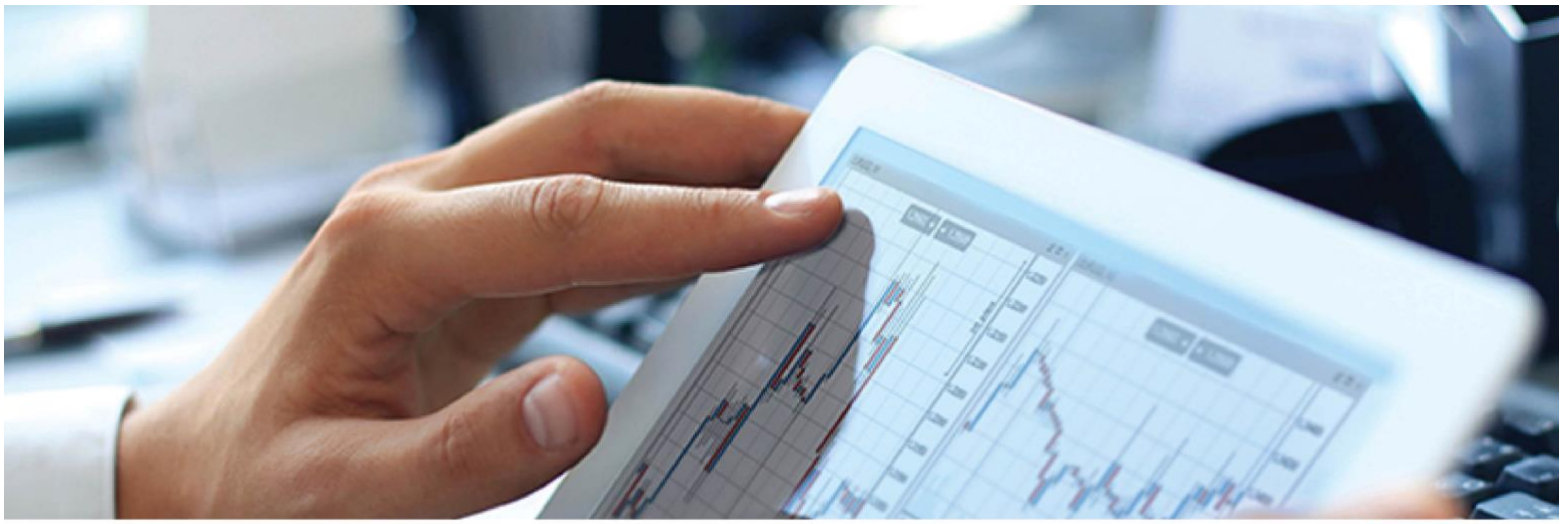
TEXAS INSIGHT
HEALTHCARE INTELLIGENCE

Health and Human Services

IDDSRAC Collaboration with Managed Care Subcommittee

October 1, 2025

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.



1. Welcome, call to order, introductions and roll call. with Beren Duttra convened the meeting.

Members present: Sue Burick; Ellen Fremion; Shari Talbot; Fredrick McCurdy.
A quorum was present.

2. Consideration of June 18, 2025, subcommittee draft meeting minutes. The minutes were approved after brief discussion on one item.

3. Medical Transportation Program brochure (Nonemergency Medical Transportation Program | Texas Health and Human Services)

Consideration and Vote on Proposed NEMT Brochure

ORIGINAL BROCHURE PROVIDED BY IDD SRAC How to Access Nonemergency Medical Transportation (NEMT) Services

Introduction Nonemergency medical transportation services provide transportation for a Medicaid beneficiary or their child to and from Medicaid-covered health care and dental services. NEMT services are for people who have no other way to get to their health care visits, including people enrolled in: • Medicaid • Children with Special Health Care Needs program (CSHCN) • Transportation for Indigent Cancer Patient (TICP) NEMT services are not for emergencies or transportation by stretcher or ambulance. If you need a nonemergency ride in an ambulance or by stretcher, call your health plan or the provider of the health care service you need the ambulance to access. If you need emergency transportation, call 911.

NEMT Services NEMT services must be delivered in a manner that meets your needs, including accessibility.

- Demand response transportation service, which provides curb-to-curb transportation to and from a health care service in an accessible passenger vehicle, bus, van, sedan, or ride-share vehicle.

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- Mass transit, which provides tickets or tokens to people to use to travel to allowable services.
- Individual Transportation Participant (ITP) services, which provides mileage reimbursement to a designated driver, who can be the individual receiving the health care service, for trips to and from a health care service.
- Meals and lodging for eligible overnight stays for people ages birth through 20 years.
- Advanced funds for ride and travel-related expenses for people ages birth through 20 years. If an individual requires an attendant, the attendant is covered.
- Airline fare when it is medically necessary and the most cost-efficient means of travel.

Setting up a Ride You should request NEMT services as early as possible, and at least two working days before you need a ride. The MCO, and its subcontractor, and HHSC must offer and arrange NEMT services to the individual and as applicable, to his or her NEMT attendant. If an attendant is required, you must mention this when scheduling your ride. In certain circumstances you may request an NEMT service with less than 48 hours' notice.

These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips to receive treatment for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours. (NB. Bold added for emphasis.) The MCO or HHSC may allow other exceptions to the 48-hour rule.

If your trip will take you out of town, call at least five working days before your appointment to schedule a ride.

Parental Accompaniment Children 17 years and younger who receive NEMT services must be accompanied by a parent or legal guardian, or by another responsible adult approved by the parent or legal guardian. Parents or legal guardians who cannot travel with their child should provide the documentation required by their health plan or HHSC to designate another adult to travel with their child. Exceptions to parental accompaniment requirements are granted for confidential appointments based on the type of appointment.

Children between the ages of 15-17 may travel without an adult with the written permission from a parent, guardian, or other responsible adult. If you have a reason for going to an appointment without your parent or without parental consent, please contact HHSC or your health plan's designated transportation resource for information on your NEMT options.

FAQs

If I drive myself, can I be reimbursed for gas? Medicaid may be able to pay you or someone else who drives you to a health care service if your trip is approved before you travel. Payments are made by the mile at the HHSC-established mileage rate. To participate, drivers must sign up through the appropriate health plan or TMHP. Drivers must provide: • Copy of valid driver's license • Copy of the driver's Social Security card (the name must match the driver's license) • Copy of the current vehicle insurance and registration for the vehicle that will be used for mileage reimbursement

If my trip request is denied, how can I appeal? You may ask your health plan or HHSC to conduct an internal review of the denied services. People with a health plan should follow their health plan's process for submitting complaints and appeals. People without a Medicaid health plan should call 877-633-8747 (877-MED-TRIP).

You also have the right to request a fair hearing at any time. The request must be made through one of the following:

- in writing via mail, fax, or email o The fax/email must be sent to the HHSC by entering the appeal in TIERS. The Fair and Fraud Hearings Department does not receive appeal requests directly.
- verbally through: o calling 2-1-1, o speaking to your transportation provider or MCO, or o contacting your local HHSC Medicaid office; or
- in person, by visiting your local HHSC Medicaid office. If the issue is not resolved you can contact the HHS Office of the Ombudsman.

You can contact them by calling 877-787-8999. You can also send a fax to 888-780-8099 or write to: HHS Office of the Ombudsman P.O. Box 13247 Austin, Texas 78711-3247

Can I take an attendant when I use NEMT services? Yes, if approved by HHSC or the health plan. If you will be traveling with an attendant, please include this in your request for NEMT services.

How do I schedule an NEMT service? If you or your child is enrolled in a Medicaid health plan, contact your health plan's designated transportation resource. This information can be found on the HHSC website for each MCO at https://www.hhs.texas.gov/services/health/medicaid-chip/programsservices/medical-transportation-program/health-plan-contact-information. If you or your child is not enrolled in a Medicaid health plan, call the toll-free HHSC MTP hotline at 877-633-8747 (877-MED-TRIP).

To report fraud, waste, and abuse, call the Office of the Inspector General at 800-436-6184 or visit oig.hhsc.gov.

The committee reviewed two handouts on non-emergent medical transportation: a recommendations draft and the brochure.

It was suggested removing a parenthetical editor's note and adding that out-of-town trips may also request mileage reimbursement.

Discussion took place regarding how the brochure addresses Medicare and dual eligibility, with nuances about when Medicare or Medicaid is the primary payer for transportation. Members agreed to clarify but not overcomplicate the brochure, possibly adding a sentence for those with Medicare.

Members discussed the need for information about NEMT to be accessible, including suggestions for a plain-language revision and possibly an instructional video.

Feedback from HHSC was sought on brochure distribution logistics and expectations, explaining there are costs to printing and physical distribution. HHSC can post brochures electronically, but further funding may be needed for physical copies.

The importance of broad and multi-channel distribution was emphasized, especially to new Medicaid recipients unfamiliar with transportation benefits.

The need for legislative advocacy for funding physical distribution was raised.

The committee approved the brochure content, pending plain-language editing and future discussion on distribution.

MOTION: Approve the content of the above brochure with the understanding that HHSC will put this into plain language prevailed.

Discussion shifted to recommendations that will now be finalized on a biennial (rather than annual) basis to match the legislative calendar (due September 30, 2026).

The group outlined the need for baseline data collection to support recommendations, especially regarding:

- The number of Medicaid members eligible and using NEMT, compared to total eligible
- Review and comparison of NEMT benefit descriptions and policies across MCOs and waiver plans, possibly using screenshots or crosswalks of materials

The organization and direction seemed to fall apart in this portion of the meeting. In some instances, data needs were identified while in others it was unclear.

Workgroup 2: Recommendations to address education on nonemergency medical transportation benefits.

Education on Non-Emergency Medical Transportation Benefits

Background: HHSC has published on its website much of the content of a brochure that previously met the approval of the IDD SRAC. The website, however, needs further improvement. The IDD SRAC continues to receive inquiries about the Non-Emergency Medical Transportation (NEMT) benefit for persons with disabilities. Therefore, it is apparent that a lack of actionable information still exists in the disability community regarding the NEMT benefit, and this must be addressed (e.g., how to access NEMT, changes to the guidelines on NEMT, and procedures for receiving reimbursement when NEMT is provided through a private vehicle, etc.).

The IDD SRAC acknowledges that HHSC now has contracts with Medicaid Managed Care Organizations (MCOs) to provide transportation services, and that each MCO contracts

with a variety of vendors of their choosing to provide NEMT. However, NEMT is also a Medicaid benefit for waiver beneficiaries that is not delivered through an MCO but rather via a fee-for-service (FFS) arrangement directly with HHSC. As a result, difficulties still exist within the disability community on NEMT, and it is incumbent on HHSC to create mechanisms that allow the disability community to fully understand the NEMT benefit, including how they utilize the benefit.

Recommendations:

1. Require HHSC to incorporate "en bloc" the brochure content previously approved by the IDD SRAC (Provided below).

2. The current list of MCOs and the "drop down" menu currently in place is inadequate and needs major changes as noted below:

a. Name of the MCO or who is managing the FFS contracting for NEMT
b. Name of the NEMT vendor
c. Phone number for the member to call
d. Name of the contact within the MCO or within FFS

3. Distribute the brochure in accessible formats (i.e., downloadable format from the HHSC website or other media formats) to the public through websites and share with all organizations serving Medicaid participants to distribute to their members. This would typically include a service coordinator or a case manager providing this brochure at an annual service planning meeting or during contractual contacts with service coordinators and case managers. This brochure should also be included in HHSC Medicaid certification and renewal packets.

4. Within the already approved brochure under the section titled "Setting Up A Ride", the following text should be set in a bold font for clarity and to bring attention to the content: In certain circumstances you may request an NEMT service with less than 48 hours' notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips to receive treatment for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

5. Also, pursuant to the section in the brochure titled “Setting Up A Ride” the statement is made, “If an attendant is required, you must mention this when scheduling your ride.” It has come to the attention of the IDD SRAC that clarity is lacking in defining how “assistance” and “attendant” accompaniment are allowed and/or adjudicated. HHSC must examine and expand the definition of what is allowed when “assistance” and/or “attendant” services are needed, as there are circumstances when no services are available, and no community resources are available to meet the beneficiary's needs. HHSC must provide directions on safe alternatives.

6. Develop and implement a person-centered process and communicate with individuals when attendants are needed for transportation to non-Medicaid or Medicaid providers and need reimbursement for the attendant. Review the policies for the IDD Comprehensive provider and the Medical Transportation benefit to assure clarity.

7. Align NEMT policies and access to be consistent for beneficiaries on either FFS or enrolled in Managed Care with an MCO.

8. Monitor call center on-hold times for NEMT to assure timely access to Medicaid transportation benefits and assure that MCOs and FFS provide reports quarterly to HHSC.

9. As noted in recommendation #3 above, HHSC should require MCOs and FFS to provide increased hours for access to call centers beyond standard workday hours, allowing individuals to speak with a representative to address their access needs. Examples to include:

a. Accessing NEMT at hospital discharge that occurs during nonroutine business hours (e.g., nights, weekends, holidays, etc.)
b. Accessing NEMT to obtain prescriptions at pharmacies or medical supplies at a Durable Medical Equipment (DME) company.
c. Accessing NEMT for a medical emergency without regard to when in a day this might occur (e.g., medical emergency requiring transport after normal business hours, in the evening, or a weekend/holiday day).
d. Accessing NEMT through an expedited process (less than the required 48 hours) when there is an unanticipated emergent transportation need (e.g., create a process to expedite prior authorization for NEMT).

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10. FFS and MCO members should have access to online scheduling and communication from the NEMT members. This transportation system needs to be accessible, and information and scheduling must be available in multiple accessible formats. Benchmarks

11. Standardize and simplify NEMT applications for Individual Transportation Participants (ITP), who provide mileage reimbursement transportation services to Medicaid recipients.

a. The applications and requirements for ITPs should be the same across all Medicaid programs and MCOs to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits.
b. Develop and implement process for automatically transfer NEMT data for ITP drivers. ITP drivers should not be required to complete new ITP applications if they have already been approved as ITP drivers by another MCO or by traditional Medicaid, to reduce barriers for Medicaid recipients who use NEMT mileage reimbursement benefits.
c. Develop and implement a process for loadable data cards for reimbursement to ITP.

Suggestions included checking standardized contract language for consistency and provider differences among MCOs.

Data Needed:
Usage of NEMT/ use rate vs eligibility
Collection of the information given from the managed care plans
MCO crosswalk

4. IDD SRAC CMC identifies information and data needed from HHSC to support the recommendations and focus on system redesign.

Workgroup 1:

Recommendations to address increasing CFC Utilization and Improved Coordination.

Background Texas was one of the first states to implement Community First Choice (CFC) as a Medicaid State Plan benefit for children and adults who meet an institutional level of care and have a functional need for services. Personal Assistance Services (PAS) and Habilitation (HAB) are the primary services available in the CFC service array. Through CFC, individuals living in the community can get assistance with tasks like eating, bathing and dressing, and habilitation to learn, develop and maintain skills for everyday life activities. CFC was designed as a cost-effective alternative to institutional care. Increased access and improvements to CFC services could potentially lead to a reduction in the number of people needing an IDD waiver. Currently, Texas receives a six percent enhanced federal match for CFC services.

Some of the current issues in the delivery of CFC include:

1. Lack of knowledge about the benefit by individuals with IDD and families.
2. Difficulty hiring and retaining CFC direct care workers due to low reimbursement rates.
3. Difficulty capturing data on the number of people authorized and receiving services.
4. Difficulty securing timely eligibility assessments due to type and length of assessment.
5. Difficulty of LIDDAs to be reimbursed for eligibility assessments for non-waiver CFC.

CFC remains a service with great promise and the state should invest the effort and resources necessary to increase utilization and improve coordination.

Recommendations

1. Increase awareness of and evaluation for CFC through a concerted, statewide outreach effort.

A. Require MCOs and LIDDAs to discuss, assess and refer for CFC services at annual assessments including STAR, STAR Kids, and any other Medicaid products with tracking and built in accountability.
B. Examine the use of an alternative institutional assessment tool such as the Intellectual Disability/Related Conditions for individuals with Level of Care 1 and not just Level of Care 8, thereby shortening the wait for assessments.
C. Require HHSC to create a CFC brochure and website content to ensure wide dissemination.

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2. Enhance the CFC service array by adding Employment, Transportation and Respite services.

3. Set sustainable CFC rates that allow for hiring and retention of direct service workers with skills and abilities in teaching habilitation.

4. Require HHSC to track and report data on the number of individuals receiving CFC by institutional eligibility type as well as the average number of paid CFC hours by waiver, non-waiver program, and region.

5. Establish a clear, streamlined and well-functioning funding mechanism and payment rate for the LIDDAs to perform eligibility determinations and CFC functional assessments for persons with IDD including those receiving non-waiver CFC.

6. Require HHSC to develop online training for CFC assessors and Service Coordinators including how to effectively use the assessment tools.

7. Timeliness and simplification with benchmark(s).

Benchmarks

1. CFC brochure and website page.
2. Quarterly data reports on the number of individuals receiving CFC by waiver, non-waiver and region.
3. Quarterly data reports on the number of hours authorized versus hours paid.
4. Training module developed and the number of individuals trained.
5. Report on funding mechanisms and payment rate for LIDDAs to perform eligibility assessments and evidence LIDDAs are receiving payment.
6. Tracking.

Extensive conversation covered CFC eligibility, the complexity of Medicaid assistance types (MAO), and the pathways for PASS/HAB services. Discussion was undirected and all over the map.

Clarification was provided that CFC requires Medicaid enrollment and functional eligibility, but some waiver groups (e.g., STAR Plus HCBS) are federally excluded from CFC but have similar services through waivers.

Members noted confusion and lack of awareness among families about CFC and related benefits, and that referral and education often depend on advocacy organizations or proactive service coordinators.

Suggestions for data collection: stratify CFC enrollment data by age (children vs. adults), MCO, and service type; review language MCOs and LIDDAs use to counsel members about CFC; and examine the impact of new legislative mandates for earlier school referrals.

Calls were made for streamlining eligibility and assessment, and for the committee to review previous recommendations and consider funding needs for LIDDAs.

Consideration for better information materials (potentially a separate CFC brochure) was raised.

Data Needed
Stratify data in benchmarks by MCO
Compare Children and Adults in CFC (utilization)
Information about wording from LIDDAs and counseling
Change pre and post bill implementation
How many reached eligibility LOC 8
Funding for assessment implementation

Expanding capacity for mental and behavioral health care services

Background Mental and behavioral health (MBH) concerns are 3-4 times more prevalent in the IDD population. Inadequate IDD-specific MBH care leads to increased acute care utilization, misdiagnosis and treatment (e.g., polypharmacy), possible trauma, increased stress and physical harm risks for individuals and families, poor social integration, overrepresentation in the criminal justice system, placement in more restrictive settings, and premature mortality. Inadequate IDD MBH care is complex and multifactorial. Contributors include inadequate assessment tools and caregiver/provider training, limited evidence-based therapies, scarce IDD MBH providers and limited MBH coverage particularly for adults, the lack of coordinated MBH care, non-medical factors that impact care access, and the lack of structured daytime activities

Currently in Texas, behavioral support payment is only granted through home and community-based waiver programs. As waiver interest waitlists in Texas are >15 yrs, adults with IDD who do not have a waiver, often have inadequate behavior support which can lead to more medications, acute/crisis behavior management interventions, safety concerns for their families and selves, and potential long-term care placement.

Recommendations

1) Establish training grants to train healthcare providers (primary care and psychiatry) to care for behavioral health needs for individuals IDD throughout the lifespan.

2) Provide payment through the Medicaid state plan for behavioral support therapy for adults with IDD who have challenging behavior or difficulty with tolerance medically necessary interventions (e.g. blood draws, physical exams, etc.) who are not able to participate in psychosocial counseling or cognitive behavioral therapy for both waiver and non-waiver recipients. Behavioral support payment should have parity with pediatric Medicaid payment for behavioral support and should include payment for telehealth services.

3) Standardize Quality Metrics for MBH management such as (1) measuring changes in patient's symptoms, daily functioning, and overall recovery progress, (2) timely access to care to address MBH concerns/exacerbation, (3) number of psychotropic medications and side effects (e.g. screening for metabolic labs and monitoring body-mass-index). Promote Value-Based Care Agreements between integrated MBH teams and managed care organizations based on quality metrics.

Benchmarks

1) Number of trainees per year. Comfort and confidence in taking care of adults with IDD in the community pre/post training and the number of patients with IDD the provider serves once in practice for 5 yrs if practicing in Texas.
2) Cost of behavioral support therapy, number of psychotropic medications prescribed pre-post 1 year of therapy.
3) Inpatient, outpatient, and emergent healthcare utilization and quality metrics for clinics under value-based care agreements.

Data Needed. Unclear if any data needs were identified

Identify and Develop Acute Health Care Initiative

Background Individuals with IDD have shorter lifespans due to higher rates of comorbidities and barriers to accessing medical and mental health care. Their complex health concerns also contribute to increased healthcare utilization and an estimated four times higher annual healthcare cost. Barriers to timely access to appropriate healthcare for those with IDD include: low health literacy leading to delays in identifying problems and navigating care; negative experiences or fear of healthcare interventions; impaired autonomy and communication; poor care coordination and integration; lack of insurance coverage and financial hardship; need for extended time and accommodations during healthcare encounters; and the sparse workforce knowledgeable and equipped to care for individuals with IDD throughout the lifespan. Providing healthcare for individuals with IDD requires some training and familiarity with common co-occurring conditions, communication and visit accommodation needs, and willingness to collaborate with families and other providers to provide integrated care. These care adaptations often require longer visit times, care coordination support between visits, and effort to address non-medical factors that impair access to optimal health care. To address health care access for adults with IDD, training and funding to support these additional care coordination services are needed. Such initiatives can lead to cost savings by preventing higher cost acute care such as potentially preventable emergency department and hospital encounters.

Recommendation

1) Establish training grants to train healthcare providers to provide comprehensive primary care for individuals IDD throughout the lifespan in partnership with medical schools and hospital systems.

2) Establish seed grants to initiate medical home clinics with care coordination and case management support for adults with IDD who have behavioral/medical complexity in partnership with medical schools and hospital systems.

3) Adopt G2211 billing code (additional $16.05 in 2024 for outpatient visits) for Medicaid recipients on par with Medicare billing criteria which allows providers to better account for the resource costs associated with visit complexity inherent to primary care and other longitudinal care.

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4) Standardize Quality Metrics for IDD and promote value-based care agreements between primary care providers seeing patients with IDD and managed care organizations based on these quality metrics such as

a. 70% Hospital and ER follow up in 7 days
b. 70% follow up for complex patients every 90 days
c. 70% non-medical determinants of healthcare access evaluation for new patients

5) Adopt Chronic Care Management billing codes on par with Medicare to support non-face-to-face care coordination for patients with chronic conditions.

Benchmarks

1) Number of training programs initiated. Outcome measures of these programs should include knowledge and comfort with IDD care and post-training practice.
2) Number of seed programs initiated. Outcome measures of these programs should include standardized quality metrics as above.
3) Rate of G2211 billing for patients with IDD diagnosis per year.

Meeting the complex medical and behavioral needs of persons with IDD served in IDD waivers and managed care programs

Background Enhanced services, coordination, and monitoring are not available to people with IDD and complex needs across all HCBS waivers and managed care programs. Access is limited by lack of funding to develop enhanced services, inadequate rates for service providers to hire and retain nursing and behavior support staff, and authorization and billing restrictions set by HHSC.

The 87th Legislature, through Rider 38, required HHSC to study the needs of people with high behavioral and medical needs and to define the scope of enhanced services through IDD waivers. Unfortunately, the study did not result in funding and initiatives for enhanced services to meet unmet needs. Additionally, HHSC implemented a Medically Fragile Project in the 1115 STAR+ HCBS Waiver program. The program bridges the gap for a very limited number of people with high nursing needs aging out of the Medically Dependent Children's Program (MDCP) program but does not address co-occurring behavioral needs

IDD SRAC recommends that the legislature, through funding and mandates to HHSC, address barriers to medical and behavioral home and community-based support for

people with complex and high medical or behavioral needs in HCBS waiver and non-waiver programs.

Recommendations

1. Fund private duty nursing in the IDD Waivers (HCS, CLASS, TxHmL, and DBMD) programs for medically fragile adults with parity to the STAR+HCBS waiver.

Benchmarks.

- HHSC completes cost analysis for inclusion of private duty nursing as an IDD Waiver benefit (HCCS, CLASS, TxHmL, DBMD) by August 2028.
- HHSC completes public notice and public comment period by June 2029
- HHSC submits request for an amendment to 1915 (c) HCBS Waivers (HCS, CLASS, TxHmL, DBMD) to add private duty nursing benefit by December 2029.

2. Fund essential services in the State Medicaid plan to support people with IDD and complex medical and behavioral needs.

a. Functional behavior assessment and management Board Certified Behavior Analyst (BCBA)
b. Positive behavior support therapy
c. Dental for adults including operative procedures and sedation in the outpatient or hospital setting
d. Orthotics necessary for ambulation
e. Speech Language Pathology
f. Communication Devices

Benchmarks:

- HHSC completes cost analysis for inclusion in the State Plan of essential service benefits supporting people with IDD and complex medical and behavioral needs by August 2028.
- HHSC completes public notice and public comment by June 2029.
- HHSC submits state plan amendment to US Department of Health and Human Services to add essential service benefits supporting persons with IDD and complex medical and behavioral needs by December 2029.

3. Fund the expansion of behavior, medical, and psychiatric health services that focus on preventing crisis and supporting families and providers of individuals who are at risk

of placement in more restrictive settings. Specifically consider the enhanced services previously defined by the SRAC and IDD Pilot Workgroup for IDD Waiver programs and non-Waiver programs.

a. Enhanced Medical Services
b. Enhanced Behavioral Therapeutic In-Home Respite
c. Enhanced Behavioral Therapeutic Out of Home Respite
d. Enhanced Behavioral/Family Caregiver Coaching Services
e. Enhanced Behavioral Extended Substance Use Disorder Services
f. Enhanced Behavioral Peer Supports

Benchmark: By September 2026, HHSC completes cost analysis for the development of the above listed enhanced services and includes a request for implementation in the 90th Legislative Appropriations Request (LAR),

4. Fund systemic changes that address barriers for individuals with high needs to access or maintain waiver and non-waiver services.

a. Complete the algorithm and implement the International Resident Assessment Instrument for Intellectual Developmental Disability (RAI-IDD). Develop and implement testing for the algorithm.
b. Develop and provide accurate and consistent administration and completion of the RAI-IDD assessment.
c. Develop resource allocation criteria that supports rates to meet individual needs determined by a person-centered service plan

Benchmark:

- HHSC completes algorithm project for implementation of the RAI-IDD Assessment by August 2027.
- HHSC completes the training curriculum for Direct Service Professionals (DSPs) serving persons with complex medical and behavioral needs by August 2027.
- HHSC completes rate analysis for enhanced rates for DSPs serving persons with complex medical and behavioral needs and requests rate increases in the 90th Legislative Appropriations Request (LAR).

5. Require HHSC to simplify eligibility processes for state plan Medicaid services and Community First Choice for person with IDD. Require HHSC to analyze the cost of eligibility processes for CFC being the same for LOC I and LOC VIII. LOC1 currently requires a DID; LOC VIII currently requires attestation by a physician, psychiatrist or

licensed psychologist). Require HHSC to develop and implement education and outreach programs to inform recipient of eligibility and access processes.

Benchmark

- HHSC appoints and coordinates a workgroup to study eligibility processes for in other states for state plan Medicaid services and CFC benefits by December 2025.
- By September 2027, HHSC workgroup submits recommendations for simplified eligibility processes for consideration in the HHSC LAR considerations for the 90th Legislature.
- Measure the number of completed educational and outreach services provided.

Data Needed. It was unclear if any data needs were identified.

The committee agreed to further investigate data availability for benchmarks and review distribution methods for the transportation brochure.

The next meeting was tentatively scheduled for January 21st, 2026, at 2:30 PM, with members asked to confirm their availability.

5. Public comment. No public comment was offered.

6. Review of action items and agenda items for next meeting.

Transportation brochure was approved and information on distribution is pending

Several Recommendations have data needs identified (*but it is unclear which ones*)

HHSC staff will review and implement plain-language edits to the NEMT brochure.

HHSC and committee members will research costs and logistics for broader brochure distribution, including digital and physical formats.

Collect baseline NEMT usage data and conduct a policy materials crosswalk across MCOs/waiver plans.

Pull and share previous committee recommendations related to CFC and assessment streamlining.

Gather CFC utilization data, stratified by age and service, and assess MCO/LIDDA member counseling practices.

Monitor impact of new legislative mandates on referral and uptake of CFC services.

The next meeting will be January 21, 2026

7. Adjourn. There being no further business the meeting was adjourned.