Health and Human Services

Intellectual and Developmental Disability System Redesign Advisory Committee

February 5, 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.

Intellectual and Developmental Disability System Redesign Advisory Committee advises on implementing an acute care services and long-term services and supports system redesign for individuals with intellectual and developmental disabilities.

The Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee (SRAC), created by Government Code, Chapter 534, advises HHSC on the implementation of the acute care services and long-term services and supports (LTSS) system redesign for people with intellectual and developmental disabilities. Chapter 534 requires HHSC to design and implement an acute care services and LTSS system for people with IDD that supports the following goals:

- Provide Medicaid services to more people in a cost-efficient manner by providing the type and amount of services most appropriate to the person's needs.
- Improve access to services and supports by ensuring that people receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for programs and services.
- Improve the assessment of each person's needs and available supports, including the assessment of functional needs.
- Promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment.
- Promote individualized budgeting based on an assessment of each person's needs and person-centered planning.
- Promote integrated service coordination of acute care services and LTSS.
- Improve acute care and LTSS, including reducing unnecessary institutionalization and potentially preventable events.
- Promote high-quality care.
- Provide fair hearing and appeals processes in accordance with applicable federal law.
- Ensure the availability of a local safety net provider and local safety net services.
- Promote independent service coordination and independent ombudsmen services.
- Ensure that people with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization.

Members:

Sheri Talbot (Chair)
Representative of Medicaid LTSS provider
Katy, TX

Susan (Sue) Burek (Vice-Chair)
Advocate for individuals with IDD receiving Medicaid waiver services or ICF services
Austin, TX

Linda Bailey
Representative of Medicaid LTSS provider or other Medicaid service delivery
Texarkana, TX

Kyle Cox
Individual with an IDD receiving services under the Medicaid waiver programs
College Station, TX

Jordan Drake
Representative of LTSS providers, including direct service workers (Medicaid managed care and non-managed care health care providers)
Lewisville, TX

Dr. Amy Foxman
Representative of LTSS providers, including direct service workers (Medicaid managed care and non-managed care health care providers)
Dallas, TX

Dr. Ellen Fremion
Representative of physicians who are primary care providers and physicians who are specialty care providers (Medicaid managed care or non-managed care health care providers)
Houston, TX

Gilda Gil
Advocate for individuals with IDD receiving services
El Paso, TX

Kimberly Lile Dowty
Representative of Medicaid LTSS provider or other Medicaid service delivery
Austin, TX

Carla Hughes
Representative of Medicaid non-managed care LTSS providers
Amarillo, TX

Charles Kerlegon
Representative of Community Mental Health and Intellectual Disability Centers
Richmond, TX

Dr. Fredrick McCurdy
Advocate for individuals with IDD receiving services
Corpus Christi, TX

Anna Yvette Moore-Simon
Advocacy organization for individuals with IDD receiving Medicaid waiver or ICF services
Duncanville, TX

Mark Olson
Advocate for individuals with IDD receiving waiver or ICF services
Boerne, TX

Linda Pemberton
Advocate for individuals with IDD receiving waiver or ICF services
Highland Village, TX

Gina Pena
Representative of Medicaid LTSS provider or other Medicaid service delivery
Corpus Christi, TX

Allan Turner
Advocate for individuals with IDD receiving services
Mansfield, TX

Janet Vega
Representative of Public ICF-IID
Laredo, TX

1. Welcome, call to order, introductions, opening remarks, and roll call. The meeting was convened by Susan (Sue) Burek, Vice-Chair. A quorum was present

2. Consideration of October 23, 2025, draft meeting minutes. The minutes were approved with a minor, nonsubstantive, amendment

3. Progress on timeliness and accuracy for processing Medicaid applications and renewals

Summary. Rachel Patton (Associate Commissioner) presented updates on the Medicaid application and renewal timeliness. She gave an overview of the Medicaid application process and decision timeline stating most clients manage accounts via "Your Texas Benefits"; electronic communication is optional but encouraged. The emphasis for recipients is on answering calls from HHSC and checking mail or electronic notifications for requests and updates.
Timeliness rate is 91%, with average days to decision being 49 days. Approximately 1,600 applications are pending the initial review. The federal timeframe is 45 days for standard cases, but disability determinations can take up to 90 days. HHSC has seen improvements in timeliness and reduced days to decision; If outliers or issues are identified, they should be reported for assistance. Renewal reconsideration period lasts up to 90 days but there are allowances for missed renewals to be reopened retroactively if documents are submitted.

The challenges in timely application processing stem mainly from difficulties contacting applicants and obtaining required information, especially during business hours.
Data sources are used to verify as much as possible, but certain federal requirements necessitate original documentation. Issues with the Form 1200 portal include lack of clarity for applicants identifying the specific type of assessment or waiver needed, with a suggestion made to improve the form interface.

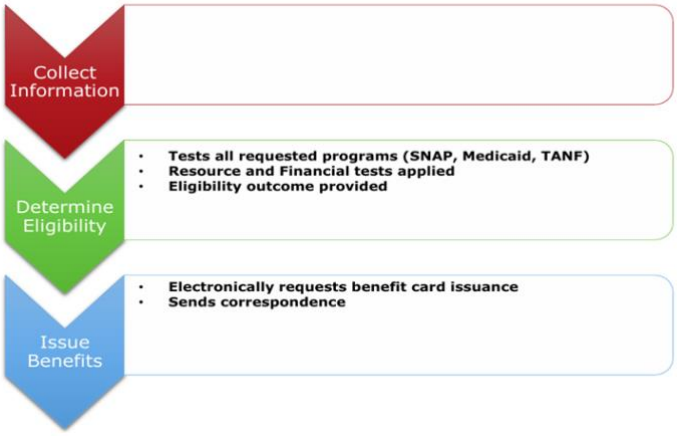
There were no noted disparities in processing between rural and urban applications; system is designed for statewide consistency. There are expected changes to Medicaid and SNAP eligibility processes due to federal policy updates, with SNAP changes effective earlier and Medicaid requirements delayed until 2027.

Suggestions were made to add fields for ABLE accounts and special needs trusts to application forms for clarity.

There are Medicaid, Waiver, and CDS Process Gaps. Families express difficulty in understanding denial reasons and Medicaid loss, especially regarding Disabled Adult Child (DAC) status. Application reconsideration policies exist, but timeframes and procedures vary; further information will be shared with stakeholders. Staff are being trained to improve DAC identification and support. Members made suggestions to improve forms' clarity (e.g., ABLE account designation, special needs trust distinction) to ease processing and improve staff efficiency were noted.

Presentation.

Medicaid Application Process



Your Texas Benefits Account: **Apply, Manage, and More** Your Texas Benefits offers a convenient way to apply for and manage benefit programs such as:

- SNAP Food Benefits
- TANF
- Medicaid
- CHIP

With a Your Texas Benefits account, you can access features such as:

1. Upload documents
2. Check your case status
3. Report changes
4. Print Medicaid cards
5. Sign up for email or text alerts Agenda Item #3

To learn more about the benefits, visit YourTexasBenefits.com

Additional Ways to Stay Connected and Informed

2-1-1 (Option 2) You can also contact 2-1-1 or 1-877-541-7905 for help with questions about your case or application, or to receive other support you may need. After you pick a language, press 2.

Answer calls from the State of Texas an Eligibility Advisor may contact you regarding your application. When they do, the caller ID will display “State of Texas”.

Watch for mail from HHSC Keep an eye out for letters and notices from HHSC, such as:

1. Requests for additional information or documents
2. Notifications about your benefit status
3. Renewal reminders
4. Other important updates that may require your response

Medicaid Application Timeliness (91%)
49 --Median number of days to process
1671-- Uninitiated applications in queue

Renewal Reconsideration Period If a client misses their renewal submission deadline, HHSC can reopen the case effective the first day of the month the renewal is received, as long as it is submitted within the program's reconsideration period:

Medicaid – Submit within 90 days of the deadline. Example: Deadline Nov 8 →Renewal received by Feb 6 → Coverage retroactive to Feb 1.

If a client submits the renewal on time but fails to provide additional requested information, they may still submit that information within the same 30-, 60-, or 90-day reconsideration period for that program.

Discussion

What are the barriers to more timely processing applications> HHSC stated the ability to reach the person or their representative. They utilize data sources but there are some things that need verification.

Is there any revisiting of having workers being located at LIDDAs? HHSC stated they would take this back.

Changes must make sense for the end users. They want a determination of how long SSA takes to make a decision.

Are there disparities based on geographical data? HHSC states that there will be outliers and there are no trends they have found.

Are there any changes to eligibility processes? There are SNAP changes that will be implemented. The Medicaid requirements are coming later.

Is there an application re-consideration period? HHSC stated that it depends on the time period?

ABLE Accounts. There is nothing on the application form designating is an ABLE account needs addressing. Also, a special needs trust is different from other trusts and that should be a separate question on the application form.

The form should be fixed so it is clear (plain English) why they have lost Medicaid coverage.

4. Administrative versus direct portion of direct care attendant rate and flexibility for providers

Summary. There was discussion of Rider 23's implementation, which increased the base assumption for attendant hourly wages to $13 and set a 90% expense target for direct care compensation. Clinical supervision costs will shift to the attendant component, aligning with federal Medicaid access rules. Certain costs (transportation, staff training, PPE) are now excluded from the direct care component and considered administrative. Providers must submit biennial cost reports that pre-populate revenue and service data. There is compliance monitoring but there is also no penalty for missing the 90% threshold.

Wage policy changes prompted concern among providers and advocates about adequacy of funding, staff shortages, and the practical impact on actual wages.

On September 1, 2025, HHSC implemented:

- New rates for attendant services were effective for dates of service on or after September 1, 2025.
- Updated reimbursement methodologies for certain services, including attendant services under Rider 23.

Presentation.

Establishment of Average Hourly Wage
2026-27 General Appropriations Act (GAA), Senate Bill 1, 89th Legislature, Regular Session, 2025 (Article II, Rider 23)

Effective 9/1/2025

- Average wage of $13.00 per attendant hour assumed in the billing unit.
- 14 or 15 percent increase for payroll taxes and Medicare/Federal Insurance Contributions Act (FICA) taxes and benefits.
- $0.24 per hour increase for the administrative rate component.
- Establish direct care wage and benefits expense ratio

End Date of Personal Attendant Base Wage ¬ The requirement to pay a base wage to personal attendants ended on August 31, 2025 when 1 TAC Section 355.7051, concerning Base Wage for Personal Attendants, was amended.

Direct Care Staff Wage and Benefits Expense Ratio ¬ Providers are required to spend at least 90 percent of attendant revenue on attendant compensation. There is no base or minimum wage requirement to personal attendant staff. The claims process for attendant services reimbursement will not change.

90% Determination. Rider 23(c) requires HHSC to calculate for each provider:

- Total amount paid to the provider that is attributable to the direct care wages, payroll costs, taxes, and benefits;
- The amount expended by the provider for that purpose; and
- The provider's ratio of direct care expenses to revenue.

- HHSC will use the following calculation to determine if the 90 percent spending threshold is met:
- Total Attendant Care Expenses / Total Attendant Care Revenue >= 90%

It is HHSC's intention to align the definition of the attendant cost component with the Centers for Medicare & Medicaid Services (CMS) Final Rule, relating to Ensuring Access to Medicaid Services. As such, HHSC will ensure that revenue for clinical supervision is shifted to the attendant component from the other direct care component or support services component, as applicable.

Excluded Costs 1 TAC §355.7052(c)(3) The following costs are not included in the calculation of the attendant cost center:

- Costs of required trainings for direct care or personal attendant workers;
- Travel costs for direct care or personal attendant workers, including mileage reimbursement or public transportation subsidies;
- Costs of personal protective equipment for direct care or personal attendant workers.

Cost Reporting Requirements ¬ The biennial cost reports will be used to determine if the provider meets the attendant care expense ratio. The cost report will contain prepopulated revenue and units of service line items. Providers are required to verify the prepopulated line items and enter attendant expenses on the cost report. HHSC will calculate whether the provider spent at least 90 percent of attendant revenue on attendant compensation. This calculation will be based on the cost report and applicable attendant services data during the cost reporting period

Legislative Reports ¬ HHSC shall report to the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House of Representatives, and the Office of the Governor on an annual basis by November 1 of each year on the findings, including a list of providers whose calculated direct care staff wage and benefits expense ratio is less than 0.90. Although HHSC has been directed to identify providers who do not meet the attendant care expense-to-revenue threshold of 90 percent, there is no provision in the rider for HHSC to pursue recoupments.

HHSC has published the following Information Letters related to Rider 23:

- IL 2025-25: Rider 23: Texas Administrative Code Rule Amendments, Personal Attendant Base Wage Discontinuation, Rate Enhancement Discontinuation, Established Average Hourly Wage Assumed in Methodology, and Established

Direct Care Wage and Benefits Expense Ratio, effective September 1, 2025 (.pdf) il2025-25.pdf

- IL 2025-24: (.pdf) (Replaces IL 2025-17) Payment Rate Actions for Attendant Services in Various Programs, effective September 1, 2025 il2025-24.pdf

HHSC has also published cost report information and the new web-based application, STEPS.

- Transition to the State of Texas Electronic Provider System | Provider Finance Department
- PFD Cost Report Information | Provider Finance Department

PFD LTSS Webpage https://pfd.hhs.texas.gov/long-term-services-supports

Discussion.

What was the rate before the 90% rate? HHSC stated there is a distinction between a rate and a wage. The current rate provides the base wage of $13,00. There was no requirement on the base rate. The add on was eliminated through rider 23.

Will there be a positive impact for PCAs? HHSC stated that this will provide the legislature will have more data moving forward.

Is there any penalty or remedy? HHSC stated this is just data collection on who can meet the 90 percent.

We struggle to provide staff. We are being asked to pay $13 per hour when other industries provide more and we have many more rules to adhere to.

5. HHSC utilization review processes

The Texas Health and Human Services Commission (HHSC) implemented processes for Utilization Review (UR) in the Community Care Services Eligibility (CCSE) Services, effective March 1, 2009.

The UR process for CCSE includes concurrent reviews of a random sample of cases for people receiving:

- Primary Home Care; and
- Community Attendant Services (CAS).

A concurrent review is a UR of an ongoing service where the cases are randomly selected. They do not occur during the application process.

5110 Concurrent Reviews of Randomly Selected Active Cases
Revision 24-3; Effective July 1, 2024
Concurrent reviews are conducted on a random sample of active Primary Home Care (PHC) and Community Attendant Services (CAS) cases. The utilization review nurse contacts the caseworker and requests all or a portion of the documentation specified for the review. The caseworker provides the documentation within seven calendar days of the request. Depending on available information, the UR nurse may make a home visit or a Home and Community Support Services agency visit in addition to a desk review.

Staff responded to previously asked questions by reading from a computer screen and not providing the written materials to the public. There have been no changes to processes over the last few years. This information was difficult to follow and should have been provided as a written handout.

- No major changes to utilization review (UR) process in recent years, but ongoing challenges around case manager and provider compliance with timely submission of renewal documentation.
- Specific deadlines for IPC (Individual Plan of Care) submission differ by program, with follow-up timelines being implemented if HHSC requests more information.
- HHSC cannot approve partial renewals; all services are put on hold until UR is complete, creating gaps in care especially for those using Consumer Directed Services (CDS), as agencies (not CDS employers) are reimbursed for retroactive service.
- Comments highlighted the need for UR process transparency, improved training for case managers/providers, and potential system simplification.
- Appeals are only available if services are reduced or denied, not for delays; ombudsman and complaint lines are available for recourse.
- Public and member comments are requested related to policy changes to allow continuation of approved services during partial UR holds. There is prioritization of urgent cases to avoid life-threatening service lapses and also greater accountability for provider and LIDDA compliance.

Discussion

Does HHSC monitor LIDDA performance for getting data into the system? HHSC stated submissions are monitored and also by TMHP. As far as meeting the requirements, the information is captured.

HHSC stated they are monitoring internal performance. HHSC stated that the most common remand reasons are numerous and are related to omitted information. LIDDA compliance is not part of the utilization process. There is a need for better trained service coordinators.

For CLASS and DBMD the provider has to pay for 180 days. Does that also apply to CDS? HHSC stated it is just agency and not CDS. The subject matter expert stated this seems discriminatory and HHSC should revisit this. There should be a safeguard during the recoupment process.

A request was made to send the information in writing. (Texas Insight says "AMEN).

Would HHSC allow all services to continue and only put a hold on the one service that has not been approved by HHSC. There are waiver recipients who experience a delay in getting one of the services approved even though the others are approved but are placed on hold. People are experiencing trauma being forced to wait. Please expedite the unapproved services by the beginning of the budget year.

Is HHSC monitoring compliance for any of the agencies that are late in submitting documents? Putting them on hold?

It was suggested to look at what is causing the IPCs to be delayed.

There are wide differences among the performance of the agencies. Is there a place in HHSC where a grade is given for the IPCs performance? HHSC stated that HHSC does not have that. That is an interesting idea. There used to be a provider audit report and there has not been a replacement.

There has been an increase in utilization reviews and there may be a new policy on this related to CLASS and DBMD. HHSC stated that there has not been a change in the reviews for CLASS and DBMD. Some questions may have changed.

Is there any way waiver recipients can elevate their renewal if it has not been approved by the beginning of the budget year?

6. HHSC updates

Summary. ABLE accounts offer tax-advantaged savings for people with disabilities, now available to those with disability onset up to age 46; funds excluded from resource limits for SSI/Medicaid up to $100,000. Set-up and administration of the accounts is via the Texas Comptroller; questions regarding management and transfer should be directed to that office. Stakeholders requested clearer policy guidance for HHSC eligibility staff on ABLE account documentation, and comparisons between Texas and other states' ABLE processes would be helpful. .

There are issues with using out-of-state ABLE accounts for Texas Medicaid eligibility and were discussed, with a reminder that appeals are possible. HHSC is reconvening a work group to review the impact of off-site individualized skills and socialization (ISS) staff ratios, with additional requests to also review on-site ratios due to concerns about participant access.

Presentation.

Achieving a Better Life Experience (ABLE) account expansion.

Achieving a Better Life Experience (ABLE) programs allow eligible individuals to establish tax-free savings accounts for the designated beneficiary's disability-related expenses. ABLE account funds can be used for the individual's disability-related expenses.

Benefits of an ABLE Account Certain contributions to an ABLE account are not considered income to the beneficiary. Interest and dividends earned on an ABLE account are countable as unearned income. Up to, and including, $100,000 in the person's ABLE account is excluded from being treated as a countable resource for Supplemental Security Income (SSI) benefits calculations.

The Texas Achieving a Better Life Experience (ABLE) Program is administered by the Prepaid Higher Education Tuition Board, which is part of the Comptroller's Office.

Texas ABLE Program - Eligibility The person must self-certify under penalty of perjury that the designated beneficiary of the account is an eligible individual under Internal Revenue Code, §529A. (34 Texas Administrative Code (TAC) §7.183(c)(3)) The beneficiary or their authorized representative must agree to provide any documents supporting his or her eligibility.

- Be a Texas resident.
- Have a disability present before age 46. (Effective 1/1/2026, eligibility expanded from age 26 to age 46).
- Be able to provide evidence of disability**.**

Resources:

- Texas ABLE | Savings Program for Texans with Disabilities
- 34 TAC 7
- Texas Constitution and Statutes Education Code Chapter 54
- Spotlight On Achieving A Better Life Experience (ABLE) Accounts | Supplemental Security Income (SSI) | SSA

Discussion.

Is there data on number enrolled on Texas ABLE? HHSC stated that they could ask the Comptroller's Office for that.

When a provider opens an ABLE account they "own the account. What happens when the person leaves their care? HHSC stated that is a question for the Comptroller.
Texas ABLE | Savings Program for Texans with Disabilities
How Do I Open An Account - ABLE National Resource Center

Presentation.

Individualized skills and socialization services ratios workgroup.

SECTION 262.917. Staffing Ratios for Off-Site Individualized Skills and Socialization, SUBCHAPTER J. INDIVIDUALIZED SKILLS AND SOCIALIZATION, CHAPTER 262. TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC), PART 1.

HEALTH AND HUMAN SERVICES COMMISSION, TITLE 26. HEALTH AND HUMAN SERVICES, Texas Administrative Code

HHSC Individualized skills and socialization services ratios

The ratios for off-site individualized skills and socialization services are as follows:

- **1:8**: One service provider to eight individuals with an LON 1 or LON 5 without an enhanced staffing rate.
- **1:2**: One service provider to two individuals with an LON 8 or LON 6.
- **1:2**: One service provider to two individuals with an LON 1 or LON 5 with the l evel one enhanced staffing rate.
- **1:1**: One service provider to one individual with an LON 1, LON 5, LON 8, or L ON 6 with the level two enhanced staffing rate.
- 1:1: One service provider to one individual with an LON 9.
- These ratios may include individuals with different levels of need and other persons receiving similar services. The lowest staffing ratio applicable to the individuals represented in the ratio must be used.

Individualized Skills and Socialization

The Individualized Skills and Socialization Provider page is an online source of information for providers of Individualized Skills and Socialization. This page allows providers to:

- Complete trainings on the Individualized Skills and Socialization service;
- Review Provider Letters and Information Letters along with other releases related to Individualized Skills Socialization, and
- Find links to rules and other services related to Individualized Skills and Socialization.

Texas DAHS Directory with Individualized Skills and Socialization Providers

Directories of DAHS facilities, including those that provide DAHS with Individualized Skills and Socialization and DAHS Individualized Skills and Socialization Only can be found at Day Activity and Health Services (DAHS).

Provider Communications

- News
- Information letters (ILs) and provider letters (PLs)

Provider Training

Individualized Skills and Socialization Provider applicants are required to complete HHSC Individualized Skills and Socialization Provider Training as well as training on the use of the TULIP application.

Prelicensure Training for Individualized Skills and Socialization Providers

This training was designed for providers who wishes to offer individualized skills and socialization services. Prior to surveys, an entity must make an application for a Day

Activity and Health Services (DAHS) license. You will learn information about the requirements to obtain a license.

Preparing for a Survey

This training was designed to assist Individualized Skills and Socialization Providers prepare for a survey. In this course, you will review the survey process and identify the licensure rules.

TULIP Navigation and Application for Individualized Skills and Socialization Providers

This training was designed to assist Individual Skills and Socialization Providers in completing the TULIP Licensure Application. In this course, you will review the steps required to create an account in TULIP and apply for a provider license.

Provider Webinars

- November 2022 – This webinar goes over the provider responsibilities, survey process, and TULIP application for Individualized Skills and Socialization providers.
    - Individualized Skills and Socialization Services Webinar
    - Individualized Skills and Socialization Services Webinar (PDF)
- July 2022 – This webinar covers the service description, ratio requirements, and licensing information based on HHSC's draft individualized skills and socialization rules.
    - Individualized Skills and Socialization Services Webinar
    - Individualized Skills and Socialization Services Webinar (PDF)
- January 2022 – This webinar provides an introduction and overview to Individualized Skills and Socialization.
    - Individualized Skills and Socialization Services Webinar
    - Individualized Skills and Socialization Services Webinar (PDF)

IDD and PI Quarterly Webinars

- Oct. 29, 2025 – Webinar Recording | Webinar Presentation (PDF)
- July 30, 2025 – Webinar Recording | Webinar Presentation (PDF)
- April 30, 2025 – Webinar Recording | Webinar Presentation (PDF)

Rules

- Texas Administrative Code, Title 26, Part 1, Chapter 559, Subchapter H: Individualized Skills and Socialization Provider Requirements
- Texas Administrative Code, Title 26, Part 1, Chapter 260: Deaf Blind with Multiple Disabilities (DBMD) Program and Community First Choice (CFC), Subchapter I
- Texas Administrative Code, Title 26, Part 1, Chapter 262: Texas Home Living (TxHmL) Program and Community First Choice (CFC), Subchapter J
- Texas Administrative Code, Title 26, Part 1, Chapter 263: Home and Community-based Services (HCS) Program and Community First Choice (CFC), Subchapter L

The ratios seem to have been impeding participation, and the work group will be reforming at the end of this month to address the problems.

7. HHSC's legislative biennial report on implementation, as required by Texas Government Code, Section 542.0054.

HHSC feedback and updates on IDD SRAC's priority recommendations and data request

Overview of IDD SRAC NEMT Recommendations. Nine of the prioritized IDD SRAC recommendations relate to NEMT and HHSC has completed some of these:

- Aligning NEMT policies and access across service delivery models
- Resolving differing requirements for NEMT services
- Implementing online scheduling and communication for transportation systems
- Ensuring timely access to Medicaid transportation benefits

HHSC NEMT Completed Activities

Collaboration with Managed Care (CMC) Subcommittee Recommendation 19: Align NEMT policies and access in fee-for service (FFS) Medicaid with managed care policies and access. Ensuring that FFS and managed care policies are aligned and consistent across service delivery models, including implementation of Managed Care Organization (MCO) contract requirements for NEMT.

CMC Recommendation 20: Monitor call center hold times for NEMT to assure timely access to Medicaid transportation benefits and assure that MCOs and FFS provide reports quarterly to HHSC. FFS and MCO members should have access to call centers beyond standard workday hours.

- Calls cannot be answered by an answering service during business hours.
- Quarterly reports are required for compliance to monitor call center standards.
- Individuals can request rides or check ride status through "Where's my Ride" from 5am to 7pm, Monday through Saturday.

CMC Recommendation 21: FFS and MCO members should have access to on-line 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. MCOs must offer an online reservation system.

HHSC is evaluating six NEMT recommendations for potential solutions.
CMC Recommendations 17 and 18 require changes and distribution of the NEMT brochure. } HHSC is analyzing content addition to ensure applicable compliance to NEMT and HHSC policy. } HHSC is reviewing potential websites to assess accessibility considerations prior to brochure distribution.

CMC Recommendations 22, 23, and 24 contemplate loadable debit cards for ITP reimbursement and streamlining the ITP application process. This item is currently under review.

CMC Recommendation 25 discusses attendant care needs during NEMT service provision. This item is currently under review.

Discussion. No discussion

Committee discussion on legislative report timeline

Background: Throughout June 2025, each subcommittee considered House Bill 4666, 89th Legislature that changed the frequency of several HHSC legislative reports, including the annual report of the IDD SRAC's recommendations to the legislature. The legislation changed the frequency from every year to every even-numbered year. Subcommittees worked on recommendations for the 2025 annual report during May and June. IDD SRAC members considered this change and recommended that the subcommittees continue to work on the agreed upon recommendations with submission for the 2026 biennial report.

Review of Draft Recommendations: Request Subcommittee Co-Chairs to review draft recommendations.

Discuss Proposed Timeline for Recommendations for the 2026 Biennial Report:

August - September: Subcommittees identify information and data needed from HHSC to support the recommendations and focus on system redesign.

October: IDD SRAC consider information and data presented by HHSC.

November - December: Subcommittees prioritize the recommendations, reducing the number of 'asks' to the Legislature.

January: IDD SRAC agrees to prioritized recommendations and consider information and data presented by HHSC.

February - March: Subcommittees develop and finalize the format and organization of the recommendations for the 2026 biennial report.

April: IDD SRAC agrees to the recommendations format and organization and consider information and data presented by HHSC.

May - June: Subcommittees finalize recommendations for consideration and approval by IDD SRAC.

July: IDD SRAC approves recommendations for the 2026 biennial report.

Approval: IDD SRAC members voted on July 24, 2025, to approve the proposed timeline for recommendations for the 2026 biennial report.

There are limitations on the data. Claims data will not be available for 2026. Data from 2025 will be available in May. Authorization of services data and utilization data were requested. Utilization data is available, but authorization data has to come from the HMOs. Prioritization of the committee data request was requested by HHSC due to the amount and size of the request.

8. IDD SRAC subcommittees updates

System Adequacy—meeting cancelled due to weather (winter storm)

Collaboration with Managed Care-- meeting cancelled due to weather (winter storm) meeting cancelled due to weather (winter storm)

Meaningful Skills Development and Employment Services—The subcommittee wants to look at those who are not receiving services and will be following up on the possibility to look at community first choice.

Public comment.

Linda Litzinger, Texas Parent to Parent commented on items 4,5, and 6.

- CLASS wages are so low people are choosing CDS to provide a dollar more. CLASS is still at $12.
- Utilization review policy is bumping against other policies, and this causes a pause. The prohibition on paying loans creates a problem with attendants having to wait for payment. Continuous payment should be made no matter who. Since CLASS is not viable, move it from the exception budget. It is always an exceptional item.
- Regarding the ABLE account, out of state accounts are being denied Medicaid due to HHSC misunderstanding. Medicaid is eventually reinstated
- ISS level of need ratios creates a huge problem with being able to pay workers.

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

Next meeting April, 30th

Agenda Items:

- Medicare presentation and dual eligibility
- Interest list data
- Waiver slot release plan
- TxHML waiver renewal
- The questionnaire update about the interest list
- Data available supporting the biennial report
- Changes to Medicaid Policy impacted by federal policy changes. (SNAP, work requirements for care givers)
- Update on Sunset Review Process

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

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