DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

December 9, 2025

Emily Zalkovsky
State Medicaid Director
Texas Health and Human Services Commission
4601 W. Guadalupe Street MC:H100
Austin, Texas 78751

Dear Director Zalkovsky:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Texas' Final Report for the COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled "Healthy Texas Women" (Project Number: 11-W-00326/6), approved on September 15, 2023. This report covers the demonstration period from March 1, 2020, through March 31, 2024. CMS determined that the Final Report, submitted on March 27, 2025 and finalized on September 9, 2025, is in alignment with the CMS-approved Evaluation Design, and therefore approves the state's Final Report.

The approved Final Report may now be posted on the state's Medicaid website. CMS will also post the approved Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE amendment. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
Digitally signed by DANIELLE DALY -S
Date: 2025.12.09 10:53:42 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Enclosure
cc: Ford Blunt, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

COVID-19 1115(a) Demonstration Evaluation: Healthy Texas Women COVID-19 Testing

As Required by
Centers for Medicare and Medicaid Services

Texas Health and Human Services Commission

Office of Data, Analytics, and Performance
Revised September 2025

TEXAS
Health and Human Services

Table of Contents

Executive Summary

To assist states with addressing the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) created a 1115(a) Demonstration opportunity that provided states flexibility and assistance enrolling and covering Medicaid members. CMS approved Texas' COVID-19 1115(a) Demonstration on September 15, 2023, with a retroactive effective date of March 1, 2020. The Demonstration remained in effect through March 31, 2024. The 1115(a) Demonstration allowed the Texas Health and Human Services Commission (HHSC) to provide COVID-19 testing to women enrolled in the Healthy Texas Women (HTW) Demonstration. This report summarizes findings from an evaluation assessing how the approved COVID-19 1115(a) Demonstration affected Texas' response to the public health emergency (PHE).

The evaluation used a descriptive case study design to examine implementation of the 1115(a) Demonstration and COVID-19 testing among HTW clients following the Demonstration. HHSC relied on administrative data to identify HTW clients who received a COVID-19 test and corresponding costs and conducted interviews with Medicaid subject matter experts (SMEs) to obtain additional information about the implementation process.

Key evaluation findings include:

- HTW clients experienced several challenges during the public health emergency (PHE) that made access to COVID-19 testing particularly important for this population, including increased financial hurdles due to their lower socioeconomic status and fewer options for treatments in more severe cases of COVID-19 (Evaluation Question 1).
- The 1115(a) Demonstration supported access to COVID-19 testing, with 66,800 HTW clients (eight percent of unique individuals enrolled over the study period) accessing at least one HTW-paid COVID-19 test (Evaluation Question 2).
- HHSC leveraged existing processes and communication channels to add new COVID-19 testing benefits to HTW and inform providers and clients of the changes (Evaluation Question 2).
- Women who received at least one HTW-paid COVID-19 test were most likely to be between 25 and 34 years old, Hispanic, and residing in a metropolitan

county. These findings align with the characteristics of the full HTW population (Evaluation Question 3).

- The total cost across all HTW-paid COVID-19 testing was approximately $10 million, or $60 per test, on average, though costs varied by type of test. There were limited administrative or programmatic costs associated with implementing the 1115(a) Demonstration (Evaluation Question 4).

The results of the evaluation should be interpreted alongside several key limitations, including common challenges with administrative data and threats to validity associated with the qualitative interview methods used in this report. Despite these limitations, findings from this evaluation indicate that the 1115(a) Demonstration helped Texas facilitate access to COVID-19 testing for women in HTW at minimal administrative cost.

1. Introduction

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constituted a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act) as amended (42 U.S.C. 1320b-5). The Secretary of Health and Human Services invoked his authority to waive or modify certain requirements of Titles XVIII, XIX, and XXI of the Act to the extent necessary, as determined by CMS, due to the consequences of the COVID-19 pandemic. Waivers or modifications to Titles XVIII, XIX, and XXI of the Act ensured that sufficient health care items and services were available to meet the needs of people enrolled in the respective programs. The waivers or modifications also ensured that health care providers who furnished such items and services in good faith could be reimbursed and exempted from sanctions for potential noncompliance, absent any determination of fraud or abuse. The authority ended upon termination of the PHE, including any extensions.

In an effort to assist states with addressing the COVID-19 pandemic, CMS created a 1115(a) Demonstration opportunity to waive or modify requirements of Title XIX of the Act. The 1115(a) Demonstration opportunity allowed states flexibility and assistance enrolling and covering Medicaid beneficiaries. CMS announced the new 1115(a) Demonstration opportunity on March 22, 2020; all approved demonstrations have a retroactive effective date of March 1, 2020.

Texas' Request for HTW COVID-19 PHE Section 1115(a) Demonstration

HHSC originally submitted a request to amend the HTW Demonstration to CMS on July 15, 2020. CMS directed HHSC to resubmit the request through the COVID-19 PHE 1115(a) Demonstration opportunity outlined in State Medicaid Director Letter #20-002. HHSC resubmitted the request to CMS on April 28, 2023.

HHSC requested authority to provide COVID-19 testing to women enrolled in the HTW Demonstration. CMS determined that the COVID-19 PHE 1115(a) Demonstration (henceforth referred to as the "1115(a) Demonstration") was necessary to assist HHSC in delivering the most effective care to its HTW beneficiaries in light of the COVID-19 PHE and approved the 1115(a)

Demonstration on September 15, 2023.[1] This approval was authorized retroactively from March 1, 2020, through the end of HHSC's unwinding period on March 31, 2024.

CMS required all states to conduct an evaluation of approved COVID-19 PHE 1115(a) Demonstrations. The purpose of these evaluations was to detail the challenges presented by the COVID-19 PHE to the Medicaid program, how the flexibilities of the demonstration assisted in meeting those challenges, and any lessons that may be applicable when responding to a similar PHE in the future. In addition, states were required to track administrative costs and health services expenditures for demonstration clients and to assess how these expenses affected HHSC's response to the PHE.

CMS informed HHSC during a call on May 5, 2023, that an internal department within HHSC could conduct the required evaluation. HHSC's Office of Data, Analytics, and Performance (DAP) conducted the evaluation of HHSC's 1115(a) Demonstration.[2] DAP is an independent division within HHSC, separate from the Medicaid and CHIP Services division. DAP has no role or responsibility in administration or implementation of the 1115(a) Demonstration. DAP is staffed by masters and doctoral-level researchers with extensive backgrounds in health and social science research methods. This report summarizes DAP's evaluation of the 1115(a) Demonstration.

[1] CMS also approved another 1115(a) Demonstration on extended spell of illness limitations during the PHE under the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver. This report only presents findings from the 1115(a) Demonstration authorized under the HTW Demonstration.

[2] CMS also provided written approval for DAP to conduct the evaluation for the other 1115(a) Demonstration under the Texas Healthcare Transformation and Quality Improvement Program 1115 waiver, referenced in the previous footnote. Findings from that evaluation are presented in a separate report.

2. Study Methods

Evaluation Questions

This evaluation is guided by four evaluation questions and five hypotheses that examine how the 1115(a) Demonstration affected HHSC's response to the PHE (see Table 1). This section provides an overview of the study design, study populations, data sources, and analytic methods. Please refer to the full evaluation design for additional information.[3]

Table 1. Evaluation Questions and Hypotheses

Evaluation Question	Corresponding Hypotheses
Evaluation Question 1. What challenges to accessing COVID-19 testing did women in HTW experience during the PHE?	**Hypothesis 1.1.** Women in HTW experienced several challenges accessing COVID-19 testing during the PHE.
Evaluation Question 2. How did the 1115(a) Demonstration increase access to COVID-19 testing?	**Hypothesis 2.1**. The 1115(a) Demonstration supported access to COVID-19 testing among women in HTW. **Hypothesis 2.2.** The state's implementation of the 1115(a) Demonstration encouraged HTW clients and providers to leverage approved flexibilities related to COVID-19 testing.
Evaluation Question 3. Which groups of women in HTW were principally affected by the 1115(a) Demonstration?	**Hypothesis 3.1.** The 1115(a) Demonstration served a diverse and vulnerable population.
Evaluation Question 4. What were the costs of implementing the 1115(a) Demonstration?	**Hypothesis 4.1** The 1115(a) Demonstration provided financial support towards the state's response to the PHE.

Study Design Overview

The evaluation relied on a descriptive case study design, integrating both quantitative and qualitative data, to provide a comprehensive understanding of how the 1115(a) Demonstration affected Texas' response to the PHE.

[3] Evaluation Design: Healthy Texas Women COVID-19 Public Health Emergency 1115(a) Demonstration

Study Population and Timeframe

The evaluation primarily focused on women enrolled in the existing HTW Demonstration between March 1, 2020, and March 31, 2024 (the duration of the 1115(a) Demonstration). This population included women ages 18 through 48 who met all other eligibility requirements of the HTW program.[4] In addition to women enrolled in HTW, DAP also interviewed Medicaid SMEs to gather information about the implementation of the program and the administrative and financial aspects of the 1115(a) Demonstration. Lastly, DAP relied on population-level COVID-19 positivity rates across the state of Texas, where appropriate, to contextualize findings of the evaluation.

Data Sources

The evaluation leveraged both administrative and primary data sources to evaluate the 1115(a) Demonstration. Specifically, the evaluation analyzed fee-for-service (FFS) claims data,[5] client enrollment files, and semi-structured interviews, as described below.

- **FFS claims data.** FFS claims data contain information on diagnosis codes, procedure codes, national drug codes (NDCs), and costs.[6] These data are housed by Texas Medicaid and Healthcare Partnership (TMHP). DAP used FFS claims to identify HTW clients who received COVID-19 testing covered by the 1115(a) Demonstration, as well as the type and cost of testing.
- **Client enrollment files**. The enrollment files were used to obtain information about the clients' demographic characteristics. Enrollment data were accessed using DAP's Data Repository (DAP-DR).
- **Semi-structured interviews**. DAP conducted virtual interviews with five HHSC Medicaid SMEs between June and September 2024. Each interview lasted approximately 30-45 minutes. Three DAP staff attended each interview, one interviewer and two note-takers, which were the same across all sessions. Interviews were used to gain insight into how the PHE and

[4] HTW only serves women between the ages of 18 and 44, but women older than 44 may have remained eligible for HTW during the PHE due to Medicaid maintenance of effort (MOE) provisions as a result of the Families First Coronavirus Response Act. The evaluation included all women enrolled in the HTW Demonstration between March 1, 2020, and March 31, 2024.

[5] HTW services are delivered exclusively through an FFS delivery model.

[6] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains more information about the codes used.

1115(a) Demonstration were perceived to have affected COVID-19 testing access among HTW clients, implementation processes and procedures, and costs.

In addition to the data sources listed above, this study leveraged data on statewide testing trends from the U.S. Department of Health and Human Services' HealthData.gov website and published literature (i.e., journal articles and reports) to enhance interpretation of evaluation findings. These sources provided further insight into challenges posed by COVID-19, the role of COVID-19 testing as a containment strategy, and the development and availability of COVID-19 testing. These data also help situate findings for the HTW population within the context of COVID-19 rates across the state of Texas.

Analytic Methods

Quantitative data were analyzed using descriptive statistics to summarize utilization and costs associated with COVID-19 tests, as well as the demographic characteristics of women who accessed testing. Descriptive statistics were also used to compare women in HTW who received a COVID-19 test to the full population of women enrolled in the HTW Demonstration. Descriptive trend analysis was used to explore changes in COVID-19 testing over time. Lastly, semi-structured interviews were examined using thematic analysis, a qualitative method that identifies themes and patterns across interviews while capturing the richness and complexity of the data (Vaismoradi et al., 2013).

3. Results

This section summarizes key results from the evaluation. Results are organized by evaluation question and hypothesis.

Hypothesis 1.1: Challenges Accessing COVID-19 Testing during the PHE

Medicaid SMEs noted that because HTW serves so many women, it was difficult to summarize challenges experienced by all HTW clients during the COVID-19 pandemic. However, a few common challenges emerged, including increased risk for severe infection, access to limited service benefits, and increased challenges complying with COVID-19 guidelines.

More specifically, Medicaid SMEs stated the HTW population tends to have lower income and socioeconomic status compared to the general Texas population and suggested this was a risk factor for severe disease. These findings align with existing research, which has found higher rates of COVID-19 infection, as well as higher prevalence of chronic health conditions associated with severe illness from COVID-19 infection, among lower income populations (Masterson, 2023; Raifman, 2020). Additionally, Medicaid SMEs noted that the HTW population is composed primarily of women of childbearing age, and that pregnancy could increase the potential risks of COVID-19 infection.

Medicaid SMEs also emphasized that because HTW provides a targeted benefit package of family planning, women's health, and postpartum coverage, which did not include COVID-19 treatment, women in the program had fewer HTW-covered treatment options in more severe cases of COVID-19. As a result, early and ongoing access to COVID-19 testing was particularly important in helping HTW clients identify and manage their illness.

Medicaid SMEs also indicated that following isolation guidelines may have been particularly challenging for the HTW population, as the guidelines may have had a greater impact on their work and finances compared to higher income populations. Finally, the cost of tests may have made it difficult for women in HTW to follow COVID-19 testing recommendations, particularly in situations where multiple tests were needed, such as when guidelines recommended isolation until receiving a negative test, or if women were subject to repeat exposures.

Hypothesis 2.1: The 1115(a) Demonstration Supported Access to COVID-19 Testing

Barriers Addressed by the 1115(a) Demonstration

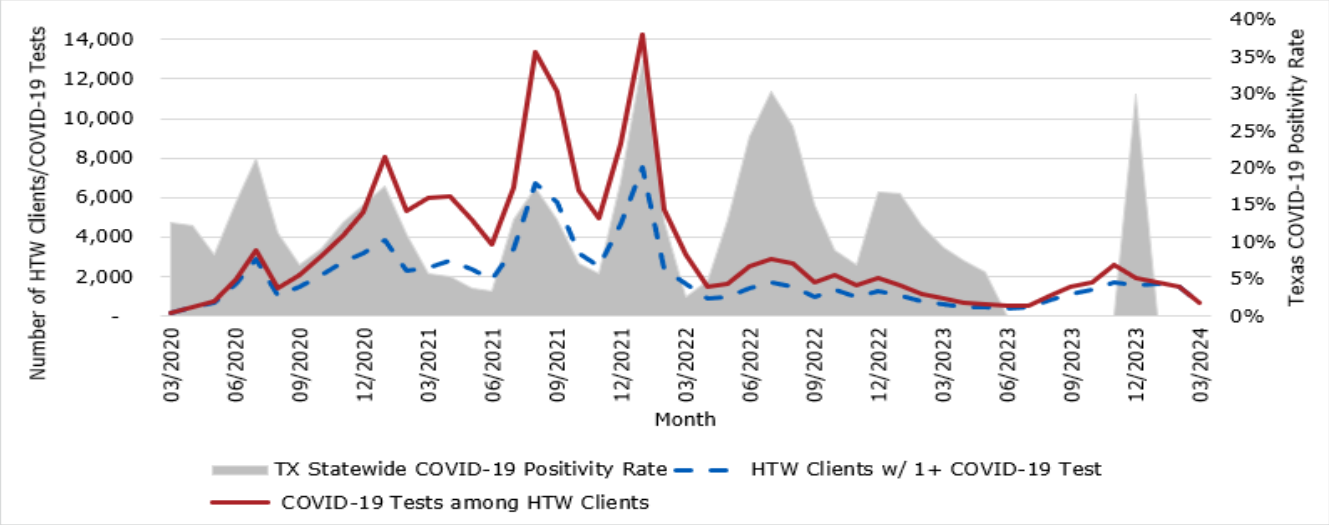
Medicaid SMEs identified two main barriers that were addressed through the 1115(a) Demonstration: cost and testing location. Medicaid SMEs noted that for people with limited resources, such as HTW clients, costs were likely a barrier to accessing tests, so adding COVID-19 testing as a no-cost HTW benefit likely increased testing rates. Medicaid SMEs also suggested that adding COVID-19 testing as an HTW benefit meant there were more locations for HTW clients to obtain tests. This was particularly beneficial in regions where testing options were limited and may have also reduced the number of people relying on testing centers, some of which were overburdened during COVID-19 waves in the early years of the pandemic.

Reducing barriers to testing may have also supported the HTW population and played a role in the overall containment strategy for COVID-19. More specifically, Medicaid SMEs noted that the 1115(a) Demonstration allowed HTW clients to be tested earlier, supported women in making informed decisions about isolation, and helped them adhere to testing recommendations after exposure or a positive test. Additionally, although HTW did not cover treatment of COVID-19, Medicaid SMEs indicated that the inclusion of COVID-19 tests allowed clinicians or pharmacists to provide guidance following a positive test, increasing HTW clients' ability to make informed health care decisions.

Utilization of COVID-19 Testing

COVID-19 testing was added as a billable benefit on April 1, 2020, with a retroactive effective date of February 4, 2020.[7] Between March 1, 2020, and March 31, 2024, 66,800 HTW clients accessed at least one HTW-paid COVID-19 test – eight percent of unique individuals enrolled during that timeframe.[8] In total, HTW paid for 167,336 COVID-19 tests between March 1, 2020, and March 31, 2024 (approximately 2.5 tests per individual tested). Utilization of HTW-paid COVID-19 testing was highest in January 2021, August 2021, and January 2022, aligning with spikes in the COVID-19 positivity rate in Texas (Figure 1). The type of COVID-19 test used varied as new tests were introduced, but the majority of HTW-paid COVID tests were molecular tests, followed by antigen tests (Figure 2). The utilization of HTW-paid home test kits also increased starting in early 2022, but individuals may have accessed these tests outside of HTW, as well. Additional details on COVID-19 testing utilization are presented in Appendix B.

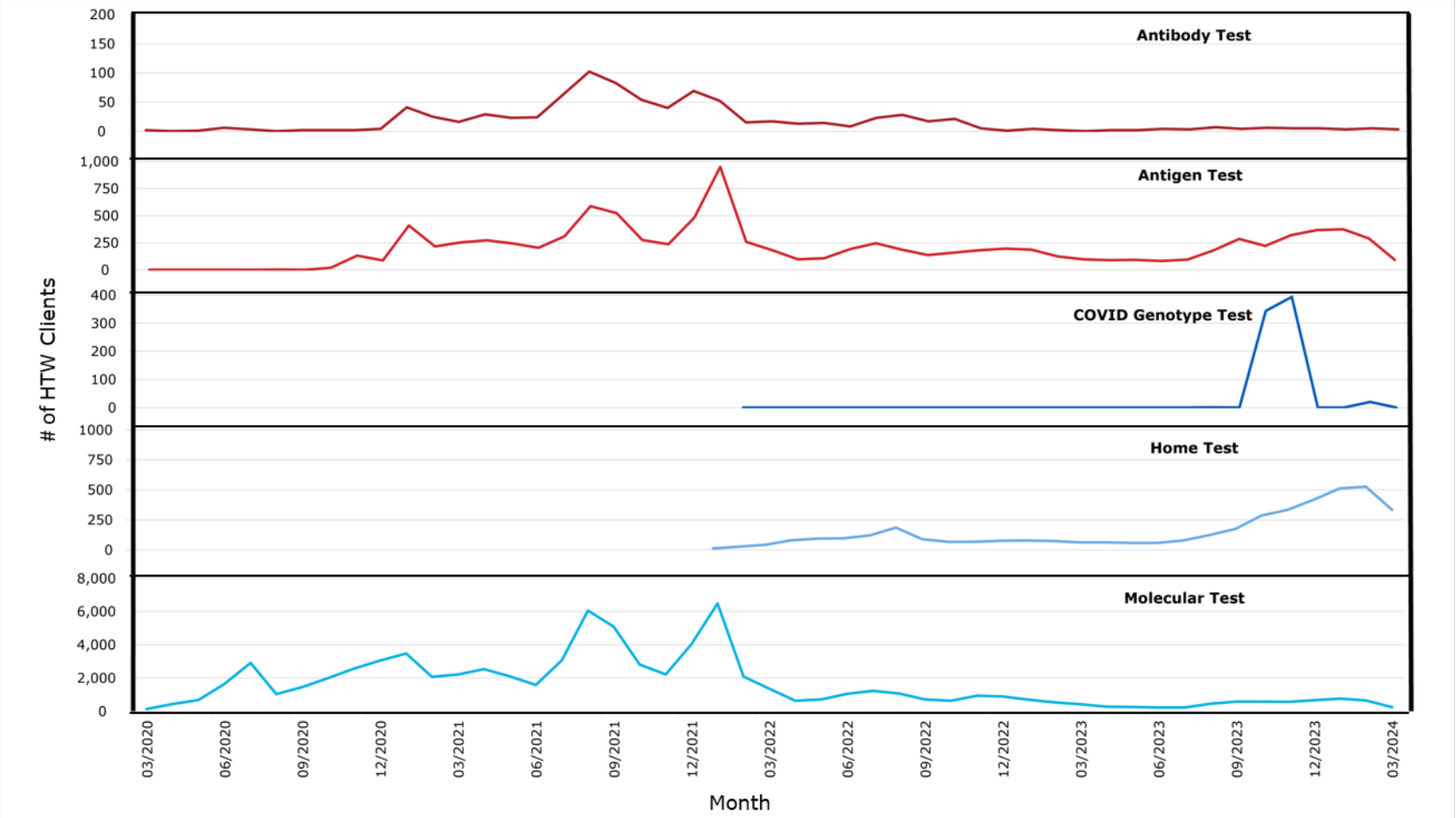
Figure 1. HTW COVID-19 Testing alongside Texas COVID-19 Positivity Rates[1]



Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. Texas COVID-19 positivity rate excludes inconclusive tests.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR; HealthData.gov, U.S. Department of Health and Human Services. Prepared by DAP, HHSC, September 2024 (MMG; DMW).

[7] Although the COVID-19 testing benefit was a billable service as early as February 4, 2020, it was not approved under the HTW Demonstration until March 1, 2020.
[8] A total of 833,994 unique individuals were enrolled in HTW for at least one month between March 1, 2020, and March 31, 2024. Monthly HTW caseloads ranged from 299,783 to 440,815 across the study period.

Figure 2. Number of HTW Clients Receiving COVID-19 Tests per Month, by Type of Test[1,2]



Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] Figure 2 only reflects HTW-paid COVID-19 tests. HTW clients likely received additional tests through co-occurring efforts, such as the Food and Drug Administration's authorization of free home tests delivered through the U.S. Postal Service. As such, testing counts presented in Figure 2 are likely an undercount of all COVID-19 tests received by HTW clients (any payer source).
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

Hypothesis 2.2: The 1115(a) Demonstration Encouraged Flexibilities related to COVID-19 Testing

Development of the COVID-19 Testing Benefits

Though adding a new Medicaid benefit is typically a lengthy process, Medicaid SMEs noted that Texas accelerated the timeline for adding COVID-19-related benefits, including HTW COVID-19 tests. Existing processes were leveraged to develop benefit and rate recommendations, hold public hearings, and direct contractors to implement the COVID-19 related benefits. Procedure codes for COVID-19 testing were added as a billable benefit on April 1, 2020, with a retroactive effective date of February 4, 2020.[9]

Outreach Efforts

According to Medicaid SMEs, HHSC leveraged the claims administrator contractor to release public articles and HHSC conducted webinars as the primary pathway for notifying HTW providers of new COVID-19 testing benefits. The articles pre-dated the COVID-19 PHE and are an established method for sharing changes in benefits, so providers knew to monitor the claims administrator website for information about HTW program updates. HHSC webinars on the agency's COVID-19 response (e.g., policy changes, new benefits, and/or rate settings) spanned the duration of the PHE.

For HTW clients, Medicaid SMEs suggested the HTW website, which included a banner displaying important programmatic updates such as adding COVID-19 testing, was likely the primary source of updates. There is also an HTW-specific email address to which HTW clients could submit questions.

Additionally, both HTW providers and clients could sign up to receive COVID-19 or Women's Health notifications through GovDelivery or attend publicly streamed events on these topics. However, these methods of communication were not specifically focused on HTW COVID-19 testing updates.

[9] Although the COVID-19 testing benefit was a billable service as early as February 4, 2020, it was not approved under the HTW Demonstration until March 1, 2020.

Perceived Challenges and Successes of Implementation

Medicaid SMEs suggested the speed at which COVID-19 testing benefits were added to HTW was the main implementation success. The only challenge Medicaid SMEs identified was getting home testing kits approved due to coding challenges. Pharmacies require an NDC to submit claims, but COVID-19 testing kits did not have an NDC. HHSC had to develop a workaround so that pharmacies could bill and be reimbursed for home COVID-19 tests.

Hypothesis 3.1: The 1115(a) Demonstration Served a Diverse and Vulnerable Population

Demographic Profile of Women in HTW with COVID-19 Testing

The HTW Demonstration serves low-income women who are not eligible for or currently receiving medical benefits through Medicaid, CHIP, Medicare, or any other credible health insurance coverage. As a result, all women receiving COVID-19 tests through HTW reflect a population with fewer means or opportunities to obtain COVID-19 tests than the general public.

Overall, women who received at least one HTW-paid COVID-19 test were most likely to be between 25 and 34 years old (47.5% of individuals tested; average age 33 years old), Hispanic (43.7% of individuals tested) or non-Hispanic Black (28.8% of individuals tested), and living in a metropolitan county (83.1% of individuals tested; Table 2). While there were some differences between the women who received at least one HTW-paid COVID-19 test and the full HTW population (Table 2), the magnitude of these differences was negligible, suggesting they may not be practically meaningful.[10]

[10] Chi-square tests of independence were used to determine if demographics significantly varied between women in HTW with a COVID-19 test and the full population. Differences between the two groups were statistically significant for all demographic characteristics, but effect sizes (Cramer's V) were negligible (<0.1), suggesting statistical significance was due to large sample sizes and not a true reflection of meaningful differences.

Table 2. Demographic Characteristics of HTW Clients who Obtained a COVID-19 Test Compared to HTW Population, March 1, 2020 – March 31, 2024

Demographic Characteristic[1,2]	# of HTW Clients with COVID-19 Test	% Among HTW Clients with COVID-19 Test	# of Total HTW Clients during Study Period[3]	% Among Total HTW Population during Study Period[3]
Total	66,800	N/A	833,994	N/A
Race/Ethnicity	**#**	**%**	**#**	**%**
Black, non-Hispanic	19,240	28.8%	194,322	23.3%
Hispanic	29,187	43.7%	405,242	48.6%
White, non-Hispanic	14,720	22.0%	180,279	21.6%
Not Reported/Other	3,653	5.5%	54,151	6.5%
Age Group	**#**	**%**	**#**	**%**
18-24 Years	9,185	13.8%	175,079	21.0%
25-29 Years	15,188	22.7%	179,585	21.5%
30-34 Years	16,571	24.8%	187,973	22.5%
35-39 Years	12,645	18.9%	147,507	17.7%
40-44 Years	9,518	14.2%	110,110	13.2%
45+ Years	3,693	5.5%	33,740	4.0%
County Type	**#**	**%**	**#**	**%**
Metropolitan	55,514	83.1%	695,711	83.4%
Micropolitan	4,467	6.7%	52,264	6.3%
Rural	6,029	8.2%	73,949	8.9%
Unknown	790	1.2%	12,070	1.4%
Medicaid Managed Care Service Area (MMCSA)[4]	**#**	**%**	**#**	**%**
Bexar	4,009	6.0%	79,675	5.0%
Dallas	10,463	15.7%	101,621	10.3%
El Paso	1,319	2.0%	30,550	4.3%
Harris	15,165	22.7%	199,129	7.6%
Hidalgo	3,924	5.9%	70,576	5.6%
Jefferson	1,663	2.5%	25,157	6.6%
Lubbock	2,076	3.1%	23,579	8.8%

Demographic Characteristic[1,2]	# of HTW Clients with COVID-19 Test	% Among HTW Clients with COVID-19 Test	# of Total HTW Clients during Study Period[3]	% Among Total HTW Population during Study Period[3]
Medicaid Rural Service Area (MRSA) Central Texas	5,587	8.4%	44,241	12.6%
MRSA Northeast Texas	4,092	6.1%	50,538	8.1%
MRSA West Texas	4,233	6.3%	44,076	9.6%
Nueces	2,476	3.7%	33,936	7.3%
Tarrant	8,011	12.0%	74,870	10.7%
Travis	2,992	4.5%	43,511	6.9%
Unknown	790	1.2%	12,535	6.3%

Notes: [1] Demographic characteristics reflect clients' most recent month of eligibility during the study period. [2] HHSC explored the feasibility of including health status as a demographic characteristic, but determined a comprehensive health status indicator could not be reliably estimated for the current evaluation due to the reliance on HTW claims data and the limited service package provided through HTW (i.e., the absence of condition-specific diagnosis codes in HTW claims data may be the result of HTW's focused service package (e.g., HTW services are focused in particular areas, inpatient services are not a covered benefit) rather than the absence of a condition itself). [3] Reflects women enrolled in HTW for at least one month during the study period. [4] Medicaid Managed Care service areas were used to identify geographic information about HTW clients who received a COVID-19 test. However, these service areas do not reflect program administration, as HTW is a FFS program offered statewide.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

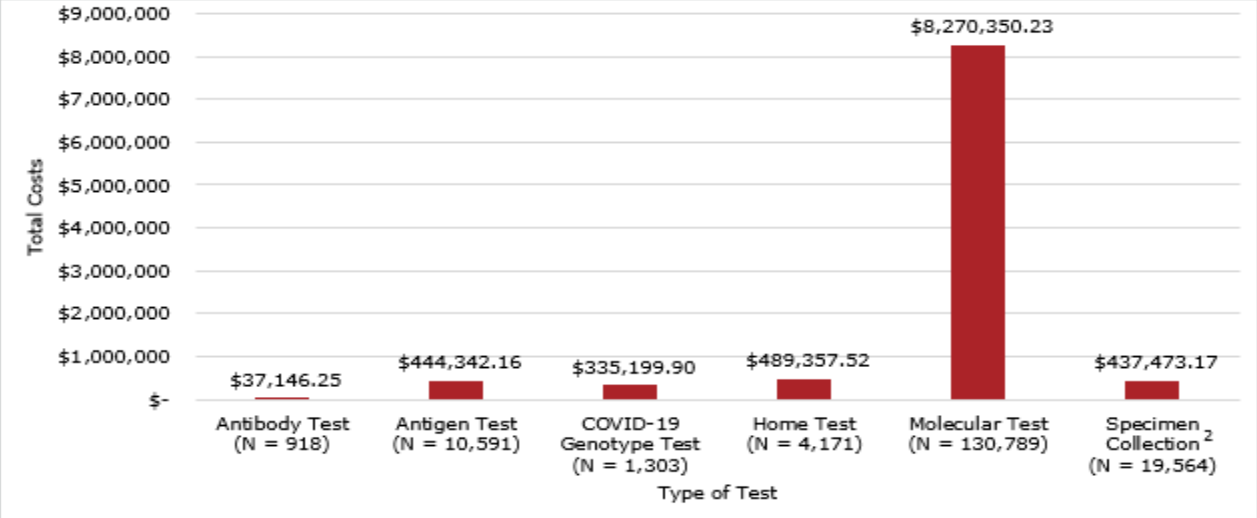
Demographic summaries should be interpreted with caution due to the changing composition of the HTW population as a whole during the study period. More specifically, Medicaid and HTW enrollment status was maintained during the PHE due to maintenance of effort(MOE) provisions in the Families First Coronavirus Response Act. Due to these provisions, women who would have transitioned to HTW (e.g., Medicaid postpartum women) remained enrolled in Medicaid programs, and women who would have left HTW (e.g., women aged 45 or older) remained in HTW. Collectively, the MOE provisions resulted in HTW clients shifting towards an older population with fewer postpartum women. As a result, the demographic composition of HTW clients with a COVID-19 test may reflect broader demographic patterns in the HTW population during the study period.

Hypothesis 4.1: The 1115(a) Demonstration Provided Financial Support

Cost of COVID-19 Tests

The total cost for the 167,336 COVID-19 tests paid by HTW between March 2020 and March 2024 was $10,013,869.23 (see Figure 3).[11] Molecular tests had the highest total cost, as expected, since it was the most common type of COVID-19 test. The most expensive type of test, per unit, was COVID-19 genotype testing at $257.25 per test, on average. The least expensive type of tests, per unit, were antibody and antigen tests, at $40.46 and $41.95, respectively (see Figure **4**). Specimen collection costs were submitted alongside 19,564 COVID-19 tests, resulting in an additional expense of $437,473.17, at an average cost of $22.36 per instance.

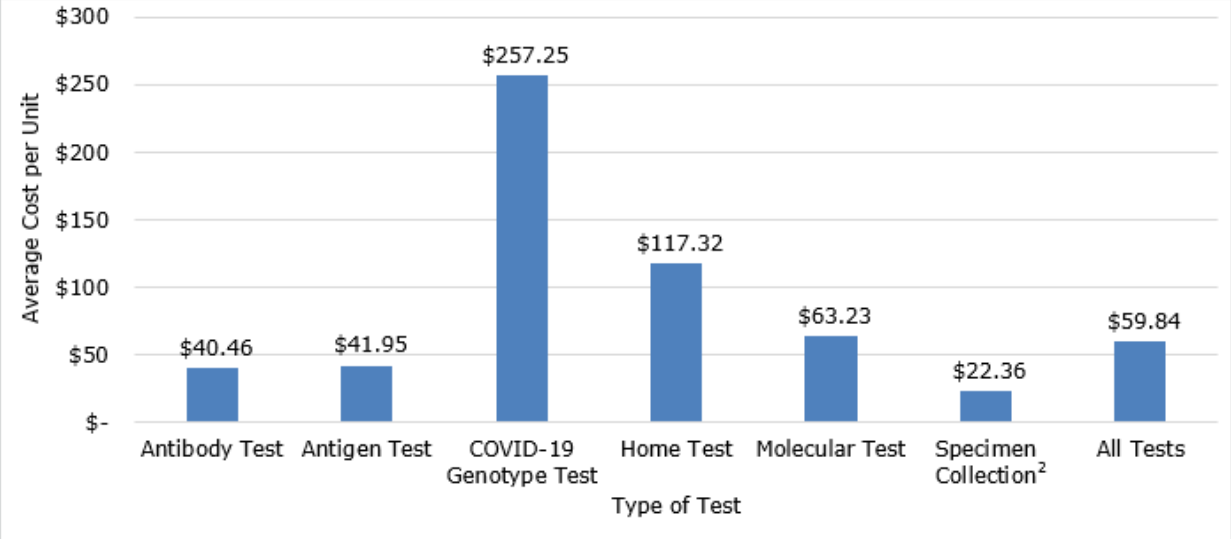
Figure 3. Total Costs for HTW-Paid COVID-19 Tests, by Type of Test[1]



Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] Specimen collection is not a type of test, but separate procedure codes billed to cover test administration costs. It is included here to reflect the full cost of COVID-19 testing.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

[11] Cost calculations for this evaluation include only claims that indicated payment through the HTW program for women whose enrollment in HTW was confirmed during the month of testing.

Figure 4. Average Cost per Unit for HTW-Paid COVID-19 Tests, by Type[1]



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Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

Differences in total costs of HTW-paid COVID-19 tests across demographic subgroups are provided in Appendix B. Findings generally align with the demographic profile of women utilizing HTW-paid COVID-19 tests (see Hypothesis 3.1), with groups utilizing COVID-19 tests the most having the highest costs.

Administrative and Program Costs

Medicaid SMEs were not aware of any direct administrative or programmatic costs associated with the 1115(a) Demonstration but noted that there could have been modest incidental costs, such as printing fact sheets related to PHE changes.

4. Limitations

The results of the evaluation should be interpreted alongside several key limitations. Most notably, Texas cannot test the causal impact of the 1115(a) Demonstration on HHSC's response to the PHE. The 1115(a) Demonstration was retroactively effective to March 1, 2020 (the beginning of the PHE), so there is no counterfactual in which Texas was responding to the COVID-19 pandemic without the COVID-19 PHE 1115(a) Demonstration. Furthermore, COVID-19 testing was neither necessary nor available prior to the PHE, so no pre-PHE data exists. As a result, findings from this evaluation are primarily descriptive in nature, consistent with CMS guidance for COVID-19 PHE 1115(a) Demonstration evaluations.

This evaluation relies on Medicaid administrative data, which were designed and collected for billing purposes rather than research. The reliance on Medicaid administrative data limits the measures available for this evaluation due to feasibility and data collection, in addition to any data lags, data errors, or reporting inconsistencies. For example, Medicaid administrative data does not include test results, so it is not possible for the evaluation to determine COVID-19 positivity rates among women who obtained an HTW-paid COVID-19 test. Additionally, this 1115(a) Demonstration is only focused on HTW-paid COVID-19 tests; women likely accessed COVID-19 tests through other sources, such as non-HTW covered providers, or self-paid or free home tests, which became increasingly available as the PHE progressed. As a result, findings from this evaluation are likely an underrepresentation of all COVID-19 tests women in HTW may have received, and findings should only be used to draw conclusions about testing provided directly through HTW.

This evaluation also draws on interviews Medicaid SMEs at HHSC. However, this evaluation does not include interviews with HTW clients, so findings do not capture their perspective. Interviews with Medicaid SMEs may also be susceptible to common threats to validity among qualitative methods, such as recall bias and social desirability bias. Additionally, interviews were held virtually via Microsoft Teams between June and September 2024, and cameras were selectively used based on interviewee preferences. A limitation of the audio-only format is that non-verbal signals such as facial expressions and body language are missed (Saarijärvi & Bratt, 2021). DAP attempted to reduce potential biases in interviews by using contextual reminders where appropriate and standardizing interview protocols. Lastly, due to staff turnover in the four years since the beginning of the PHE, some

SMEs were no longer available to provide insight into the perceived influence of the PHE on HTW and the implementation of the 1115(a) Demonstration.

Finally, the PHE presented significant changes to the entire Medicaid system, including an influx of new women becoming eligible for HTW due to economic changes during the PHE, as well as Medicaid MOE policies tied to the Families First Coronavirus Response Act. Collectively, this resulted in an increase in the number of women enrolled in HTW over the course of the PHE, as well as changes in the demographic composition of those enrolled. These changes to the HTW population likely influenced the overall volume of COVID-19 testing, as well as the characteristics of HTW clients who received a COVID-19 test. Additionally, the need and desire for COVID-19 testing was likely influenced by geographic factors, such as region-specific COVID-19 surges, as well as evolving isolation recommendations and treatment options, including the development of vaccines. Evaluation findings should be interpreted alongside these key population and environmental changes over the course of the PHE.

Despite these limitations, this evaluation provides broad insight into Texas' response to the COVID-19 PHE in light of the flexibilities granted under this 1115(a) Demonstration.

5. Conclusion

The evaluation of the 1115(a) Demonstration examined the challenges presented by the COVID-19 PHE to women in HTW, how providing access to COVID-19 testing helped address those challenges, and lessons learned for future PHEs.

According to Medicaid SMEs, people enrolled in HTW faced a variety of challenges during the PHE, including being at risk for more severe infection, having access to a limited benefit package, and financial challenges related to following PHE-related guidelines.

Medicaid SMEs emphasized that the 1115(a) Demonstration increased access to COVID-19 testing, both by making testing available at more locations and reducing the cost of testing. Between March 2020 and March 2024, 66,800 HTW clients (eight percent of the total population) accessed at least one HTW-paid COVID-19 test. The total cost across all HTW-paid COVID-19 tests was $10,013,869.23. Women who received at least one HTW-paid COVID-19 test were most likely to be between 25 and 34 years old, and Hispanic, and residing in a metropolitan county. Further, utilization of HTW-paid COVID-19 tests mirrored spikes in COVID-19 positivity rates throughout the state of Texas, suggesting the 1115(a) Demonstration supported public health measures during more severe phases of the PHE.

Medicaid SMEs noted that the 1115(a) Demonstration leveraged existing processes to inform HTW providers and clients of COVID-19 testing benefits throughout the PHE, resulting in few administrative challenges and costs.

Collectively, these findings suggest women in HTW faced unique challenges during the PHE, and the 1115(a) Demonstration helped address those challenges by providing low-income women with access to no-cost COVID-19 tests.

Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes

Table 3. Procedure and National Drug Codes Included in Analysis

Test Category	Type of Code	Code List
Antibody Tests	Procedure Codes	86328, 86769, 86408, 86409, 0224U, 86413, 86318
Antigen Tests	Procedure Codes	87426, 87811, 87428[1]
COVID-19 Genotype tests	Procedure Codes	87913
Specimen Collection	Procedure Codes	COVID-19 Specific: G2023, G2024, C9803; General: 99211[2,3]
Home Tests	NDCs	08337000158, 11877001129, 11877001133, 11877001140, 14613033972, 51044000842, 60008095487, 82607066026, 96852025431, 96852095300[4]
Molecular Tests	Procedure Codes	U0001, U0002, 87635, U0003, U0004, U0005, 0223U, 0202U, 0225U, 0226U, 87636, 87637

Notes: Some procedure codes that are associated with COVID-19 testing may not have been included in the above lists if they were not covered by the HTW program, including K1034, 0202U, 0223U, 0224U, 0225U, 0226U. [1] Procedure code 87428 was a COVID-Flu combination test. [2] 99211 was only included if it matched a date of a COVID-19 test and there were no specimen collection codes specific to COVID-19 with the same date. [3] General specimen collection procedure codes 99001 and S8301 were also included but no paid claims to HTW clients matched these codes. [4] NDC 14613033937 was also included in the data pull query but no paid claims to HTW clients were found with this code.

Technical Notes. Cost calculations for this evaluation include claims that indicated payment through the HTW program, based on header type program or adjudicated FFS type program 68 or 69 in the Analytical Data Store (ADS), or type program 41 in the Vendor Drug Database. Enrollment in HTW for the month of service was confirmed using the 8Month Eligibility Database; claims for participants not enrolled in HTW during the month of service were excluded from calculations. Claims also only included procedure codes and NDCs that had been approved for the HTW program. The study period starts in March 2020, when the 1115(a) Demonstration took effect retroactively, and ends March 2024, when the demonstration ended.

Appendix B. Supplemental Findings

Table 4. Number of HTW Clients Receiving a COVID-19 Test, by Type of Test and Year[1]

Year	Any Test[2]	Antibody Test	Antigen Test	COVID-19 Genotype Test[3]	Home Test[3]	Molecular Test	Specimen Collection[4]
2020[5]	14,008	20	229	N/A	N/A	13,658	1,554
2021	33,001	525	3,399	N/A	N/A	29,668	5,639
2022	19,331	193	2,551	0	590	15,761	5,334
2023	8,673	40	1,974	474	1,011	4,907	2,803
2024[6]	3,024	11	729	20	724	1,593	1[7]
Full PHE[8]	66,800	760	7,945	484	1,880	57,300	13,603

Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] All Tests column may not be equal to the sum of all other kinds of tests as some HTW clients received more than one type of COVID-19 test in a calendar year. [3] COVID-19 genotype and home tests were not available until later in the PHE (Calendar Year 2022). [4] Separate specimen collection claims were submitted alongside a limited number of COVID-19 tests (~11%). Specimen collection claims were most common for antigen and molecular COVID-19 tests. [5] Calendar Year 2020 only includes HTW-paid COVID-19 tests between March 1, 2020, and December 31, 2020. [6] Calendar Year 2024 only includes HTW-paid COVID-19 tests between January 1, 2024, and March 31, 2024. [7] Only one specimen collection claim was submitted in 2024, likely due to limited time frame represented (through March 31, 2024) and the decreased reliance on antigen and molecular tests over time. [8] Represents the unique count of HTW clients who received at least one COVID-19 test (of a certain type, where applicable) during the full PHE (March 1, 2020, through March 31, 2024). The Full PHE row may not be equal to the sum of all other years' totals as some HTW clients received tests in multiple years.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

Table 5. Number of Tests Administered through HTW, by Year[1]

Year	All Tests	Antibody Test	Antigen Test	COVID-19 Genotype Test[2]	Home Test[2]	Molecular Test	Specimen Collection[4]
2020[3]	22,439	22	255	N/A	N/A	20,172	1,990
2021	85,172	593	4,202	N/A	N/A	72,860	7,517
2022	41,177	227	3,148	0	975	29,977	6,850
2023	14,696	59	2,205	1,283	1,825	6,118	3,206
2024[5]	3,852	17	781	20	1,371	1,662	1[7]
Full PHE[6]	167,336	918	10,591	1,303	4,171	130,789	19,564

Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] COVID-19 genotype and home tests were not available until later in the PHE (Calendar Year 2022). [3] Calendar Year 2020 only includes HTW-paid COVID-19 tests between March 1, 2020, and December 31, 2020. [4] Separate specimen collection claims were submitted alongside a limited number of COVID-19 tests (~11%). Specimen collection claims were most common for antigen and molecular COVID-19 tests. [5] Calendar Year 2024 only includes HTW-paid COVID-19 tests between January 1, 2024, and March 31, 2024. [6]March 1, 2020, through March 31, 2024 [7] Only one specimen collection claim was submitted in 2024, likely due to limited time frame represented (through March 31, 2024) and the decreased reliance on antigen and molecular tests over time.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

Table 6. Unique HTW Clients with COVID-19 Test, by Year[1]

Year	Unique HTW Clients[2]	Unique HTW Clients with at Least One COVID-19 Test	Percentage of HTW Clients with at Least One HTW-Paid COVID-19 Test
2020[3]	401,816	14,008	3.5%
2021	453,327	33,001	7.3%
2022	476,918	19,331	4.1%
2023	663,740	8,673	1.3%
2024[4]	411,571	3,024	0.7%
Full PHE[5]	833,994	66,800	8.0%

Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] Unique client counts reflect the total number of unique individuals enrolled in HTW for at least one month during the Calendar Year or PHE. Numbers to not reflect average monthly caseloads. [3] Calendar Year 2020 only includes HTW-paid COVID-19 tests between March 1, 2020, and December 31, 2020. [4] Calendar Year 2024 only includes HTW-paid COVID-19 tests between January 1, 2024, and March 31, 2024. [5] Represents the unique count of HTW clients who received at least one COVID-19 test (of a certain type, where applicable) during the full PHE (March 1, 2020, through March 31, 2024). The Full PHE row may not be equal to the sum of all other years' totals as some HTW clients received tests in multiple years.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

Table 7. Demographic Characteristics of HTW Clients who Obtained a COVID-19 Test, by Year[1,2]

Demographic Characteristic	CY 2020[3]	CY 2021	CY 2022	CY 2023	CY 2024[4]	Full PHE[5]
Total HTW Clients with 1+ COVID-19 Test	14,008	33,001	19,331	8,673	3,023	66,800
Race/Ethnicity	**CY 2020[3]**	**CY 2021**	**CY 2022**	**CY 2023**	**CY 2024[4]**	**Full PHE[5]**
Black, non-Hispanic	24.9%	29.4%	30.6%	32.6%	27.5%	28.8%
Hispanic	47.9%	42.6%	41.9%	39.7%	43.3%	43.7%
White, non-Hispanic	22.8%	23.0%	21.7%	20.8%	21.9%	22.0%
Not Reported/Other	4.4%	5.0%	5.8%	6.9%	7.3%	5.5%
Age Group	**CY 2020[3]**	**CY 2021**	**CY 2022**	**CY 2023**	**CY 2024[4]**	**Full PHE[5]**
18-24	24.6%	20.1%	15.0%	17.0%	23.0%	13.8%
25-29	26.9%	24.7%	22.2%	21.4%	22.3%	22.7%
30-34	22.3%	23.6%	23.9%	24.8%	25.7%	24.8%
35-39	15.3%	17.3%	19.1%	19.3%	17.8%	18.9%
40-44	9.9%	12.0%	15.3%	14.0%	10.5%	14.2%
45+	1.0%	2.3%	4.5%	3.5%	0.6%	5.5%
County Type	**CY 2020[3]**	**CY 2021**	**CY 2022**	**CY 2023**	**CY 2024[4]**	**Full PHE[5]**
Metro	81.7%	83.8%	83.8%	83.8%	82.0%	83.1%
Micro	7.8%	7.0%	6.9%	5.9%	7.0%	6.7%
Rural	10.1%	8.9%	8.7%	9.9%	10.5%	9.0%

Demographic Characteristic	CY 2020[3]	CY 2021	CY 2022	CY 2023	CY 2024[4]	Full PHE[5]
Unknown	0.4%	0.4%	0.6%	0.4%	0.2%	1.2%
MMCSA[6]	**CY 2020[3]**	**CY 2021**	**CY 2022**	**CY 2023**	**CY 2024[4]**	**Full PHE[5]**
Bexar	7.1%	6.0%	5.1%	3.6%	4.9%	6.0%
Dallas	14.0%	15.0%	17.8%	20.8%	16.9%	15.7%
El Paso	3.1%	1.8%	2.0%	1.0%	0.6%	2.0%
Harris	17.6%	26.4%	21.8%	16.6%	20.3%	22.7%
Hidalgo	6.5%	4.5%	6.0%	7.6%	6.7%	5.9%
Jefferson	2.8%	2.6%	2.1%	1.7%	1.6%	2.5%
Lubbock	4.3%	2.7%	2.8%	3.8%	2.6%	3.1%
MRSA Central Texas	8.8%	8.9%	9.3%	9.7%	7.5%	8.4%
MRSA Northeast Texas	6.1%	6.4%	5.1%	5.6%	6.8%	6.1%
MRSA West Texas	7.9%	5.9%	6.9%	6.8%	9.6%	6.3%
Nueces	4.3%	3.8%	3.5%	1.9%	3.1%	3.7%
Tarrant	11.2%	11.1%	13.5%	16.8%	15.6%	12.0%
Travis	5.8%	4.5%	3.7%	3.7%	3.2%	4.5%
Unknown	0.4%	0.4%	0.6%	0.4%	0.5%	1.2%

Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] Percentages in this table represent the percent of HTW-paid COVID-19 testing recipients in a particular year in each demographic category. Percentages may not sum to 100 because of rounding. [3] Calendar Year 2020 only includes HTW-paid COVID-19 tests between March 1, 2020, and December 31, 2020. [4] Calendar Year 2024 only includes HTW-paid COVID-19 tests between January 1, 2024, and March 31, 2024. *Table notes continued onto next page.*

[5] This column represents the unique count of HTW clients who received at least one COVID-19 test during the full PHE (March 1, 2020, through March 31, 2024). It may not be equal to the sum of all other years' totals as some HTW clients received tests in multiple years.
[6] Medicaid Managed Care service areas were used to identify geographic information about HTW clients who received a COVID-19 test. However, these service areas do not reflect program administration, as HTW is an FFS program offered statewide.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

Table 8. Amount Paid for COVID-19 Tests through HTW, by Year[1]

Year	All Tests	Antibody Test	Antigen Test	COVID-19 Genotype Test	Home Test	Molecular Test	Specimen Collection[3]
2020[2]	$1,873,929.86	$371.22	$5,230.16	N/A	N/A	$1,822,219.81	$46,108.67
2021	$4,443,254.80	$24,841.62	$176,034.45	N/A	N/A	$4,070,759.74	$171,618.99
2022	$2,155,301.47	$9,472.61	$144,164.17	$0	$83,247.91	$1,766,780.70	$151,636.08
2023	$1,192,422.27	$1,859.27	$89,589.10	$330,050.90	$230,154.29	$472,672.77	$68,095.94
2024[4]	$348,960.83	$601.53	$29,324.28	$5,149.00	$175,955.32	$137,917.21	$13.49[5]
Total	$10,013,869.23	$37,146.25	$444,342.16	$335,199.90	$489,357.52	$8,270,350.23	$437,473.17

Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] Calendar Year 2020 only includes HTW-paid COVID-19 tests between March 1, 2020, and December 31, 2020. [3] Separate specimen collection claims were submitted alongside a limited number of COVID-19 tests (~11%). Specimen collection claims were most common for antigen and molecular COVID-19 tests. [4] Calendar Year 2024 only includes HTW-paid COVID-19 tests between January 1, 2024, and March 31, 2024. [5] Only one specimen collection claim was submitted in 2024, likely due to limited time frame represented (through March 31, 2024) and the decreased reliance on antigen and molecular tests over time.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, September 2024 (MMG; DMW).

Table 9: Amount Paid for COVID-19 Testing, by Demographic Subgroup[1]

Demographic Characteristic[2,3]	# of HTW Clients w/ COVID-19 Test	Total # of COVID-19 Tests[4]	Total Cost Across all COVID-19 Tests[5]
Total	66,800	147,772	$10,013,869.23
Race/Ethnicity	**#**	**#**	**$**
Black, non-Hispanic	19,240	45,549	$3,096,636.18
Hispanic	29,187	63,621	$4,306,733.37
White, non-Hispanic	14,720	30,676	$2,067,793.11
Not Reported/Other	3,653	7,926	$542,706.57
Age Group	**#**	**#**	**$**
18-24	9,185	18,206	$1,290,084.89
25-29	15,188	32,562	$2,202,645.75
30-34	16,571	36,989	$2,508,594.13
35-39	12,645	29,028	$1,961,647.23
40-44	9,518	22,352	$1,492,338.84
45+	3,693	8,635	$558,558.36
County Type	**#**	**#**	**$**
Metro	55,514	123,102	$8,364,638.74
Micro	4,467	10,082	$657,954.17
Rural	6,084	12,982	$885,405.19
Unknown	735	1,606	$105,871.13
MMCSA[6]	**#**	**#**	**$**
Bexar	4,009	9,399	$643,843.43
Dallas	10,463	22,697	$1,506,041.57
El Paso	1,319	3,496	$232,142.10
Harris	15,165	38,035	$2,478,272.53
Hidalgo	3,924	8,414	$653,223.32
Jefferson	1,663	4,351	$301,757.29
Lubbock	2,076	3,432	$201,955.13
MRSA Central Texas	5,642	11,076	$828,771.83
MRSA Northeast Texas	4,092	9,544	$627,114.17

Demographic Characteristic[2,3]	# of HTW Clients w/ COVID-19 Test	Total # of COVID-19 Tests[4]	Total Cost Across all COVID-19 Tests[5]
MRSA West Texas	4,233	8,403	$538,285.29
Nueces	2,476	5,343	$349,594.44
Tarrant	8,011	16,221	$1,134,557.22
Travis	2,992	5,755	$412,439.78
Unknown	735	1,606	$105,871.13

Notes: [1] Appendix A. COVID-19 Testing Procedure Codes and National Drug Codes contains a list of codes used to identify COVID-19 testing. [2] Demographic characteristics reflect clients' most recent month of eligibility during the study period. [3] HHSC explored the feasibility of including provider type in this subgroup analysis, but determined results may be misleading due to differences in testing administration (e.g., at-home tests were ordered by one provider, but dispensed via pharmacies, while other tests may have been ordered and conducted within the same office visit). [4] Separate specimen collection claims were submitted alongside a limited number of COVID-19 tests (~11%). The count of unique tests in this table excludes separate specimen collection claims. [5] The cost for specimen collection claims submitted alongside COVID-19 testing claims has been included in this cost calculation. [6] Medicaid Managed Care service areas were used to identify geographic information about HTW clients who received a COVID-19 test. However, these service areas do not reflect program administration, as HTW is an FFS program offered statewide.
Sources: Analytical Data Store, TMHP; Vendor Drug Database, DAP-DR; 8Month Eligibility Database, DAP-DR.
Prepared by DAP, HHSC, August 2025 (MMG; DMW).

List of Acronyms

Acronym	Full Name
ADS	Analytical Data Store
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
DAP	Office of Data, Analytics, and Performance
DAP-DR	Office of Data, Analytics, and Performance Data Repository
FFS	Fee-for-Service
HHSC	Health and Human Services Commission
HTW	Healthy Texas Women
MMCSA	Medicaid Managed Care Service Area
MOE	Maintenance of Effort
MRSA	Medicaid Rural Service Area
NDC	National Drug Code
PHE	Public Health Emergency
SME	Subject Matter Expert
TMHP	Texas Medicaid and Healthcare Partnership

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