



Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

August 31, 2026

Texas Health and Human Services Commission

Submitted via email to HHS_CostContainment@hhsc.state.tx.us

Re: Cost Containment Recommendations

To Whom It May Concern,

The Texas Association of Health Plans (TAHP) represents the managed care organizations (MCOs) responsible for the Medicaid and CHIP programs in Texas. We appreciate the opportunity to provide recommendations in response to the cost containment rider in the General Appropriations Act for the 2026-2027 biennium, which directs HHSC to achieve \$550 million in savings by reducing fraud, waste, and abuse; maximizing federal flexibility under the Medicaid program; and making programs and administrative supports more efficient.

We share that goal, and we believe managed care is the state's best tool for achieving it. Managed care's commitment to prevention, wellness, and care coordination has improved access and outcomes for Texas patients while saving Texas taxpayers billions of dollars. The recommendations below are designed to meet the Legislature's savings target by paying appropriately for services actually delivered and by giving MCOs the flexibility to manage cost. Critically, every recommendation that follows can be achieved without reducing the amount, scope, or duration of covered services and without diminishing members' access to high-quality care.

While each of the recommendations below would contribute to the Legislature's savings target, we believe four represent the largest and most immediate opportunities, and we encourage HHSC to prioritize them.

Prescription drugs. Pharmacy is among the fastest-growing costs in the program, running well above the trend assumed in the rates, and much of that growth is avoidable. Pharmacy cost growth is near 15 percent, against the roughly 2 percent that was assumed in rates. By steering the Vendor Drug Program toward the lowest-cost clinically appropriate drug, through stronger step-therapy criteria, generic and biosimilar steering, and closing the gaps that leave high-cost drugs uncontrolled, the state can capture substantial savings without changing what is covered.



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

Plans have already identified single-drug opportunities in the millions of dollars, including an estimated \$3.35 million on a single drug, Farxiga.

Service coordination. Since 2024, HHSC has added prescriptive service coordination requirements that the Legislature never directed, and their cost is enormous. Using HHSC's own rate documents, one of the state's largest plans estimates these requirements have increased service coordination spending by approximately \$404 million per year statewide, with no measurable improvement in quality. A fiscal analysis and a move to a risk-based, outcomes-measured model that lets plans use innovative technology and care models such as telehealth would recover much of that.

Electronic Visit Verification (EVV). EVV is the clearest fraud-prevention opportunity in the program, and it is being underused. Giving plans clear authority to act on geolocation data, requiring that the data be captured, and closing the system gaps that let the same attendant bill for overlapping visits would allow plans to stop improper payments before the dollars go out the door rather than chase them afterward. One plan's review identified roughly \$1.2 million in overlapping-visit claims alone.

Across-the-board provider rate reductions. Plans are at financial risk for provider costs, but an approval process that can take months keeps them from acting. Repealing the prohibition, or streamlining the timeline so plans can right-size provider rates promptly, would let savings the state could already capture actually materialize.

The full set of recommendations follows, organized by area: prescription drugs, program integrity, right-pricing, and restoring MCO flexibility.

I. Prescription Drugs: Steer Members Toward the Lowest-Cost Clinically Appropriate Drug

Prescription drugs are among the fastest-growing costs in Texas Medicaid, and they are an area where stronger utilization management can contain spending immediately without affecting patient access. The Vendor Drug Program's formulary and Preferred Drug List (PDL) should steer utilization toward the lowest-cost clinically appropriate therapy while preserving access when a higher-cost drug is medically necessary. Because MCOs bear financial risk for pharmacy costs, plans are well positioned to serve as an additional utilization-management backstop wherever statewide policy, criteria, or processes do not achieve that result. The recommendations

below identify where that is happening today; the dollar figures are drawn from individual plans' experience and understate the statewide total.

Recommendation #1: Authorize MCOs to Apply Interim Utilization Controls Where the State Has None.

Proposal: Where HHSC has not established a utilization control for a covered drug (because the drug has no therapeutic class or no assigned PDL status), HHSC should authorize MCOs to apply interim utilization management until a statewide control is in place. Any such control would be evidence-based and would not restrict a member's access below the statewide standard.

Rationale: Some high-cost drugs are covered on the Texas Medicaid formulary with no utilization control at all, most often because the drug has no therapeutic class or PDL status and therefore sits open access (payable with no prior authorization) even at very high cost. Examples reported by plans include Cablivi (~\$8,800 per month), Rivfloza (~\$68,000 per month), and Myalept (~\$6,000 per month), and plans report many more. HHSC's recent expansion of Temporary Non-Preferred status to new drugs awaiting Drug Utilization Review Board (DURB) review closes much of the gap for drugs entering the formulary, but it does not reach drugs already sitting open access outside the PDL framework. For these drugs, a conventional "step therapy" requirement is often inapplicable: where a drug has genuinely no therapeutic alternative, there is nothing to try and fail first. The appropriate control is instead a clinical-appropriateness prior authorization confirming the FDA-approved indication, diagnosis, and dosing. Because MCOs bear the cost of these drugs, the most direct fix is to let plans apply that control on an interim basis wherever the state has not, subject to clinical-appropriateness and access protections.

Recommendation #2: Strengthen Step-Therapy Criteria So a Higher-Cost Non-Preferred Drug Is Approved Only After Lower-Cost Preferred Options Have Genuinely Failed.

Proposal: HHSC should strengthen the criteria that gate access to non-preferred drugs so that a higher-cost drug is approved only after the lower-cost preferred alternatives have actually been tried and failed. Specifically, HHSC should:

- Require trial and failure of more than one preferred drug where multiple clinically appropriate preferred alternatives exist, rather than a single preferred drug.

- Require actual evidence of treatment failure, within a defined lookback period, rather than approving a non-preferred drug based on historical paid claim for a preferred drug.
- Require trial of a lower-cost preferred alternative within the same class even when no direct generic equivalent exists, so a high-cost non-preferred drug is not approved simply because it lacks a generic alternative.
- Use manual review for high-cost non-preferred drugs where automated approval is insufficient.

Where statewide criteria fail to meet these standards, MCOs should be permitted to apply additional evidence-based criteria above the statewide floor.

Rationale: Texas Medicaid too often clears a higher-cost non-preferred drug when a lower-cost preferred option would suffice. The PDL generally allows a non-preferred drug after failure of “at least one preferred agent,” and its automated logic will approve a non-preferred drug based on any past paid claim for a preferred drug, with no lookback period and no evidence the preferred drug failed. Tolmetin, a high-cost non-preferred NSAID that auto-approves on historical use, shows the cost: at roughly \$82 per unit against preferred alternatives at \$0.19 to \$0.72, one plan incurred approximately \$250,000. HHSC already does require “trial with each preferred agent” for some drugs, such as stomach acid reducers, but the stronger standard should be applied universally. The same gap appears when a non-preferred drug has no generic equivalent but clinically appropriate lower-cost preferred alternatives exist in its class. Dolobid 375mg, for example, has no generic equivalent, but several lower-cost preferred NSAIDs are available, and criteria should still require trying those alternatives first.

Recommendation #3: Require the Lower-Cost Version When the Same Therapy Is Available at a Lower Price.

Proposal: Where a lower-cost version of essentially the same therapy is available, whether an interchangeable biosimilar, the individual components of a combination product, or a lower-cost NDC of the same drug, the PDL should steer utilization to the lower-cost option. Specifically, HHSC should:

- Make lower-cost generics preferred over their brand-name equivalents, and eliminate brand-generic parity, so the PDL steers utilization to the generic, as with Farxiga, which is preferred over its lower-cost generic dapagliflozin.



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

- Make reference biologics non-preferred where a lower-cost interchangeable biosimilar exists (e.g., Humira), and require trial of the specific preferred biosimilar before the reference product (e.g., Stelara).
- Ensure lower-cost biosimilar products, strengths, and NDCs are actually loaded on the formulary, since only about two of seven Humira biosimilars are currently available. (Yuflyma and Amjevita, for example, are on the PDL but not on the formulary, so no plan can dispense them).
- Require use or trial of the lower-cost individual components before approving a substantially more expensive combination product, such as a naproxen/esomeprazole combination at about \$25.78 per unit versus about \$1.52 for the components separately.
- Manage to the lower-cost NDC when the same drug and strength is available more cheaply under a different label.

Where the state does not act, MCOs should be permitted to steer to the lower-cost equivalent above the statewide floor, while preserving access to the higher-cost option when medically necessary.

Rationale: Separate from how many drugs a member must fail, Medicaid routinely pays far more for a product when a clinically equivalent version is available at a fraction of the cost. The largest opportunities are in brand-versus-generic steering. Farxiga, for example, is currently preferred over its non-preferred generic, dapagliflozin. If those statuses were reversed so the generic is preferred, one plan estimates a 90 percent shift to the generic would save approximately \$3.35 million. For Ravicti, the PDL prefers the brand while leaving the cheaper generic non-preferred, steering members to the brand at \$173.88 per unit instead of the generic at \$42.44. For Sabril, the brand and generic are both preferred and therefore at parity, so nothing pushes utilization to the cheaper generic even though the brand runs \$198.59 per unit against \$37.51 for the generic. One plan paid roughly \$1.18 million for the two brands and estimates the same utilization would have cost about \$275,000 as generics, a potential savings of about \$909,000.

Cost can also turn on dosage form. A 300 mg ibuprofen tablet runs about \$2,400 for 180 tablets, roughly 200 times the cost of dispensing a 600 mg tablet taken as a half dose (about \$10 to \$14 per prescription), yet the 300 mg product stays on the formulary despite being non-preferred with multiple preferred alternatives.

Biosimilar adoption remains low because reference biologics are co-preferred with their lower-cost biosimilars, criteria do not require the biosimilar first, and in several cases the cheaper biosimilar is not even loaded on the formulary, so no plan can route to it regardless of criteria (Humira, for example, remains co-preferred with its biosimilars, and Yuflyma and Amjevita are on the PDL but not loaded on the formulary). The same dynamic drives combination products, which can cost many times their separately available components, such as the naproxen/esomeprazole combination noted above, and high-cost NDCs, where the identical drug and strength is available far more cheaply under another manufacturer's label. In each case the therapy is essentially the same; only the price differs.

Recommendation #4: Ensure Adopted Drug Controls Actually Operate, and Allow Interim MCO Control When They Fail.

Proposal: HHSC should ensure its systems accurately implement adopted drug policy, and should authorize MCOs to apply interim controls when an implementation error defeats an intended control. Specifically, HHSC should:

- Reconcile the master formulary (TIFF), public PDL, formulary search tools, and non-risk (NRP) files, and the federal drug rebate participant list, before publication.
- Ensure new products and strengths of existing drugs are assigned to their correct therapeutic class and inherit that class's status.
- Establish minimum advance-notice standards for formulary, PDL, and clinician-administered drug changes.
- Create a rapid-correction process, with interim MCO control authority, when an error prevents an intended control from operating.

Rationale: Even a correct policy fails to contain costs when the files, tools, or notices that carry it out are wrong:

- A new 640mg strength of metaxalone was not assigned to its existing muscle-relaxant PDL class, so it did not inherit that class's non-preferred status and controls, allowing claims of roughly \$7,000 each to adjudicate unmanaged.
- Gabarone, a brand form of gabapentin, was not assigned to the PDL class its generic sits in, so it is never reviewed by the DURB and costs \$16.33 per unit against \$0.02 for the preferred generic, about \$85,546 year to date at one plan.

- The 1000 mg strength of methocarbamol was not assigned to the class that holds its 500 mg strength, leaving it open access at \$8.34 per unit versus about \$0.04.

Assigning every product and strength to its correct class lets the DURB set PDL status and steer to the lower-cost option

The files can also be wrong in ways that cost money directly. One plan identified 735 NDCs on the VDP formulary from manufacturers not on the federal drug rebate list, which the contract prohibits covering, and because plans treat the VDP file as the source of truth, that plan paid about \$900,000 year to date across 4,179 claims, plus about \$1 million on 370 claims before VDP removed one such drug, Xifaxan. And drugs designated non-risk have been dropped from the NRP file distributed to plans (Wegovy tablets, Daybue STIX), creating uncertainty over payment responsibility. In each case the underlying policy was right, but the implementation defeated it.

II. Program Integrity: Stop Paying for Care That Was Upcoded, Improperly Billed, or Never Delivered

Reducing fraud, waste, and abuse is the Legislature's first named priority, and it is the area where savings are both largest and least disruptive to members. Every dollar recovered here is a dollar the state was never supposed to spend.

Recommendation #6: Fully Implement Emergency Room "Triage Leveling" to Stop Paying Emergency Rates for Non-Emergency Visits.

Proposal: HHSC should fully implement a leveling policy that pays the appropriate evaluation-and-management (office-visit-level) rate for emergency room claims that are not, in fact, emergencies, and should confirm MCOs' contractual authority to apply that leveling consistent with the Legislature's original 2011 directive.

Rationale: In 2011, facing a historic budget shortfall, the Legislature adopted a Medicaid cost-containment rider (Rider 61) directing HHSC to establish more appropriate emergency department rates for non-emergency visits. HHSC implemented the policy by reducing facility payments for non-emergency services delivered in an emergency department, and estimated the initiative would save approximately \$25.6 million in General Revenue for the biennium, exceeding its \$16.8 million target. The methodology remains on the books today: under 1 Texas



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

Administrative Code §355.8061, lower-level emergency visits are reimbursed at a flat fee tied to the Medicaid physician office-visit rate (currently about \$51) rather than at full emergency rates. Over time, however, the policy has not kept pace with the billing practices that followed, and the leveling authority was never fully built out to give MCOs the ability to reassign the level of care. As a result, much of the original intent, and a meaningful share of the savings, has been lost.

Meanwhile, the underlying problem has grown. Since roughly 2015–2017, Texas has seen a well-documented pattern of ER upcoding, accelerated when supplemental funding became tied to higher-level codes. MCOs report that hospitals bill levels three, four, and five at far higher rates than levels one and two, and that a large share of level four and five (trauma) claims arrive with no accompanying emergency transportation, which is a strong indicator that these are not the trauma cases the codes represent. A patient driving themselves to the emergency department is not presenting the trauma case a level five represents.

Because this policy originated in a legislative directive, aligning MCO contracts to that guidance would allow plans to reimburse at the appropriate level without renegotiating each facility contract by mutual agreement. This would not be a new benefit limitation, as members receive the same care. Texas simply stops paying emergency rates for non-emergency services, which is a cost containment initiative the Legislature already endorsed and scored as real savings, and one that has only become more valuable as upcoding has spread.

Recommendation #7: Close Electronic Visit Verification (EVV) Gaps That Enable Fraud, Waste, and Abuse.

Proposal: The Electronic Visit Verification (EVV) program presents one of the clearest fraud-prevention opportunities in Texas Medicaid, but four gaps in its current design limit MCOs' ability to detect and prevent improper billing. HHSC should close each of them:

- Update the EVV Policy Handbook to authorize MCO enforcement actions based on geolocation data for fraud, waste, and abuse, define what “in the community” means, and require providers to keep the mobile-app geolocation feature enabled.
- Require the EVV system and proprietary system operators to prevent the same attendant from recording overlapping clock-ins and clock-outs across different agencies, and verify this control in the system readiness reviews.



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

- Reduce the visit-maintenance window, the period during which a provider may retroactively edit a visit, from 95 days back to seven days.
- Expand the in-scope EVV services to include speech therapy, private duty nursing, and behavioral health services delivered in the home, which are currently outside EVV and therefore outside fraud, waste, and abuse monitoring.

Rationale: The EVV program is one of the clearest FWA opportunities in Texas Medicaid, but its current design limits MCOs' ability to detect and prevent improper billing.

First, HHSC has taken a half-step on geolocation but not finished it. In May 2026, HHSC issued an MCO notice stating that plans may use all EVV datasets, including GPS data, to identify and prevent fraud, waste, and abuse. However, the agency has not updated the EVV Policy Handbook to authorize enforcement action once an issue is found, even though the handbook governs enforcement for every other aspect of EVV compliance. MCOs need clear guidance so that they are able to prevent fraud, waste, and abuse, as fraud recoupments generally result in the state receiving pennies on the dollar.

The handbook also uses the term "in the community" (Sections 7020 and 7060) without ever defining it, and providers can disable the mobile app's geolocation feature, leaving visits with no coordinates at all. The result is that plans see visits recorded many miles from the member's home, including out of state in Las Vegas, and attendants clocking in from outside the United States, which CMS does not permit. HHSC should define "in the community," authorize MCO enforcement on out-of-policy geolocation, and require providers to keep geolocation enabled.

Second, the EVV system does not prevent the same attendant, who carries a unique attendant ID, from recording overlapping visits in more than one member's home at the same time, whether the attendant works for one agency or several. One plan's two-year lookback identified approximately \$1.2 million in paid claims tied to overlapping visits. HHSC should require the HHAeXchange system and proprietary system operators to prevent overlapping visits and should verify that control in the system readiness reviews.

Third, providers currently have 95 days after the date of service to perform "visit maintenance," retroactively editing multiple elements of a visit, including the service delivered and the length of the visit, both of which drive payment. The window was seven days under DADS, was set to 60 days at the 2019 aggregator go-live, and grew to 95 days in 2021 to match the timely-filing window, at providers' request. Roughly 48 percent of one plan's EVV visits receive a



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

maintenance edit more than seven days after the date of service. A window this long allows a provider to bill, change the underlying EVV data, and bill again, with no safety net in the aggregator. There is no legitimate operational reason the window must exceed seven days, and HHSC should return it to seven.

Fourth, several high-cost, home-delivered services, including speech therapy, private duty nursing, and in-home behavioral health, are not currently subject to EVV at all. Leaving them out of scope means the state has no electronic verification that the visits occurred, which is exactly where EVV is designed to prevent fraud, waste, and abuse. HHSC should bring these services into EVV scope.

Recommendation #8: Strengthen Private Duty Nursing Delivery Accountability.

Proposal: HHSC should strengthen accountability for the delivery of private duty nursing by requiring that a legal guardian be present during the delivery of PDN services, and by establishing provider accountability measures, including monitoring, documentation standards, and corrective action for non-compliance.

Rationale: Private duty nursing is among the most intensive and costly services in Texas Medicaid, and much of it is delivered in the home with limited independent verification that the authorized care actually occurred. Requiring a legal guardian to be present during PDN delivery, paired with provider monitoring, documentation standards, and corrective action, gives the state a straightforward check that the services billed were in fact rendered. This pairs directly with bringing PDN into EVV: together they close the verification gap on one of the program's highest-cost services, protecting members and ensuring the state pays only for care that was delivered.

III. Right-Pricing: Pay Rates Aligned With Appropriate and National Benchmarks

A second category of savings comes not from changing what is covered, but from correcting what Texas pays. In several areas Texas reimburses well above appropriate or national benchmarks, providing the same service at the wrong price.



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

Recommendation #9: Conduct a Study Comparing Texas Medicaid Rates to National Benchmarks, Beginning With Therapy Services.

Proposal: HHSC should conduct a rate study comparing Texas Medicaid reimbursement rates to national Medicaid benchmarks to identify services where Texas pays significantly above the national average, beginning with therapy services.

Rationale: MCOs have long observed that certain Texas Medicaid rates run well above national norms. Therapy services are a documented example, and testimony at a prior legislative hearing showed Texas therapy costs running multiple times the national average. A systematic comparison would let the state target right-pricing where the gap is largest, capturing savings without reducing the availability of services. Aligning outlier rates to appropriate benchmarks would not change the amount, scope, or duration of any covered service.

Recommendation #10: Review and Right-Price Targeted Case Management, and Give MCOs Benefit-Design Flexibility to Prevent Waste.

Proposal: HHSC should review and adjust the Medicaid fee schedule for targeted case management (TCM), and give MCOs additional flexibility in the design and oversight of the benefit so that services are covered appropriately.

Rationale: MCOs report that Texas overpays for TCM and that the way the benefit is designed limits plans' ability to apply the utilization controls and oversight that would prevent waste. As TAHP has noted in prior cost containment recommendations, elevated reimbursement in this area has fostered rapid utilization growth and attracted actors whose billing practices raise FWA concerns. Adjusting the fee schedule to align with comparable provider types, and giving MCOs the flexibility to design and oversee the benefit appropriately, would contain costs while preserving access for the members who need these services.

Recommendation #11: Modernize Exceptional-Circumstance DME Policy to Allow Appropriate Reimbursement.

Proposal: HHSC should revise its exceptional-circumstance durable medical equipment (DME) policy so that MCOs can set appropriate reimbursement rates for equipment covered outside the state plan, rather than defaulting to manufacturer's suggested retail price (MSRP).

Rationale: Under the current exceptional-circumstance provision, MCOs are required to cover DME items that are not on the state plan. This obligation is rooted in a federal provision that



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

operates much like EPSDT, but for adults. Because these items fall outside the state plan, plans have limited ability to set a rate below MSRP, which does not reflect an appropriate acquisition or market price. The goal is not to deny medically necessary equipment but to pay an appropriate rate for it. Members receive the same equipment, but the state stops paying an inflated price.

IV. Restoring MCO Flexibility: Let Plans Manage Utilization and Networks to Value

The third category reflects a recurring theme across every MCO we represent: Texas Medicaid is, in many areas, more prescriptive than other states, and that prescriptiveness adds cost without adding value. Where the state ties plans' hands, it forces higher-cost care that delivers no better outcome. Restoring flexibility lets MCOs manage to value while members keep the same access and quality of care.

Recommendation #12: Unwind HHSC's Overly Prescriptive Service Coordination Requirements That Raise Costs Without Adding Value.

Proposal: HHSC should conduct a fiscal analysis of the service coordination requirements it has added since 2024, and of any it proposes going forward, because these changes were not directed by the Legislature and their cost has never been formally measured. It should roll back the most prescriptive of them, particularly the automatic assignment of members who do not use long-term services and supports into the highest service-coordination levels. Further, the agency should move from a process-counting model to a risk-based, outcomes-measured model. MCOs should be allowed to use risk-based analysis to identify the members who actually need service coordination, and then the agency should judge plans on member outcomes and satisfaction rather than the number of visits and calls logged. HHSC should also allow plans to use innovative technologies and care models to deliver service coordination more efficiently, including telehealth, automated member outreach, and AI-driven risk stratification.

Rationale: Service coordination has become one of the fastest-growing costs in Texas Medicaid, driven by increasingly prescriptive contract requirements that HHSC has added year after year without legislative direction or any fiscal analysis. The growth is documented in HHSC's own rate documents, which set the per-member-per-month (PMPM) amount the state pays plans for service coordination. Since 2017, that amount has risen about 75 percent for STAR Kids (from roughly \$65 to about \$114 PMPM) and nearly 300 percent for STAR+PLUS (from roughly \$28 to about \$109 PMPM), with the steepest increases arriving after the 2024 contract changes.



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

Holding membership constant at projected 2027 levels to strip out enrollment swings, a statewide analysis built from these rate documents by one of the state's largest MCOs estimates that the requirements added between 2024 and 2027 have increased service coordination spending by approximately \$404 million per year. That figure is a directional estimate, but it rests on the state's own rate data, and even read conservatively it is a very large and unbudgeted number.

The increase reflects more members, more visits, and more expensive staff, all specified in the September 2024 STAR+PLUS contract. That contract expanded the highest coordination tier, Level 1, from 41,000 to 57,800 members (from 30 to 40 percent of membership) by newly sweeping in populations such as pregnant members, high-cost catastrophic cases, members with co-occurring mental health and substance use diagnoses, and members in their first six months transitioning from STAR Kids. It roughly doubled required face-to-face visits and increased required telephonic visits nearly tenfold, from about 12,000 to about 115,600 a year, by moving from one call a year for certain members to two calls a year for every Level 1 member. And it required that Level 1 coordinators be primarily RUG-certified registered nurses, which forces MCOs across the state to hire hundreds of additional staff, predominantly RNs, at a time when nurses are scarce and plans must raise salaries to compete with hospitals for them.

Much of this coordination produces no measurable benefit. A member receiving dialysis for end-stage renal disease is now assigned a registered-nurse coordinator and repeated contacts even though nothing the coordinator does changes the course of that care; every pregnant STAR+PLUS member is placed in Level 1 regardless of need; and a member transitioning from STAR Kids is placed in the most intensive Level 1 tier for their first six months regardless of need. Because resources are spread across everyone this way, plans are less able to concentrate on the members with the highest needs. At the same time, HHSC forecloses the efficiencies that would contain the cost, as the agency does not permit telehealth for service coordination visits, and it recently moved to bar automated two-way check-in technology before partially relenting to allow an auto-dialer. Plans are ready to use risk-based analysis and technology to find and serve the members who need coordination most, but the state's all-or-nothing, process-counting approach does not allow it.

These are administrative choices, not legislative mandates, and their cumulative cost is now large enough to inflate total Medicaid spending, which is then held against managed care. The state should instead measure what it is buying by conducting the fiscal analysis, judging plans on outcomes, and giving them the flexibility to manage service coordination to actual need. Doing

so protects access for the members who genuinely need coordination while ending spending on contacts that add cost without value.

Recommendation #13: Allow Preferred and Narrow Provider Networks, and Streamline the Approval of Alternative Payment Models and Preferred Provider Arrangements.

Proposal: HHSC should take two steps to let MCOs pay for value. First, it should remove the barriers that prevent MCOs from using the preferred and narrow provider networks that many other state Medicaid programs allow. Second, for alternative payment models (APMs), which MCOs are already permitted to use, HHSC should streamline and standardize its approval process, remove unnecessarily restrictive requirements, and treat plans consistently, so that administrative processes do not slow implementation and adoption. In particular, once HHSC has approved one MCO for a given type of APM, every other MCO should be automatically cleared to use the same arrangement.

Rationale: Texas Medicaid largely prohibits the narrow provider networks that other states allow, arrangements that would let plans steer members to high-value, cost-effective providers and both contain cost and improve quality. Alternative payment models can do the same, and MCOs are already permitted to use them, but MCOs report that HHSC's approval process is slow, inconsistent, and applied unequally across plans, which delays or forecloses the savings. In one case, it took a plan years to obtain approval for the same incontinence-supply preferred provider arrangement that other plans already had, because HHSC did not want a larger MCO's participation to upset the providers involved. Those were years of foregone savings on a single arrangement. Approving one plan for an arrangement and then making others wait serves no cost-containment purpose. HHSC should set clear guardrails and then standardize approvals, apply them evenhandedly, and let an arrangement approved for one plan proceed for all.

Recommendation #14: Let MCOs Implement Across-the-Board Provider Rate Reductions Without Unnecessary Delay.

Proposal: HHSC should either repeal the prohibition on across-the-board provider rate reductions or streamline the approval process so plans can act on them without extended delay. Under the current managed care contract, an MCO must submit a written request to reduce rates for all similarly situated providers at least 90 days before the planned effective date, and the reduction may proceed only if HHSC does not disapprove it in writing within 45 days. HHSC should shorten the MCO request lead time from 90 days to 30 days and its own disapproval



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

window from 45 days to 15 days of receipt, and any HHSC disapproval should require a demonstration that the reduction would negatively impact the Medicaid program. Plans would remain subject to their network-adequacy obligations, so member access is unaffected.

Rationale: Government Code Section 540.0264 and the managed care contract limit MCOs' ability to adjust provider reimbursement across the board, and the extended timelines delay savings the state could otherwise capture. Giving plans a faster, clearer path to right-size provider rates (or removing the prohibition altogether) lets them manage cost more responsively while HHSC retains oversight through a disapproval right exercised on a documented showing of harm to the program.

Recommendation #15: Private Duty Nursing, Personal Care Services, and Respite Through Standardized Assessments

Proposal: HHSC should adopt standardized, task-and-time-based assessments across private duty nursing (PDN), personal care services (PCS), and respite so that each service is authorized at a level matched to the member's assessed need and duplication across the three is eliminated. For PDN, this means determining the appropriate level of hours and supporting an appropriate mix of attendant care and skilled nursing rather than defaulting to 24-hour PDN. For PCS, HHSC should implement a standardized assessment modeled on Form 2060 that assigns a consistent time per task. For respite in the MDCP waiver, a standardized task-and-time assessment would prevent duplication with PDN and PCS.

Rationale: Private duty nursing is one of the largest cost drivers in Texas Medicaid, and Texas relies on 24-hour PDN to a greater degree than other states, which use a mix of attendant care and skilled nursing. A standardized assessment tool would match nursing hours to assessed need, ensuring members receive the care they require while avoiding automatic authorization of the most expensive option in every case. We recognize HHSC has previously cited litigation (*Alberto N.*) as a barrier to a standardized assessment; we believe that concern is worth revisiting, as a properly designed assessment sets hours based on each member's individual needs and is fully consistent with maintaining every member's access to medically necessary care.

The same logic applies to personal care services and respite. A standardized PCS assessment modeled on Form 2060, assigning a consistent time per task, would reduce variation between members and across MCOs and cut the higher-level reviews, denials, and fair hearings that inconsistent assessments generate. A standardized respite assessment in the MDCP waiver would



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

prevent respite hours from duplicating the PDN and PCS already authorized for the same member, an issue that is especially acute for complex members transitioning into STAR+PLUS. Standardizing all three tightens the match between services and need without reducing any member's access to medically necessary care.

Recommendation #16: Tighten Non-Emergency Medical Transportation Criteria for Appropriate Utilization.

Proposal: HHSC should adopt clearer, more appropriate criteria for non-emergency medical transportation (NEMT), particularly for end-stage renal disease (ESRD) dialysis transportation and "exceptional circumstance" trips, establish a reasonable limit on the number of trips per member per month, and enforce existing requirements that assisted living facilities provide the member transportation already funded in their rates.

Rationale: MCOs have identified opportunities to better manage NEMT utilization where current criteria are broad or ambiguous, particularly around ESRD dialysis transportation and exceptional-circumstance trips. One plan covered more than 750,000 rides in a single year. A reasonable per-member monthly trip limit would encourage members to bundle appointments and use mail-order pharmacy without affecting access to necessary transportation. A separate driver is duplicate payments, as some assisted living facilities refuse to transport members even though that transportation is already funded in their facility rates. Because the licensing agency does not enforce the requirement, MCOs authorize NEMT to avoid a care gap, so the state pays twice. HHSC should enforce the facility transportation requirement so that MCOs reimburse NEMT only when travel is outside the service delivery area or the circumstances are genuinely unique. Clearer criteria would ensure transportation is provided when appropriate while preventing spending on trips that fall outside a sound medical-necessity standard.

We appreciate the ongoing collaboration with HHSC in serving Texas' Medicaid population, and we recognize the seriousness of the budget environment the state faces this biennium. The recommendations above reflect the everyday experience of the MCOs doing this work, and represent tangible opportunities to contain costs that leave members' access to high-quality care and coverage fully intact. We would welcome the opportunity to discuss any of them in greater detail, to provide the supporting data referenced above, or to meet with your team to identify additional cost drivers and solutions. Thank you for the opportunity to share our recommendations.



Texas Association of Health Plans

1001 Congress Ave., Suite 300

Austin, Texas 78701

P: 512.476.2091

www.tahp.org

Sincerely,

A handwritten signature in black ink that reads "Jamie Dudensing". The script is fluid and cursive, with the first letter of each word being capitalized and larger than the others.

Jamie Dudensing, RN

CEO, Texas Association of Health Plans