with income at or below 204.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their postpartum coverage period.

Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

Financial Analysis

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact - is approximately $17.5 Million with a General Revenue (GR) cost of approximately $4.8 Million (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9 Million AF and $8.8 Million GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to

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Enrollment, Cost Sharing and Service Delivery
There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

Location and times of Public Hearings
HHSC will host two meetings to provide information about the demonstration extension as well as an opportunity for the public to provide comments. Locations, dates and times are as follows:

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Feedback from Tribal Governments

CMS requires the State to seek advice from the tribal governments regarding any changes to the State's waivers that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. To allow sufficient time for consideration of the tribal government's comments or questions, HHSC requests your feedback by March 11, 2024.

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Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Myra Sylestine
Health Director
Alabama-Coushatta Tribe of Texas
571 State Park Road, #56
Livingston, Texas 77351

Dear Ms. Sylestine:

The purpose of this letter is to notify members of the Alabama-Coushatta Tribe of Texas that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
- Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.
- Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.
- Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

- Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.
- Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.
- Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.
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Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the

Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

1. **Methods of Administration: Transportation Section 1902(a)(4)**

   To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

2. **Amount, Duration, and Scope of Services (Comparability) Section 1902(a)(10)(B)**

   To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

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Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

TEXAS
Health and Human Services

Texas Health and Human Services Commission

Cecile Erwin Young
Executive Commissioner

February 9, 2024

Omer Tamir, MPA
Executive Director
Texas Native Health
1283 Record Crossing Road
Dallas, Texas 75235

Dear Mr. Tamir:

The purpose of this letter is to notify members of the Texas Native Health that the Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

- Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.
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- Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

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The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. Healthy Texas Women

Effective through December 31, 2029, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children’s Health Insurance Program (CHIP), ages 18 through 44 with income at or below 204.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their postpartum coverage period.

Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment

Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

- Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

Financial Analysis

The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact - is approximately $17.5 Million with a General Revenue (GR) cost of approximately $4.8 Million (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9 Million AF and $8.8 Million GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to

twelve months after the extension period begins). This transition may influence measures related to access, quality, and cost. As a result, the evaluation for the HTW demonstration extension will focus on the impacts of this service delivery change. HHSC will also add new evaluation components, where necessary, to ensure the evaluation provides a comprehensive assessment of HTW services delivered under managed care.

Enrollment, Cost Sharing and Service Delivery
There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

Location and times of Public Hearings
HHSC will host two meetings to provide information about the demonstration extension as well as an opportunity for the public to provide comments. Locations, dates and times are as follows:

On February 22, 2024 at 1pm, HHSC will hold a hybrid public hearing with both virtual and in-person options. The public hearing will be held in conjunction with the quarterly State Medicaid Managed Care Advisory Committee (SMMCAC) meeting and will be located at the Texas Department of State Health Services, Moreton Building, Room M100, First Floor, 1100 West 49th Street, Austin, Texas 78756. Members of the public must pre-register to provide oral comments virtually during the meeting and written comments by completing a Public Comment Registration form at https://texashhsmeetings.org/SMMCAC_PCReg_Feb2024 no later than 5pm on Tuesday, February 20, 2024.

On March 5, 2024 at 10:30 a.m., HHSC will hold a public hearing at 801 S. State Highway 161, 2nd Floor, Lone Star Conference Room #200, Grand Prairie, TX 75051. This is an in-person hearing. Public comments will be accepted at this meeting. Members of the public may provide oral comments during the hearing at the hearing location either by pre-registering using the Public Comment Registration form at https://texashhsmeetings.org/HTW_PCReg_Mar2024 or without pre-registering by completing a form at the entrance to the hearing room. The Public Comment Registration form must be completed no later than 5pm on March 1, 2024.

A link to the webcast and virtual registration for commenters wishing to provide testimony during the hybrid public hearing on February 22, 2024, will be included in the agenda posted in the Texas Register and on the HHSC's website.

Feedback from Tribal Governments

CMS requires the State to seek advice from the tribal governments regarding any changes to the State's waivers that are likely to have a direct effect on Indians, Indian health programs, or Urban Indian Organizations. To allow sufficient time for consideration of the tribal government's comments or questions, HHSC requests your feedback by March 11, 2024.

To obtain a free copy of the proposed waiver extension, provide comments, ask questions, or request additional information regarding this extension request, please contact Nicole Hotchkiss by March 11, 2024 by phone at (512) 438-5035, by mail at Texas Health and Human Services Commission, 701 W. 51st Street, Mail Code H310, Austin, TX 78751, or by e-mail at TX_Medicaid_Waivers@hhs.texas.gov

Sincerely,

[redacted]

Kathi Montalbano
Director, Federal Coordination, Rules, and Committees
Medicaid/CHIP Division, HHSC

From: TexReg@sos.texas.gov
To: Pons,Tammy (HHSC)
Subject: TEXAS REGISTER ACKNOWLEDGMENT OF RECEIPT
Date: Tuesday, January 30, 2024 6:20:48 PM

ACKNOWLEDGMENT OF RECEIPT

Please note that this email acknowledges receipt of your filing only.
If we find that the document or submission form does not conform to statutory filing requirements or our administrative rules, we may refuse to accept it for filing and publication.
If we refuse your filing, we will notify you.

TRD Number: 202400339
For Issue of: 02/09/2024

Submission Date: 2024-01-30 17:27 PM
Receipt Date: 2024-01-30 18:20 PM

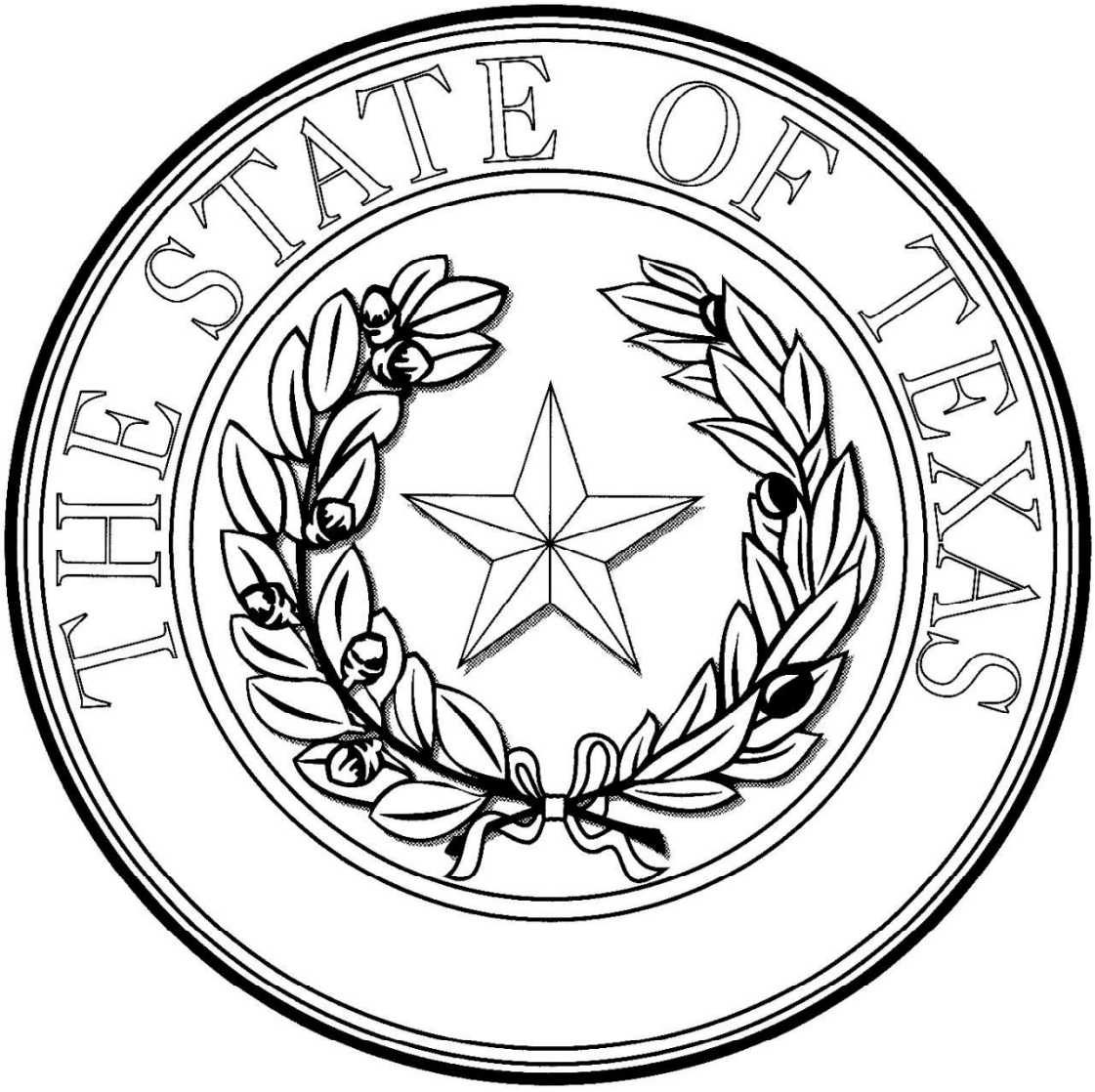
Miscellaneous Document Submission

Agency Name: Texas Health and Human Services Commission
Agency Code: 0315
Liaison: Tammy Pons
Title of Document: Public Notice ? Extension of the Healthy Texas Women (HTW) Section 1115 Medicaid Demonstration

File Name: 0130b0315.docx

TEXAS REGISTER

Volume 49 Number 6 *February 9, 2024* *Pages 599 - 804*



HHSC revised performance measure G.a.8 data source to replace the term "CLASS Consolidated Microsoft Database" with "Quality Assurance and Improvement Data Mart."

HHSC revised performance measure G.a.9 data source to replace the term "Salesforce Abuse, Neglect, and Exploitation Database" with "Critical Incident Management System."

HHSC revised performance measure G.a.11 data source to replace the term "LTSS Policy SoftChalk Database" with "HHSC Provider Learning Portal." Revised the frequency of data aggregation and analysis.

HHSC revised performance measure G.b.1 data source to replace the term "Notification of Critical Incidents Database" with "Critical Incident Management System."

HHSC revised performance measure G.b.2 and G.b.3 data source to replace the term "CLASS Consolidated Microsoft Database" with "Quality Assurance and Improvement Data Mart."

HHSC revised performance measure G.c.1, as well as the numerator, to replace the term "referred for further investigation" with "that were in compliance with requirements related to unauthorized restraint." Revised data source to replace the term "Notification of Critical Incidents Database" with "Critical Incident Management System." The revised measure reads as, "Number and percent of provider-reported incidents of restraint that were in compliance with requirements related to unauthorized restraint. N: Number of provider-reported incidents of restraint that were in compliance with requirements related to unauthorized restraint. D: Number of provider-reported incidents of restraint."

HHSC revised performance measure I.a.1, as well as the numerator, to add the term "coded and." The revised measure reads as, "Total dollar amount and percent of total dollar amount of paid claims, including those from FMSAs, that were coded and paid for according to the reimbursement methodology specified in the approved waiver. N: Total dollar amount of paid claims that were coded and paid for according to the reimbursement methodology specified in the approved waiver. D: Total dollar amount of paid claims."

HHSC removed performance measure I.a.2 that read, "Number and percent of monitored financial management services agencies (FMSAs) for which claims were paid in accordance with the employee's established rate of pay and the service hours actually worked." Replaced I.a.2 with new performance measure that reads, "Number and percent of FMSAs that received a contract monitoring review that were free from recoupment of the FMS fee. N: Number of FMSAs that received a contract monitoring review that were free from recoupment of the FMS fee. D: Number of FMSAs that received a contract monitoring review."

HHSC revised performance measure I.b.1 data source to replace the term "Rate Analysis" with "Provider Finance."

Miscellaneous

HHSC updated references to the TAC changing references from Title 40 to Title 26 throughout the waiver application. Rules of the former Department of Aging and Disability Services (DADS), which were in Title 40, have been transferred to Title 26.

HHSC changed the term "Policy Development Support" to "Federal Coordination, Rules and Committees".

HHSC removed references to the DADS because that agency was abolished in 2017 and its functions transferred to HHSC.

HHSC changed the term "provider" to "service provider" and the term "program provider" to "provider agency."

HHSC changed the term "face-to-face" to "in-person".

HHSC changed the term "provider investigations" to "Long-Term Care Regulation (LTCR)" or "HHSC CII".

HHSC changed the terms "Texas Department of Family and Protective Services" to "HHSC Complaint and Incident Intake (CII)" or "HHSC LTCR".

HHSC changed the term "Texas Department of Family and Protective Services" to "HHSC Child Care Regulation".

HHSC changed the term "Rate Analysis Department" to "Provider Finance Department".

To obtain a free copy of the proposed waiver renewal, ask questions, obtain additional information, or submit comments, please contact Jayasree Sankaran by U.S. mail, telephone, fax, or email at the addresses and numbers below. A copy of the proposed waiver renewal may also be obtained online on the HHSC website at:

https://www.hhs.texas.gov/laws-regulations/policies-rules/waivers

Comments about the proposed waiver renewal must be submitted to HHSC by March 11, 2024.

The Access and Eligibility Services for local benefit offices will post this notice for 30 days and will have copies of the renewal available for review.

Addresses:

U.S. Mail

Texas Health and Human Services Commission

Attention: Jayasree Sankaran, Waiver Coordinator, Federal Coordination, Rules and Committees

701 West 51st Street, Mail Code H-310

Austin, Texas 78751

Telephone

(512) 438-4331

Fax

Attention: Jayasree Sankaran, Waiver Coordinator at (512) 323-1905

Email

TX_Medicaid_Waivers@hhs.texas.gov

TRD-202400340
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: January 30, 2024

♦ ♦ ♦

Public Notice - Extension of the Healthy Texas Women (HTW) Section 1115 Medicaid Demonstration

The Texas Health and Human Services Commission (HHSC) announces its intent to submit to the Centers for Medicare & Medicaid Services (CMS) a request to extend the Healthy Texas Women (HTW) demonstration under section 1115 of the Social Security Act.

The current demonstration is approved through December 31, 2024. The proposed effective date for the extension is January 1, 2025. The extension request is for five years, which will allow the demonstration to operate through December 31, 2029. There is a fiscal impact to the extension of the HTW demonstration.

The requested extension will allow Texas continued flexibility to pursue the established goals of the HTW demonstration, which are to:

Increase access to women's health and family planning services to avert unintended pregnancies, positively affect the outcome of future pregnancies, and positively impact the health and well-being of women and their families.

Increase access to preventive health care, including screening and treatment for sexually transmitted infections, hypertension, diabetes and high cholesterol; to positively impact maternal health; and reduce maternal mortality.

Increase access to women's breast and cervical cancer services to promote early cancer detection and referral to treatment in existing state programs.

Implement state policy to favor childbirth and family planning services that do not include elective abortions or the promotion of elective abortions within the continuum of care or services and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Reduce the overall cost of publicly funded health care (including federally funded health care) by providing low-income Texans access to safe, effective care across a woman's lifecycle.

Proposed Changes

House Bill (H.B.) 133, 87th Legislature, Regular Session, 2021, requires HHSC to contract with Medicaid managed care organizations (MCOs) to provide HTW services. To comply with H.B. 133, the extension request proposes to change the delivery of HTW services from the current fee-for-service (FFS) model to a managed care model, except that enrollees who are members of a federally recognized tribe will be able to voluntarily enroll in managed care or remain in FFS. Under a managed care model, MCOs will contract, credential, and reimburse HTW providers for HTW services. The proposed effective date for the transition to a managed care model is Quarter 1 of State Fiscal Year 2026. This is the only requested programmatic change to the demonstration.

Transitioning the delivery of HTW services to a managed care model will:

Further the goals of the demonstration by reducing the overall cost of publicly funded health care, including federally funded health care, and providing Texas women access to safe, effective services.

Increase access to and utilization of preventive health care, breast and cervical cancer services, and critical health services.

Improve the health of women in the HTW program by incorporating core features of Medicaid managed care programs into HTW, such as the establishment of a primary care provider, person-centered service coordination, and value added services.

Increase access to women's health and family planning services by enhancing continuity of care for women transitioning among Texas' managed care programs - STAR, the Children's Health Insurance Program (CHIP), and HTW throughout a woman's lifecycle. This includes young women transitioning from adolescent to well woman care, pregnant women transitioning from well woman to obstetric care, and postpartum women transitioning back to well woman care.

Additionally, the extension request reflects an increase in the state's comparable income limit to convert existing state income threshold standards from 200% of the Federal Poverty Level (FPL) to 204.2% of the FPL, the equivalent to Modified Adjusted Gross Income (MAGI) standard.

Waiver and Expenditure Authorities

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2025 through December 31, 2029. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Texas to carry out the Healthy Texas Women section 1115 Demonstration.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authorities:

All Medicaid requirements apply, except the following:

Methods of Administration: Transportation Section1902(a)(4)

To the extent necessary to enable the state to not assure transportation to and from providers for the demonstration population.

Amount, Duration, and Scope of Services (Comparability) - Section 1902(a)(10)(B)

To the extent necessary to allow the state to offer the demonstration population a benefit package consisting only of family planning services, family planning-related services, and other preconception women's health services.

Retroactive Coverage - Section 1902(a)(34)

To the extent necessary to enable the state to not provide medical assistance to the demonstration population for any time prior to when an application for the demonstration is made.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - Section1902(a)(43)(A) To the extent necessary to enable the state to not furnish or arrange for EPSDT services to the demonstration populations. Freedom of Choice - Section 1902(a)(23)(A) To the extent necessary to enable the state to limit freedom of choice of provider in accordance with state law as described in the STCs. To the extent necessary, to enable the state to restrict freedom of choice of providers through the use of mandatory enrollment in managed care plans for the receipt of covered services.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Texas to operate the above-identified section 1115(a) demonstration.

1. Healthy Texas Women. Effective through December 31, 2029, expenditures for extending Medicaid eligibility for family planning services, family planning-related services and other preconception women's health services to women who are otherwise ineligible for Medicaid or the Children's Health Insurance Program (CHIP), ages 18 through 44 with income at or below 204.2 percent of the Federal Poverty Level (FPL), including women who are losing Medicaid pregnancy coverage at the conclusion of their postpartum coverage period.

Additionally, HHSC is proposing to add the following expenditure authority with this extension request:

2. Expenditures Related to Managed Care Organization (MCO) Enrollment and Disenrollment Expenditures made under contracts that do not meet the requirements in section 1903(m) of the Act specified below. Managed care organizations (MCOs) delivering HTW services will be required to meet all requirements of section 1903(m) of the Act except the following:

Section 1903(m)(2)(H) of the Act and Federal regulations at 42 CFR Part 438, to the extent that the regulations implementing

section 1932(a)(4) of the Act are inconsistent with the enrollment and disenrollment provisions contained in STC 18(c) of the HTW demonstration's STCs, which permit the State to authorize automatic re-enrollment in the same MCO if the beneficiary loses eligibility for less than six (6) months.

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The extension of the HTW demonstration (effective date January 1, 2025) will result in a revised budget neutrality model that will be negotiated with CMS and will include transitioning the HTW demonstration to a managed care delivery model. The change to a managed care delivery model may impact budget neutrality due to the addition of capitation related expenses for MCO administrative costs, risk margin and premium tax. It is estimated that the All Funds (AF) costs of capitation for Calendar Year 25 - which includes seven months of impact -is approximately $17.5M with a General Revenue (GR) cost of approximately $4.8M (27.6 percent of AF). The first full year impact in Calendar Year 26 is estimated to cost approximately $31.9M AF and $8.8M GR (27.6 percent of AF). The impact to budget neutrality will ultimately depend on the revised budget neutrality model as the change in delivery model occurs after the current demonstration ends and will be part of extension negotiations with CMS.

Evaluation Design

HHSC will continue to comply with federal evaluation monitoring and reporting requirements during the HTW demonstration extension. Evaluation monitoring and reporting will remain critical as the HTW demonstration will undergo a change during the extension period when the delivery of services transition from FFS to managed care during Quarter 1 of State Fiscal Year 2026 (approximately nine to twelve months after the extension period begins). This transition may influence measures related to access, quality, and cost. As a result, the evaluation for the HTW demonstration extension will focus on the impacts of this service delivery change. HHSC will also add new evaluation components, where necessary, to ensure the evaluation provides a comprehensive assessment of HTW services delivered under managed care.

Enrollment, Cost Sharing and Service Delivery

There are no proposed changes to eligibility requirements and no expected impact to total enrollment in the HTW demonstration. Transitioning the delivery of HTW services to a managed care model will require HTW clients to select and enroll with an MCO. Default enrollment and eligibility processes will apply. Under the extension, there will continue to be no beneficiary cost sharing.

Full Public Notice

This is the full public notice set forth in 42 CFR § 431.408(a)(1)(i). The full public notice regarding this extension request will be available at: https://www.hhs.texas.gov/regulations/policies-rules/waivers/healthy-texas-women-1115-demonstration.

Location and times of Public Hearings

HHSC will host two meetings to provide information about the demonstration extension as well as an opportunity for the public to provide comments. Locations, dates and times are as follows:

On February 22, 2024 at 1:00 p.m., HHSC will hold a hybrid public hearing with both virtual and in-person options. The public hearing will be held in conjunction with the quarterly State Medicaid Managed Care Advisory Committee (SMMCAC) meeting and will be located at the Texas Department of State Health Services, Moreton Building, Room M100, First Floor, 1100 West 49th Street, Austin, Texas 78756. Members of the public must pre-register to provide oral comments virtually during the meeting and written comments by completing a Public Comment Registration form at https://texashhsmeetings.org/SMMCAC_PCReg_Feb2024 no later than 5 p.m. on Tuesday, February 20, 2024.

On March 5, 2024 at 10:30 a.m., HHSC will hold a public hearing at 801 S. State Highway 161, 2nd Floor, Lone Star Conference Room #200, Grand Prairie, Texas 75051. This is an in-person hearing. Public comments will be accepted at this meeting. Members of the public may provide oral comments during the hearing at the hearing location either by pre-registering using the Public Comment Registration form at https://texashhsmeetings.org/HTW_PCReg_Mar2024 or without pre-registering by completing a form at the entrance to the hearing room. The Public Comment Registration form must be completed no later than 5 p.m. on March 1, 2024.

A link to the webcast and virtual registration for commenters wishing to provide testimony during the hybrid public hearing on February 22, 2024, will be included in the agenda posted in the *Texas Register* and on the HHSC's website.

Copies of Demonstration Extension Application

The complete extension application is available online at: https://www.hhs.texas.gov/regulations/policies-rules/waivers/healthy-texas-women-1115-demonstration.

Public Comments

The public is invited to submit comments on the Healthy Texas Women Section 1115 Medicaid Demonstration for a period of 30 days, beginning Friday, February 9, 2024. The public comment period will end on Monday, March 11, 2024.

An individual may obtain a free copy of the proposed demonstration extension, ask questions, obtain additional information, or submit comments regarding this extension by March 11, 2024, by contacting Jayasree Sankaran by U.S. mail, telephone, or email. The addresses are as follows:

U.S. Mail

Texas Health and Human Services Commission

Attention: Jayasree Sankaran, Waiver Coordinator, Federal Coordination, Rules and Committees

701 W. 51st Street

Mail Code: H310

Austin, Texas 78751

Telephone: (512) 438-4331

Fax: (512) 323-1905

Email: TX_Medicaid_Waivers@hhsc.state.tx.us.

TRD-202400339
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Filed: January 30, 2024

♦ ♦ ♦

Public Notice - Home and Community-Based Services Adult Mental Health (HCBS-AMH) §1915(i) State Plan Benefit

The Texas Health and Human Services Commission (HHSC) announces its intent to submit transmittal number (TN) 24-0008 to the Texas State Plan for Medical Assistance under Title XIX of the Social Security Act.