



Health and Human Services

Medicaid Advisory Committee

May 19, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.





The Medicaid Advisory Committee (MAC), formerly known as the Medical Care Advisory Committee, is a federally mandated committee that reviews and makes recommendations to the state Medicaid director on proposed changes that involve Medicaid policy or affect Medicaid-funded programs.

HHSC has established a Beneficiary Advisory Council (BAC) as required by CFR § 431.12 and operates as a standing subcommittee of the MAC. As outlined in 42 CFR 431.12(f)(1) BAC members are not required to include their names in a BAC membership list and meeting minutes.

Doug Svien, MAC Chair

Provider

Mary Helen Tieken, RN, BSN, MAC Vice Chair

Registered Nurse

Salil Deshpande, M.D.

Managed Care Organization Representative

Lou Driver

Nursing Home Administrator

Lisa Wright

Community Health Choice President/CEO

Robert Hilliard, Jr., M.D.

Physician, Ob/Gyn

Sandy Crisp

LPC Private Practice
Licensed Professional Mental Health Therapist

Donna S. Smith

Physical Therapist

Christina Paz

Centro San Vicente
Doctor of Nurse Practice/NP-CEO

Joseph Modesto

Dream Therapy Center
President and CEO

Carol Daulton

Texas Health Resources
Senior Director Supplemental Payment Program

Subject Matter Experts (SMEs)

Alma Allen Johnson

Senior Policy Analyst, Public Health Policy Advancement, Texas Department of State Health Services

1. Call to order, opening remarks, introductions, and roll call. The meeting was convened by Salil Deshpande, M.D. A quorum was present.

2. Consideration of February 12, 2026, draft meeting minutes. The minutes were approved as drafted.



3. Executive Commissioner introduction and update. The Executive Commissioner laid out her priorities and entertained questions.

- Sunset review: HHSC and other HHS agencies are undergoing the 12-year Sunset process; HHSC has participated in 139 meetings with Sunset staff, totaling 975 staff hours, and has fulfilled 534 information requests (with additional requests pending).
- Fraud, waste, and abuse (FWA): continued state/federal focus; HHSC emphasized Texas' long-standing emphasis on prevention and partnership with the Office of Inspector General, while also increasing data/policy work with MCO partners.
- Organizational realignment: aim to better manage the continuum of services across behavioral health (state hospitals and community services) and IDD (state supported living centers and community services), including a narrowed focus under Jordan Dixon to identify gaps and align LAR planning.
- Provider enrollment/revalidation: improvements to the provider enrollment system/process (PEMS) are a major focus; process changes have been implemented, but HHSC is still seeing providers who have not attempted re-enrollment despite flexibilities.
- Flexibilities are not guaranteed indefinitely; providers who do not submit/attempt revalidation risk dis-enrollment.
- Eligibility operations: SNAP error rate currently exceeds 6%, triggering concern due to new federal cost-sharing requirements; HHSC is focused on both processing efficiency and reducing error rate to mitigate state fiscal impact.

Discussion

- Lisa Wright asked about consumer risk if providers do not re-enroll; HHSC stated providers who have not attempted/submitted revalidation may be disenrolled, and HHSC is conducting targeted outreach.
- Dr. Deshpande asked whether providers may think they initiated revalidation, but HHSC cannot see it; HHSC described categories (not started, in-flight/not submitted) and "rolling" dates, with hands-on outreach especially for high-volume providers and those with flexibilities expiring in June.
- Donna Smith described therapists being removed from the Medicaid master file and cases stuck "in flight" for 9–12 months; HHSC directed her to share specific cases for review.
- HHSC identified Mike Lopez (Medicaid) as a point to investigate specific enrollment issues; Kathy Montalbano said she would connect offline via email.



- Christina Paz raised delays in Medicaid enrollment and MCO credentialing; HHSC noted enrollment completion is required before credentialing can proceed.
- Valerie Mays offered to connect Ms. Paz (via Kathy Montalbano) with Kymisha Banks (Managed Care) to identify whether the issue is health-plan credentialing or upstream enrollment.
- Ms. Paz asked about timely filing/deadlines in the context of enrollment delays; HHSC tied the approach to flexibilities/extension policy and emphasized providers must submit and engage in the process.
- Joseph Modesto asked how to reach a contact beyond the TMHP call center due to long wait times; HHSC advised providing details to Kathy Montalbano for follow-up and research of the specific case.
- SNAP cost-sharing discussion: Commissioner Muth explained OB3-related changes, clarified error rate drivers (including client-reported changes), and noted impacts are not direct to Medicaid entitlement funding but could affect overall state budget capacity.

4. Medicaid and Children’s Health Insurance Program (CHIP) activities update.

Summary

Vaccines: Texas Medicaid covers vaccines and administration as recommended by ACIP. The CDC revised the childhood immunization schedule in January 2026 (effective immediately), creating three categories: universal recommendation, high-risk groups, and shared clinical decision-making. Texas Medicaid coverage did not change because all vaccines recommended prior to 12/31/2025 remain included in one or more categories; HHSC is monitoring federal legal action and guidance.

Fraud Waste and Abuse response to governor directive. The focus areas include MCO special investigations unit training and targeted conversations for applied behavior analysis, Community First Choice, non-emergency medical transportation (NEMT), and peer support.



January 16, 2026. Governor Greg Abbott today sent a [letter](#) directing the Texas Health and Human Services (HHS) Office of Inspector General and the Texas Health and Human Services Commission (HHSC) to launch investigations into potential Medicaid fraud in Texas to safeguard taxpayer funds, maintain access for eligible Texans, and ensure efficient, high-quality healthcare delivery.

"Texas provides critical healthcare services to children, pregnant women, the elderly, and people with disabilities through the state's Medicaid program," reads the letter. "Access to medical services is a key component in supporting these individuals and Medicaid fraud robs taxpayers and impairs their ability to receive necessary healthcare. During my tenure as Governor, Texas has policed the Medicaid program and proactively combatted fraud, but we will strengthen our efforts to further protect taxpayers, preserve access for eligible Texans, and maintain the integrity of Texas' Medicaid Program."

At the Governor's direction, HHSC will further implement anti-fraud measures and launch investigations into potential fraud and misdirection of Texas taxpayer dollars to protect taxpayers, preserve access for eligible Texans, and maintain the integrity of Texas' Medicaid program.

Governor Abbott is taking action to eliminate potential fraud in publicly funded services and protect taxpayer dollars by:

- [Directing](#) investigations into potential childcare funding fraud
- [Volunteering](#) Texas to participate in the U.S. Department of Housing and Urban Development pilot program that seeks to eliminate fraud in federal affordable housing programs

[Read the Governor's letter here.](#)

[Report suspected fraud, waste, or abuse in Texas' Medicaid program here.](#)

Additional targeted reviews are planned to include MCO policy reviews for susceptible services (including durable medical equipment and mental health rehabilitation).

The Autism services utilization review report is on track for completion this summer

There will also be a utilization review of Community First Choice attendant/habilitation services, strengthened oversight of consumer-directed services, and targeted policy review of NEMT.



Discussion. No discussion

5. One Big Beautiful Bill Act (OBBBA), Public Law No. 119-21, effective July 4, 2025, House Resolution 1 update on eligibility policy changes.

OB3 (passed July 2025) and delayed implementation of several Medicaid/CHIP eligibility and enrollment rule items until September 2034. Other impacts:

- Social Security Death Master File is now required quarterly starting in 2027 (Texas already uses biannually).
- Medicare Savings Program-related rules that would have been implemented April 2026 were delayed.

The Medicare Savings Programs (MSPs) help Medicare beneficiaries with limited income and resources pay for all or some of their out-of-pocket Medicare expenses. These expenses include premiums, deductibles and coinsurance.

There are four MSPs:

- Qualified Medicare Beneficiary (QMB) Program
- Specified Low-Income Medicare Beneficiary (SLMB) Program
- Qualifying Individual (QI) Program
- Qualified Disabled and Working Individual (QDWI) Program

The income limits for the MSPs are based on the federal poverty level (FPL), which is adjusted annually.

The resource limits for the MSPs, except QDWI, are updated annually based on the Consumer Price Index (CPI). The QDWI resource limits are based on the current SSI resource limits. All regular Medicaid for the Elderly and People with Disabilities (MEPD) policies for resources, income and non-financial eligibility apply to this program, except those specifically identified in this chapter.

Transfer of assets, spousal impoverishment and co-payment policy and procedures do not apply to MSPs.

A person is not eligible for MSP coverage if they:

- are in the custody of penal authorities; or
- are over 20 but under 65 years and live in an institution for mental diseases (IMD).

Note: Children under 19 who are certified for MSP will receive 12 months of continuous eligibility, with limited exceptions. Refer to continuous Medicaid coverage policy for exceptions.

Related Policy

Medicare Savings Program Information, [Appendix IX](#)

Medicare Savings Programs, [A-8000](#)

Continuous Medicaid Coverage, [B-6600](#)



- Prior-month coverage: reduction from three months to two months (state option for CHIP) effective January 2027, with noted impact for nursing facilities.

Prior to this change, In Texas, prior-month Medicaid coverage allowed applicants to be eligible for coverage during the three-month period before the month they apply. To apply for prior coverage, individuals must complete Form H1113, which is necessary if they have unpaid medical bills incurred during the three months before the application month. This form must be submitted to the Health and Human Services Commission (HHSC) within 90 days of the date services were received or within the month following denial of other healthcare coverage. This has been reduced to two months.

- Alien eligibility changes: effective October 1, 2026, certain statuses (e.g., asylees and refugees) will no longer be eligible for Medicaid; Cuban/Haitian entrants, legal permanent residents, and COFA members are not changing. HHSC is rerunning determinations through SAVE to ensure updated immigration status and will send notices to impacted clients. [A-340, Qualified Alien Status Eligibility Charts | Texas Health and Human Services](#)
- Reasonable opportunity period: 90 days remains in place for documentation issues.

A reasonable opportunity period (ROP) is a 90-day timeframe during which applicants can provide documentation to verify attested information when electronic verification is unavailable.

Definition and Purpose

A reasonable opportunity period is designed to allow individuals applying for programs like Medicaid or health insurance to submit proof of information they have attested to on their application, such as citizenship, immigration status, or household income, when the system cannot immediately verify the information electronically. This period ensures that eligible applicants are not denied benefits solely due to temporary verification issues.

Duration and Start Date

The standard ROP is 90 days. For Medicaid, it begins from the date the applicant receives notice of the reasonable opportunity period, which is generally considered five days after the notice is sent, unless the applicant can demonstrate they did not receive it within that timeframe. For health insurance through platforms the 90-day period begins on the date the application is submitted.

Application During the Period

During the ROP, agencies must continue efforts to verify the applicant's information and may provide benefits to otherwise eligible individuals even before verification is complete

Applicants are given the opportunity to:

- Submit additional documentation to resolve discrepancies.
- Correct information in electronic verification systems.
- Receive assistance in obtaining necessary documents, such as Social Security numbers for citizenship verification

Extensions and Limitations

States or agencies may extend the ROP if the applicant is making a good faith effort to provide documentation or if additional time is needed to complete verification. However, agencies may also establish reasonable limitations on the number of ROPs an individual can receive, particularly if there are concerns about program integrity

Impact on Benefits

Benefits may be furnished during the ROP, and federal matching funds are generally available for services provided during this period, regardless of whether eligibility is ultimately confirmed. If an applicant fails to provide the required documentation within the ROP, agencies may take administrative actions, such as terminating eligibility or coverage

- No change to emergency Medicaid; no change to CHIP eligibility
- Enrollment impact estimate: fewer than 70,000 Texans currently enrolled may be affected (future impacts unknown).
- HHSC plans communication toolkits and outreach coordination with MCOs, 2-1-1 resources, language supports, and the eligibility ambassador program ahead of the October 1 implementation.

6. [House Bill 26, 89th Legislature, Regular Session, 2025.](#)

Summary HHSC reviewed House Bill 26 (89th Texas Legislature, 2025) authorizing Medicaid managed care organizations (MCOs) to offer nutrition support services as in-lieu-of services (ILOS), when medically appropriate and cost-effective substitutes for state plan services. Bill requirements include evidence-based nutrition counseling and



instruction (available broadly to Medicaid managed care members; no additional statutory population restriction was described).

Pilot authority (through Aug 31, 2030) for high-risk pregnant women in Medicaid managed care was authorized. Pilot ILOS categories HHSC may add:

- Nutrition counseling and instruction (also included in pilot options).
- Medically tailored meals, required to be paired with nutrition counseling/instruction.
- Other evidence-based nutrition support services as determined by HHSC.

High-risk pregnancy examples in statute include chronic conditions/diseases contributing to complications (e.g., gestational diabetes, hypertension, obesity).

Reporting requirements:

- Annual report to the Legislature on all Medicaid ILOS implemented (not limited to HB 26 services).
- One-time report focused on the HB 26 pilot nutrition support ILOS.

A final list of HB 26 nutrition support ILOS must be approved by the State Medicaid Managed Care Advisory Committee (SMCCAC) and HHSC also intends to engage other advisory committees.

Implementation

- HHSC completed literature review/research on:
- Existing Texas Medicaid nutrition services have been inventoried (to avoid duplication and identify gaps).
- Other states' experiences implementing similar ILOS (e.g., medically tailored meals).
- HHSC compiled research into a draft proposal and began targeted stakeholder feedback.
- Stakeholder outreach began "as of yesterday," including an MCO notice published May 18.
- Feedback window is open through June 12.
- "Other evidence-based nutrition support services" described as items found in literature such as:
 - **Medically tailored groceries** (foods/ingredients rather than prepared meals).
 - **Prescription produce** / voucher-style programs where members redeem food and prepare meals themselves.



Rate setting discussion: ILOS rate development follows the same managed care service rate-setting process and is considered in capitation. Rate setting will have to be completed before services start; HHSC is already beginning financial work.

The Pilot is due to end date (Aug 31, 2030 per statute) for the high-risk pregnancy pilot services; nutrition counseling/instruction for broader members is not constrained by that end date.

Evaluation planning: HHSC is early in evaluation design; no dedicated evaluation funding was provided. Draft feedback survey includes questions on data elements needed .(.

High-level timeline:

- Research/literature review began in fall 2025.
- Stakeholder feedback begins spring 2026 (in-progress).
- Finalize proposed ILOS list through the fall.
- Target effective date: September 2027 (SFY 2028 managed care contracts).
- Contact for follow-up questions: dsqi@hhs.texas.gov .

Presentation

H.B. 26 [HB00026F.pdf](#) (89th TX Leg.) requires HHSC to permit Medicaid managed care organizations (MCOs) to offer medically appropriate, cost-effective, evidence-based nutrition counseling and instruction services in lieu of services specified in the Medicaid state plan. It further allows HHSC to establish a pilot that permits MCOs to offer the following in lieu of services (ILOS) to pregnant women with high-risk pregnancies through August 31, 2030:

- nutrition counseling and instruction services,
- medically tailored meals, in combination with nutrition counseling and instruction services,
- other evidence-based nutrition support services.

The bill requires HHSC to submit to the Texas Legislature:

- annual report on all Medicaid ILOS,
- one-time report on pilot ILOS.

Implementation

In Progress – Literature review and research on existing Medicaid nutrition support services in Texas and other states.

In Progress – Development of a draft support services. proposal of the ILOS nutrition

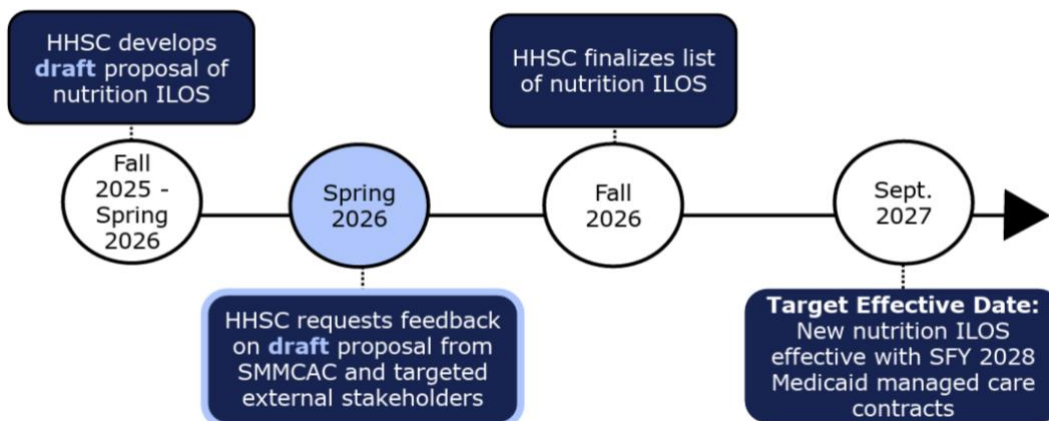
Spring 2026 – HHSC will request feedback from the State Medicaid Managed Care Advisory Committee (SMMCAC) and targeted external stakeholders on the draft the legislation.

Targeted External Stakeholder Engagement -- HHSC’s goal is to engage targeted external stakeholders during this draft development stage before the proposal for the new ILOS is finalized. HHSC will request feedback on the following categories of nutrition support services to implement in lieu of a Medicaid state plan service.

Nutrition Support Services ILOS Categories as Described in H.B. 26

H.B. 26 ILOS	ILOS 1	ILOS 2	ILOS 3
ILOS Category	Nutrition Counseling and Instruction (NCI)	Medically Tailored Meals + NCI	Other evidence-based nutrition support services
Target Population	Medicaid managed care members	Medicaid managed care women with a high-risk pregnancy	Medicaid managed care women with a high-risk pregnancy

H.B. 26 High-Level Implementation Timeline



[Leveraging In Lieu of Services in Medicaid Managed Care](#)

7. Discuss Medicaid Advisory Committee rule changes.

HHSC presented proposed rule revisions to comply with CMS access rules (42 CFR 431.12), including requirements to create/support a Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC). Key rule changes described:

- Committee name change from Medical Care Advisory Committee to Medicaid Advisory Committee (MAC).
- Establish Beneficiary Advisory Council (BAC) as a standalone subcommittee.
- Remove Hospital Payment Advisory Committee (HPAC) as a MAC subcommittee (Provider Finance will manage and develop separate rules); HHSC said it will continue to provide HPAC updates to this committee.
- Clarify MAC tasks, add annual reporting requirements, specify membership categories and BAC membership requirements.
- Add meeting requirements (frequency/type/quorum) and member term requirements.
- Members appointed to six-year terms and cannot serve consecutive terms; clarify ex officio membership and chair/vice chair appointments; limit ex officio members to two.
- Add training and travel reimbursement provisions consistent with HHSC advisory committee standards.

Rulemaking process: There will be an Informal and formal comment periods, and the rules were posted today for informal comment (the informal comment period runs through June 1). The formal comment is expected via Texas Register with a presentation to the Executive Council anticipated in the fall.

Discussion. No discussion

8. Consideration of the draft revisions and updates to the MCAC bylaws

The bylaw updates were read aloud and include:

- aligned to CMS access regulation changes:
- Adjusted composition from 12 to up to 15 to accommodate BAC membership requirements.



- Reporting language: HHSC has 30 days to post annual report after finalization.
- Clarified six-year member terms; confirmed no consecutive terms; clarified holdover period is not a separate/consecutive term.
- Added conflict-of-interest disclosure requirement tied to reviewing agenda in advance.
- Quorum updated to 8 members .
- Updated dates (revised May 19; amended date set to 2026).

The bylaws were discussed but were not made available to the public

MOTION: Adopt the amended bylaws prevailed

9. Office of Inspector General update.

OIG discussed actions following a **January** letter from **Governor Abbott** requesting work related to high-risk services and noted Texas already monitors many of the identified services; since January, data team conducted deeper data dives and made referrals to investigations/claims review/audits as appropriate.

OIG noted some issues reported and said some have been resolved, with continued work ongoing with MCOs. OIG provides additional training to SIUs on specific topics based on fraud trends/risks.

In promoting public fraud reporting the OIG described hotline/website promotion; adding reporting access to Your Texas Benefits website/app and partnering on social media.

LMHA fully resolved issues that were presented during previous inspection

The OIG returned to a Local Mental Health Authority to determine if recommendations regarding payment practices and continued stay authorizations, presented during a 2023 inspection, had been implemented [LMHA fully resolved issues that were presented during previous inspection | Office of Inspector General](#)

New tech tools increase OIG productivity

The OIG continues to develop new AI- and algorithm-driven tools that enhance the agency's ability to counter bad actors who use emerging technology to commit fraud,

waste and abuse. [New tech tools increase OIG productivity | Office of Inspector General](#)

Hospice provider did not coordinate care with attending physicians, MCOs and outside providers

A recent audit found that a pediatric hospice provider failed to include attending physicians as part of the care team and did not document coordination with managed care organizations when clients received services outside the hospice provider [Hospice provider did not coordinate care with attending physicians, MCOs and outside providers as required | Office of Inspector General](#)

OIG works with local prosecutors to charge benefit fraudsters

During the first two quarters of fiscal year 2026, the OIG Benefits Program Integrity Unit completed 11,065 investigations and referred 52 cases for prosecution. Many of the referred cases involved individuals who unlawfully received tens of thousands of dollars in benefits for which they were not eligible. [OIG works with local prosecutors to charge benefit fraudsters | Office of Inspector General](#)

Regarding enrollment, the Texas Health and Human Services Office of Inspector General (OIG) Provider Enrollment Integrity Screenings team has received an unusually high volume of enrollment applications, which is causing processing delays. Most applications are being processed within 90–120 days. The OIG recognizes the impact these delays have on providers and is working closely with HHSC to minimize disruption. OIG is addressing applications in the order received and prioritizing applications with upcoming revalidation deadlines. Be assured that OIG is working diligently to resolve the current backlog. Eight new staff have been onboarded adding 2 vacancies; moving 4 staff from another team; OIG believes a TMHP backlog contributed to the surge and that the surge may be easing. HHSC plan was referenced with 60-day extensions for providers with applications “in flight” to avoid billing cutoffs.

Provider Enrollment Delays

The OIG Provider Enrollment Screenings Team has received an unusually high volume of enrollment applications, which is causing processing delays. Most applications are being processed within 90-120 days. The OIG recognizes the impact these delays have on providers and is working closely with HHSC to minimize disruption. We are addressing applications in the order received and prioritizing

applications with upcoming revalidation deadlines. Thank you for your patience and understanding, and please be assured that we are working diligently to resolve the current backlog.

Provider Enrollment Integrity Screenings (PEIS) Overview

The core functions of the OIG's Provider Enrollment Integrity Screenings (PEIS) team achieve the "prevention" portion of OIG's mission by completing all federally and state-required screenings for providers seeking to enroll in an HHS health care program, primarily Medicaid or CHIP.

Providers seeking to enroll, re-enroll or be revalidated are required to be screened based on their assigned risk level as a prerequisite of participation in Texas HHS programs. The Centers for Medicare and Medicaid Services (CMS) assigns a categorical risk level to each provider type based on its potential for fraud, waste and abuse. The Health and Human Services Commission (HHSC) is permitted to assign a higher risk level than the federally defined category but is not allowed to assign a lower risk level. For Medicaid-only provider types, HHSC, in collaboration with the OIG, determines the categorical risk level. Failure to appropriately screen and enroll providers in compliance with federal program integrity requirements may result in audit findings and potential loss of federal funding for the State of Texas.

After an application has been submitted, processed by Texas Medicaid & Healthcare Partnership (TMHP), and determined to be complete, the application is routed to the OIG for screening. By statute, the OIG has 10 business days to complete screening activities. Based on the outcome of the OIG's review, a recommendation is made regarding whether the provider should be allowed to enroll in the HHS program. The OIG PEIS team works closely with the TMHP, OIG Chief Counsel, HHSC Medicaid CHIP Services (MCS), CMS, and a variety of other stakeholders in conducting this process.

[View the Provider Enrollment Process Chart \(PDF\).](#)

Discussion

- Expedited requests are rarely granted due to the volume; status inquiries typically result in "in the queue." When pressed OIG may provide a rough timeframe.
- Estimate to return to 10-day timeline: likely early next year, with the rest of this year needed to work back down.
- Claims/timely filing question was raised during revalidation delays; OIG deferred to HHSC who said they would take the question back and follow up offline.



- OIG described selection of certain fraud focus areas (e.g., ABA, non-emergency medical transportation, peer support) as driven by federal direction and risk signals that have been noticed in other states; peer support chosen in part because it had received less attention previously.

10. Consideration of the first annual report (required by 42 Code of Federal Regulations Section 431.12(i)).

Draft of the annual report was considered but was not made available to the public.

MOTION: Approve the (mystery) annual report prevailed without discussion

11. 1115 post award forum Texas Healthcare Transformation and Quality Improvement Program (THTQIP)

Summary. HHSC presented the annual public forum for the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 demonstration, as required by STC 79 and 42 CFR 431.420(c).

Public forum requirement: within 6 months of implementation and annually thereafter, the public must have an opportunity to comment on demonstration progress. HHSC noted the most recent annual monitoring report must be posted with the public forum announcement. Written public comments were accepted until 5:00 PM on May 15.

Since 2011, Texas Medicaid has carved additional benefits/services into managed care (including inpatient hospital days, pharmacy, dental, certain Medicaid-eligible adults in HCBS, nursing facility services, and others). Managed care programs expanded statewide: STAR, STAR+PLUS, and STAR Kids.

The THTQIP 1115 waiver is the primary vehicle Texas uses to deliver services to Medicaid-eligible individuals through managed care. As of January 2026: 4.08 million Texans received full Medicaid or CHIP benefits; 95% were in managed care.

HHSC contracts with managed care organizations (MCOs) and pays capitation (per member per month); MCOs contract with providers and are expected to incentivize and



deliver high-quality, cost-effective care. Programs authorized through the waiver and enrollment distribution:

- STAR (acute care for low-income families, children, pregnant women): 82%.
- STAR+PLUS (acute + LTSS for older adults and adults with disabilities): 14%.
- STAR Kids (acute + LTSS for children with disabilities): 4%.
- Children’s Medicaid Dental Program: dental care for most children under 21 (children also counted in the medical program figures above).

CMS monitoring redesign and HCBS reporting updates

CMS issued a June 25, 2025 letter updating 1115 monitoring for all demonstrations to reduce state burden, standardize information, and strengthen CMS program integrity oversight. Key changes included:

- New CMS-prescribed annual monitoring report template and completion instructions.
- Annual monitoring report due date extended from 90 to 180 days after the end of the demonstration year.
- Quarterly monitoring reports eliminated; annual reports only going forward.
- CMS monitoring calls moved from monthly to quarterly cadence starting January 2026.
- HHSC submitted the draft DY14 monitoring report to CMS on March 26, 2026 (DY14 period: Oct 1, 2024–Sep 30, 2025).
- CMS developed template will include base metrics for all demonstrations; CMS is still developing policy-specific metrics for certain authorities.
- STAR+PLUS HCBS reporting expectations were expanded to align with six federal HCBS assurances in the STCs:
 - Administrative authority.
 - Level of care determinations.
 - Service planning.
 - Health and welfare protections.
 - Financial accountability.
 - Qualified providers.

STAR+PLUS HCBS reporting deliverables include: HCBS Quality Improvement Strategy, HCBS Performance Measure Report, HCBS Evidentiary Report, and HCBS Deficiency Remediation and Abuse/Neglect/Exploitation Incident Report.

Payments: supplemental pools and directed payment programs



Regarding supplemental payments no major payment changes were noted. The Uncompensated Care (UC) pool will be resized this year based on FY2025 data; HHSC is working on this now with through the summer.

Public Health Provider Charity Care Program (PHPCCP) is anticipated to remain unchanged and maintained at \$499 million; cost report process occurs in the fall.

Directed Payment Programs (DPPs): most are in annual renewal except QIPP which is in the third year of a three-year preprint approval.

HHSC recently submitted preprints (including CHIRP, TIPS, RAPS, DPPBHS) to CMS and received confirmation of receipt for completeness with a CMS review to follow.

A provider question was asked whether audits would occur like DSRIP? HHSC stated DPPs are structured differently from DSRIP, and the requirements vary by program and are not a traditional DSRIP-style audit.

Program structure highlights:

- QIP is quality-based.
- CHIRP and TIPS include a uniform rate increase component plus a quality component.
- RAPS and DPPBHS use scorecards and have annual zero-sum reconciliation based on actual utilization.
- Quality metrics typically update annually.
- Clarification was sought on PHPCCP vs UC. HHSC stated that the difference is primarily in eligible provider types.

Evaluation and budget neutrality

Evaluation focus areas include :

- Medicaid Managed Care (MMC): continued monitoring of access and quality across largely managed-care-delivered populations/services, including evaluation of new transitions into MMC (example mentioned: NEMT services).
- Supplemental Payment Programs (SPPs): whether SPPs support uncompensated care and PHPCCP providers; whether they support network adequacy and community health.



- UHRIP: whether it supported the hospital delivery system after UC transitioned to charity care only.
- Overall demonstration questions including costs of providing care under the demonstration; administrative costs; how DPPs/SPPs support providers and Medicaid sustainability; whether quality initiatives influenced quality-based payment systems.

Evaluation design approvals: The original evaluation design was approved by CMS in May 2022. Then an updated evaluation design was approved by CMS in June 2025 to add measures related to the medically fragile population and case management for children and pregnant women.

- Interim report #1 (DY7–DY11 / FFY2018–2020): reported positive impacts from DSRIP, improvements in health outcomes and client satisfaction after transition to MMC, and overall cost savings.
- Interim report #2 in development by Texas A&M University School of Public Health; due to CMS by March 31, 2027.
- Interim report #3 and the summative report will build on interim report #2 and include evaluation of future amendments.

Budget neutrality:

Key priority under the 10-year extension was preserving budget neutrality to sustain DPPs and UC/charity care pools and maintain flexibility for future initiatives with CMS approval. The CMS “rebasings” policy now ties the spending cap to current state spending (instead of a hypothetical fee-for-service comparison), tightening budget neutrality space. Despite rebasing, HHSC indicated sufficient budget neutrality room remains to support current pools and DPPs. Budget neutrality model finalization has involved ongoing, iterative negotiations with CMS since FFY2023; no significant concerns have been reported, but there is no new status update beyond continued discussions.

Clarifications shared during Q&A:

- Baseline now reflects managed care spend (given 95% of members are in managed care), rather than fee-for-service.
- DPPs were included in the baseline when establishing costs (built into the cap).
- UC/PHPCCP budget neutrality room supported in part by a placeholder tied to the former UPL program; CMS projection methodologies (e.g., CPI-based trends) also influence budget neutrality room.

Presentation



Updates on the following 1115 Transformation waiver topics:

- Historical Overview
- Monitoring Redesign
- Supplemental Payments
- Directed Payment Programs (DPPs)
- Evaluation
- Budget Neutrality
- Link to 1115 Demonstration Year (DY14) annual report
- Public Comment

Since 2011, the waiver has enabled HHSC to expand use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth; and
- Transition to quality-based payment systems across managed care and providers.

The waiver is the federal authority that Texas uses to deliver Medicaid managed care. • The following programs are under the 1115 authority: • STAR • STAR+PLUS • STAR Kids • Children's dental program.

Monitoring Changes CMS issued a new monitoring approach to section 1115 demonstrations that updated aspects of demonstration monitoring for the THTQIP demonstration:

- Reporting cadence and due date
- CMS prescribed monitoring report template
- Demonstration monitoring calls

STAR+PLUS HCBS Reporting requirements

- Expanded HCBS Reporting Expectations-- Increased focus on service access, timeliness, interest lists, and person-centered service planning.
- Alignment with HCBS Quality Measures--States must report standardized HCBS quality measures to support consistency and transparency.
- Stronger Oversight and Transparency --CMS uses comparable data to identify risks, vulnerabilities, and best practices across HCBS programs.

Supplemental Payments



Uncompensated Care Payments

- Eligible providers include hospitals, physician groups, public ground ambulance, and public dental providers.
- Demonstration Year (DY) 9-11 Pool Size is \$3.87 billion.
- DY12 to DY16 is \$4.5 billion. The UC pool will be resized this summer.

Public Health Providers Charity Care Program

- \$500 million in All Funds for DY11 and DY12.
- Payments issued for DY11 (uncompensated care) ~\$460 million.
- Payments issued for DY12 (charity care) ~\$499 million
- Payments in process for DY13 (charity care) ~499 million

Directed Payment Programs (DPPs) Programs that direct payments to enrolled providers through Medicaid Managed Care Organizations. Programs estimated at over \$11.6 billion annually in FY26 include:

- Quality Incentive Payment Program for nursing facilities.
- Comprehensive Hospital Increased Reimbursement Program for hospitals.
- Texas Incentives for Physician and Professional Services for physician groups.
- Rural Access to Primary and Preventive Services for Rural Health Clinics.
- Directed Payment Program for Behavioral Health Services for Community Mental Health Centers.

Evaluation

Purpose: Examine the state's progress on the overarching goals of the 1115 Demonstration

Main components:

Medicaid Managed Care (MMC)

- Quality Monitoring
- Nonemergency Medical Transportation (NEMT)
- STAR+PLUS HCBS

Supplemental Payment Programs (SPPs)

- Uncompensated Care (UC)
- Public Health Providers Charity Care Pool (PHP-CCP)

Overall 1115 Demonstration

- Costs of the 1115 Demonstration



- Use of Alternative Payment Models
- Provider and Managed Care Organization (MCO) Perceptions

Evaluation Design Plan was approved by the Centers for Medicare and Medicaid Services (CMS) in May 2022 (Amended June 2025). Texas A&M University will continue their role as the external evaluator.

Evaluation Reports Schedule

Evaluation Report	DYs Covered	Due to CMS
Interim Report #1	DY7 – DY11	March 2024*
Interim Report #2	DY10 – DY14	March 2027
Interim Report #3	DY10 – DY16	September 2029
Summative Report	DY10 – DY19	March 2032

*Interim Report #1 is currently under review by CMS

Budget Neutrality Key Principles

- Preserve budget neutrality and create room for Delivery System Reform Incentive Payment transition, including DPPs and charity care programs.
- Sustain vital budget neutrality for directed payment programs moving forward.
- “Without Waiver” expenditures will be rebased and include directed payment program funding.
- Account for potential adjustments for COVID-19 adverse impacts to enrollment and expenditures used for rebasing.
- Incorporation of new CMS budget neutrality policies for state 1115 waivers, released in early FY 2023.
- Rebasing effective in FFY 2023 is currently underway; discussions with CMS regarding the application of above adjustments and policies are ongoing.

Published Updates

On May 19, 2026, at 9 a.m., HHSC will hold a hybrid public forum with both virtual and in person options, to present updates on the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration. The public forum will be held in conjunction with the quarterly Medicaid Advisory Committee (MAC), formerly known as the Medical Care Advisory Committee (MCAC), meeting and will be held at



the Texas Health and Human Services Commission, John H. Winters Building, Public Hearing Room 125, First Floor, 701 West 51st Street, Austin, Texas 78751.

Read the draft [1115 annual report, Demonstration year 14 – Oct. 2024 - Sept. 2025 \(Excel\)](#)

Members of the public must pre-register to provide oral comments virtually during the meeting and written comments by completing a [Public Comment Registration](#) for no later than 5pm on Friday, May 15.

Agenda and [instructions for attending in person and virtually](#).

On September 24, 2024, the Centers for Medicare & Medicaid Services (CMS) approved the following items for the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) 1115 demonstration:

- The Public Health Provider – Charity Care Program pool limits for DY 13 – DY 17.
- Technical corrections and clarifications to the Attachment H Protocol and the Uncompensated Care cost report tool.
- A technical correction to the Special Terms and Conditions (STCs) to reflect the extension of continuous postpartum Medicaid coverage in Texas to 12 months.
- An update to Attachment Q, Delivery System Reform Incentive Payment Transition Plan, to reflect counties that currently participate in the Texas Dual-Eligibles Integrated Care Demonstration Project.
- Read the [updated STCs and attachments \(PDF\)](#).

On June 8, 2022, CMS issued technical corrections to the Special Terms and Conditions to Texas' section 1115 Texas Healthcare Transformation and Quality Improvement Program (THTQIP) waiver. For more information on the STC Technical Corrections, [view the Waiver Renewal page](#).

On Aug. 2, 2022, CMS approved the Interim Evaluation Report for the 1115 Evaluation Design Plan associated with the demonstration approval period between Jan. 1, 2018 and Sept. 30, 2022. For more information on the approved Interim Evaluation report, [view the Waiver Overview and Background Resources page](#).

On May 26, 2022, CMS approved the 1115 Evaluation Design Plan for the demonstration extension authorized through September 2030. For more information on the approved 1115 Evaluation Design Plan, [view the Waiver Overview and Background Resources page](#).



On Jan. 15, 2021, HHSC received Federal approval for the [Texas Healthcare Transformation and Quality Improvement 1115 Demonstration Waiver \(PDF\)](#).

HHSC has posted the [1115 waiver Special Terms and Conditions, "Fast Track" application template, and Extension Appendices for public comment on the 1115 Waiver Renewal page](#).

Public Comments on 1115 Waiver No public comment was offered

12. [Texas Home Living waiver renewal](#)

Summary HHSC provided an update and requested feedback on the TXHML 1915(c) waiver renewal (renewal required every five years). The current waiver expires Feb 28, 2027; requested renewal effective date Mar 1, 2027.

Tentative schedule:

- Draft renewal document posted **August** with Texas Register public notice of intent and **30-day comment period**.
- Submission to CMS planned **October 2026** (about 120 days before effective date, per CMS preference).

Services overview: all TXHML services are available via **Consumer Directed Services (CDS)** option. On **Sept 1, 2025**, cost limit increased from **\$17,000** to **\$31,684** per plan year. There are anticipated renewal changes:

- Review/update performance measures across CMS's six assurances; add new measure for HCBS settings compliance.
- Remove day habilitation from the waiver application (previously discontinued; replaced by individualized skills and socialization ISS).
- Update Texas Administrative Code references (Title 40 to Title 26), update billing/payment guideline links, and make grammar/punctuation consistency edits.
- Update language to align with rules/policy/procedures; update unduplicated participants and cost projections based on utilization; update CDS participant counts.



- Eligibility: TXHML serves individuals with intellectual disability (and related conditions/limited reserve capacity group); it is a support waiver without a residential component; eligibility aligns with the HCS waiver.

Presentation

The 1915(c) TxHmL waiver is renewed every 5 years. The current waiver cycle is 03/01/22-02/28/27. Upcoming Critical Dates include:

- Web Posting: August 2026
- Public Comment Period: August to September 2026
- Submission to CMS: October 2026
- Renewal Effective Date: March 1, 2027

Tentative dates

TxHmL Service Array

- Community support
- Transportation
- Individualized Skills and Socialization
- Employment assistance
- Respite
- Supported employment
- Adaptive aids
- Audiology
- Behavioral support
- Dental
- Dietary services
- Minor home modifications
- Nursing services
- Occupational, physical, and speech therapy
- Financial Management Services
- support consultation

All services can be provided by the CDS option

Here are some of the changes HHSC intends to incorporate:

- Revise performance measures
- Discontinuation of day habilitation service
- Updated Texas Administrative Code References
- Updated links to Billing and Coding handbooks
- Grammar and punctuation updates (acronyms, hyphenations, etc.)
- Add and update language to align with rules, policy, and procedures
- Updates to the unduplicated count of participants, reserve capacity numbers and waiver cost projections in Appendix J for the five-year renewal period
- Updates the consumer directed services (CDS) participants



13. Hospital Payment Advisory Committee (HPAC) update. *Texas Insight* covered this meeting in full. Follow the link to access the report. [Hospital Payment Advisory Committee – Texas Insight](#)

14. Beneficiary Advisory Council (BAC) update BAC held its 4th meeting on May 5 at 10:00 AM. They received a presentation that covered managed care member and marketing materials policy updates, including impacts of Senate Bill 963:

- Marketing guidelines may not prohibit Medicaid MCOs from informing people about qualified health plans (QHPs) offered through the exchange.
- Marketing guidelines may not prohibit advertising Medicare Advantage plans at community enrollment/other events.
- Guidelines must require MCOs to inform individuals about availability of QHPs through the exchange.
- MCOs must inform individuals about potential deductibles, copays, and other cost-sharing under a QHP.
- MCOs may not offer material/financial gain as an incentive to enroll in a QHP.

There was no specific feedback from the committee, but one member commented changes seemed positive for clarifying expectations. The next BAC meeting will occur before the August Medicaid Advisory Committee meeting.

15. Public comment. No public comment was offered

16. Review of action items and agenda items for future meeting

- Frequent updates on provider enrollment
- Follow Up on Questions related to the Executive Commissioner Presentation (credentialing and more)
- Feedback on Nutritional Counseling

Future Meetings

- August 12, 2026, Public Hearing Room 125, 1st Floor 701 West 51st Street, Austin, Texas 78751



- November 12, 2026, Public Hearing Room 125, 1st Floor 701 West 51st Street, Austin, Texas 78751

17. Adjourn. There being no further business, the meeting was adjourned.

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