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HEALTHCARE INTELLIGENCE

# Health and Human Services

# IDD SRAC | Collaboration with Managed Care Subcommittee

# April 22, 2026

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*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.*

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**Members of the Subcommittee:**

**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

**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)

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

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

## 1. Welcome, call to order, introductions and roll call

The meeting was convened by the Chair, Ellen Fremion. ,

**Members present.**
Ellen Fremion, Fredrick McCurdy, Sheri Talbot, Sue Burick, Linda Pemberton

A quorum was present.

## 2. Consideration of October 1, 2025, subcommittee draft meeting minutes.

The minutes were approved as drafted

## 3. IDD SRAC CMC discussion on data needed from HHSC to support the recommendations and focus on system redesign

HHSC presented a table outlining their response to the data requests by the subcommittee. (Tables were collected from screen shots and may be difficult to read). They also may not be complete. Further down in the report are the data tables that HHSC were able to provide, in detail.

| Committee | Requested Timeframe | Recommendation | Data Indicator | Requested Data | HHSC notes |
|---|---|---|---|---|---|
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | NEMT | Network Capacity | By MCO, number of contracted NEMT providers<br><br>By MCO, number of contracted NEMT providers that bill services | For utilization data, only 2024 data is available at this time. 2025 data will be available in May 2026. 2026 data is not yet available.<br><br>There will be limitations for this because not all NEMT service providers will be contracted with an MCO. For example, Uber and Lyft providers do not contract with the MCO.<br><br>Refer to Tab 1. NEMT (HHSC Data) |
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | Increase Community First Choice (CFC) Utilization | Customer Experience: Trends in Utilization | By Region:<br>Number of children authorized for CFC<br>Number of adults authorized for CFC<br>Number of waiver participants<br>Number of non-waiver participants<br>Number of non-waiver CFC participants | HHSC cannot provide authorized data. Additionally, the focus of this request is "trends in utilization". HHSC assumes that the committee is requesting utilization data.<br><br>HHSC is unable to share the utilization broken out by region because of small utilization rates. Can discuss during subcommittee meeting<br><br>For utilization data, 2026 data is not yet available.<br><br>Refer to Tabs 2c-2e of this workbook |
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | Expand capacity for mental and behavioral health care services | Establish Baseline: Network Capacity | Number of waiver participants authorized for behavior supports<br><br>Number of waiver participants utilizing behavior supports | HHSC cannot provide authorized data.<br><br>For utilization data, 2026 data is not yet available<br><br>Refer to Tab 3 - Behavior Support Services |
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | Increase Community First Choice (CFC) Utilization | Network Capacity | Number of persons/units authorized for CFC services by MCO<br><br>Number of CFC services utilized for persons/units by MCO | Pending - Data will be sent when it has been received from MCOs |

## Still Waiting on Information

leeded/ Received:

| Committee | Requested Timeframe | Recommendation | Data Indicator | Requested Data | HHSC response |
|---|---|---|---|---|---|
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | Non-Emergency Medical Transportation (NEMT) | Customer Experience: Challenge Accessing NEMT | Number of people with authorized NEMT services | Request sent to MCOs for data for on-time pick-ups and on-time drop-offs, cancellations, and delays for demand response Non-Emergency Medical Transportation (NEMT) services for FY 2024, FY 2025, FY 2026 1st and 2nd Quarter. |
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter<br><br>*Note from HHSC: For utilization data, only 2024 data is available at this time. 2025 data will be available in May 2026. 2026 data is not yet available.* | NEMT | Customer Experience: Challenge Access NEMT | Number of people utilizing NEMT services | |
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter<br><br>*Note from HHSC: For utilization data, only 2024 data is available at this time. 2025 data will be available in May 2026. 2026 data is not yet available.* | Increase Community First Choice (CFC) Utilization | Customer Experience: Challenge Accessing CFC | Number of people authorized by LOC 1 (DID) for CFC services<br><br>Number of people authorized by LOC 8 (physician attestation) for CFC services | HHSC can provide utilization data for these populations but not authorization data. |

**Unable to Provide**

| Committee | Requested Timeframe | Recommendation | Data Indicator | Requested Data | HHSC response |
|---|---|---|---|---|---|
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | Increase Community First Choice (CFC) Utilization | Customer Experience: Accurate Assessment of CFC Needs | Number of individuals IMCO and LIDDA staff) trained | If the committee is asking for the number of people qualified to conduct assessments for CFC needs, then HHSC would need to request that information from each LIDDA and each MCO. It is also unknown if that information would be available. Consider removing from request or de-prioritizing. |
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | Expand capacity for mental and behavioral health care services | Establish Baseline: Network Capacity | Number of training grants to train health care providers to care for behavioral health needs for people with IDD | HHSC does not offer such grants and therefore would not have this information. |
| CMC | FY 2024, FY 2025, FY 2026 1st and 2nd Quarter | Expand capacity for mental and behavioral health care services | Establish Baseline: Network Capacity | Number of training grants to train healthcare providers to provide comprehensive primary care for people with IDD | HHSC does not offer such grants and therefore would not have this information. |

**As reference for discussion, *Determination of Intellectual Disability-- DID***

HHSC shared a data workbook supporting the subcommittee's draft recommendations; most available data covered state fiscal years 2024 and 2025, with FY 2026 not yet finalized/released. "Unable to provide" items included: number of workers qualified to do CFC assessments (not tracked centrally; would require self-reported LIDDA/MCO data with potential quality issues), and information on grants for training healthcare providers (HHSC indicated they do not offer/track these grants).

Data limitations were repeatedly tied to privacy/small numbers (suppression when counts are under ~30) and the difference between utilization data vs. authorization data. Other limitations:

NEMT: provider counts are incomplete because some NEMT modes (public transit, Uber/Lyft where used) don't directly contract with HHSC/MCOs; utilization/billing may be visible, but "provider counts" are not a reliable measure. The initial NEMT worksheet had an issue and would be corrected and sent back to the subcommittee.

**Workgroup 1: Recommendations to address increasing CFC Utilization and Improved 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 (IDRC) 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.

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. 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.

8. Timeliness and simplification...with benchmark(s)....



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***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….

*The group discussed adding a recommendation to improve ongoing tracking of "assessors vs. people receiving CFC" since the workforce data isn't currently tracked.*
*HHSC emphasized that they generally can provide utilization, but not reliable authorization data for fee-for-service/waiver programs; managed care authorization data must be requested from MCOs and would be shared once complete.*

*Because of HIPAA concerns, small denominators prevented sharing some regional breakouts, especially for smaller programs (e.g., DVMD) and in some regions for CLASS, HCS, and Texas Home Living.*

*HHSC clarification: People who are in a waiver, you do not have to do another assessment for CFC. STAR Plus is different however because though it acts like a C waiver, but it is not a C waiver.*

*STAR+PLUS non-HCBS / STAR Kids non-MDCP = people not enrolled in another waiver; if in CLASS/HCS/DBMD/etc., they would be counted in those waiver categories.*

*Discussion underscored urgency for CFC access among STAR+PLUS/STAR Kids "non-waiver" members because they lack other habilitation options and may otherwise face long wait lists.*

*Work group interest centered on whether DID (**Determination of Intellectual Disability**) assessments are a barrier to timely CFC eligibility determination and whether IDRC (related conditions tool/attestation pathway) can reduce delays.*
*Elizabeth Tucker described the DID as resource-heavy and slow; asked for counts of people found eligible via DID vs. IDRC to assess how often the faster pathway could be used. HHSC agreed to look more closely at DID vs. IDRC eligibility breakdown.*

*As a practical workflow suggestion, it was suggested to include a related-condition physician attestation indicator in MCO referrals to LIDDAs so LIDDAs can prioritize the quicker IDRC route when appropriate.*

*SME input suggested a substantial portion of individuals presenting for services may have related conditions (autism cited as increasingly common), potentially enabling faster CFC entry via attestation/IDRC while still pursuing DID for other program eligibility as needed.*

*SME asked for total counts of people in each category (e.g., total CLASS under/over 18, etc.) to compute what percentage receive CFC. HHSC noted similar waiver enrollment counts were likely pulled for another subcommittee (System Adequacy), and HHSC could align those data for comparison.*

*The "all waiver services" tab (see data breakout provided by HHSC below) was described as utilization-based unduplicated client counts (not necessarily "enrollment"), and HHSC noted they could pull enrolled data if needed.*

*A concern was raised about a STAR Kids non-MDCP number in the waiver services table not aligning with known STAR Kids population totals; HHSC agreed to follow up.*

*There was confusion and discussion concerning STAR+PLUS HCBS and CFC. HHSC explained the STAR+PLUS HCBS "outlier" situation is tied to federal eligibility group rules and that, in some scenarios, attendant services may be delivered through STAR+PLUS HCBS rather than CFC due to eligibility/funding stream constraints. Members asked for examples where someone appears eligible (e.g., SSI) yet is not receiving attendant services through CFC; HHSC requested those cases be shared for follow-up*.

**Workgroup 2: Recommendations to address education on non-emergency medical transportation benefits.**

**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



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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 non-routine 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).

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.

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



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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.

**Benchmarks**

1. HHSC will revise and update both the brochure and the webpage.
2. HHSC will revise the webpage "drop down" menu as noted in the recommendations.
3. HHSC will make the brochure widely available in multiple formats.
4. HHSC will clarify and expand the definition of what is allowed when a beneficiary requires assistance.
5. HHSC will align the NEMT policies across all Medicaid products.
6. HHSC will collaborate with MCOs and FFS to enhance 24/7/365 call center access.

*HHSC noted additional NEMT data from MCOs, including performance standards (on-time pickups, completed trips, cancellations, delays) for demand-response transportation. The subcommittee discussed practical barriers when rides are late (clinic no-shows, access-to-care impacts) and interest in real-time scheduling/notifications.*

*Members asked about an "app" for requesting rides; HHSC said MCOs are required to have an online reservation system (not necessarily an app) and offered to ask MCOs to share details/features.*

*A prior HHSC response about potential funding needs for printing/distributing NEMT brochures had not been provided; HHSC agreed to follow up*.

**<u>Expanding capacity for mental and behavioral health care services</u>**

**Recommendation**

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 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. Behavioral support payment should have parity with adult psychosocial counseling/cognitive behavioral therapy payment or 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.

*Add a recommendation for collaborative care models. Dr. Fremian suggested adding a recommendation to expand the Collaborative Care Model (integrated behavioral health within primary care) and noted an existing pilot. Policy Council for Children and Families report also supports increasing collaborative care models.*

**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) Healthcare utilization and quality metrics for clinics under value-based care agreements.

**Identify and Develop Acute Health Care Initiative**

**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.

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% social determinants of health 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.[3]

**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.
4) Number of practices value-based agreements and comparison of hospital and emergency room encounters for individuals with IDD established with value-based care providers vs encounters for those not established with value-based care providers).
5) Frequency of billing codes submitted. Cost of CCM and comparison of utilization costs for practices with high versus low CCM billing.

*There is continued support for training programs to increase clinicians knowledgeable in IDD care across the lifespan. Interest was expressed in enabling non-face-to-face care coordination (e.g., chronic care management billing concepts/value-based approaches) to support complex care*.

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

**Recommendations**

1. Fund the inclusion of 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 persons with IDD and complex medical and behavioral needs.

a. Functional behavior assessment by BCBA
b. Positive behavior supports
c. Dental for adults
d. Orthotics necessary for ambulation
e. Speech Language Pathology
f. Communication Devices
g. Assessments and training

**Benchmarks**:

- HHSC completes cost analysis for inclusion in the State Plan of essential service benefits supporting persons 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



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

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 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. Assessment (RAI-IDD), improving the authorization of services that best meet the complex needs of adults and children
b. Staff Training
c. Rates

**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).

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~~5.Fund expansion of behavior, medical, psychiatric health, and other recent program efforts that focus on preventing crisis and supporting families and providers of individuals who are at risk of placement in more restrictive settings~~.

6.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 LOCVIII. LOC1 currently requires a DID; LOCVIII currently requires attestation by a physician, psychiatrist or licensed psychologist).Consider allowing like processes for persons qualifying for services based on LOC1 and LOC VIII.

**Move Recommendation 6 to the Work Group 1 Document**

**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.

~~Benchmarks~~

~~1. Number of completed educational and outreach services provided.~~

~~2. Consider benchmarks from HHSC for STAR Kids and CFC.~~

*Members discussed revising language from "private duty nursing" to clearer terms (e.g., "direct nursing"/nursing services aligned to need), to avoid confusion with pediatric state plan PDN and EPSDT.*

*individuals with significant medical needs may feel forced to move from IDD waivers (e.g., CLASS/HCS with critical residential supports like host home) to STAR+PLUS to access sufficient nursing, risking institutional placement when STAR+PLUS doesn't meet residential support needs. HHSC noted waiver cost neutrality requirements (waiver costs cannot exceed institutional cost thresholds); changes could require waiver amendments and analysis, and potentially CMS interaction depending on the magnitude.*
*Committee noted that while the impacted population may be relatively small, the consequences are severe (nursing facilities/SSLC risk), especially during transitions at age 21. There was a suggestion to consider data on ages of people entering long-term care facilities to support the recommendation's rationale.*



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**There was consensus that the recommendations needed simplification and this will be addressed at subsequent meetings.** The Subcommittee agreed to simplify, prioritize and finalize recommendations for discussion at the July IDDSRAC meeting; no votes taken at this meeting.

The group discussed clarifying confusing language that referenced "level one vs. level eight" by instead naming the assessment tools directly (DID vs. IDRC).

Dr. McCurdy suggested simplifying the CFC recommendation set overall: focus on "simplify the process" rather than multiple detailed bullets (A/B/C) and potentially use the "item #6" language as the replacement anchor. There was agreement to coordinate edits via email/shared editing between meetings, with optional workgroup calls if needed.

**Data Sheets Provided by HHSC**

**CFC by Age**

| State FY | Service Group | Age Group | CFC Clients |
|---|---|---|---|
| 2024 | Community Living Assistance and Support Services | 18+ | 6,010 |
| 2024 | Community Living Assistance and Support Services | 18- | 214 |
| 2024 | Deaf-Blind Multiple Disabilities | 18+ | 138 |
| 2024 | Deaf-Blind Multiple Disabilities | 18- | 46 |
| 2024 | Home and Community-Based Services | 18+ | 3,271 |
| 2024 | Home and Community-Based Services | 18- | 321 |
| 2024 | Texas Home Living Waiver | 18+ | 2,320 |
| 2024 | Texas Home Living Waiver | 18- | 134 |
| 2024 | *STAR Kids MDCP | 21+ | 65 |
| 2024 | STAR Kids MDCP | 21- | 2,139 |
| 2024 | *STAR Kids Non-MDCP | 21+ | 174 |
| 2024 | STAR Kids Non-MDCP | 21- | 2,647 |

**2025**

| State FY | Service Group | Age Group | CFC Clients |
|---|---|---|---|
| 2025 | Community Living Assistance and Support Services | 18+ | 6,125 |
| 2025 | Community Living Assistance and Support Services | 18- | 122 |
| 2025 | Deaf-Blind Multiple Disabilities | 18+ | 151 |
| 2025 | Deaf-Blind Multiple Disabilities | 18- | 54 |
| 2025 | Home and Community-Based Services | 18+ | 3,486 |
| 2025 | Home and Community-Based Services | 18- | 333 |
| 2025 | Texas Home Living Waiver | 18+ | 2,621 |
| 2025 | Texas Home Living Waiver | 18- | 89 |
| 2025 | STAR Plus HCBS | 18+ | 47,328 |
| 2025 | STAR Plus Non-HCBS | 18+ | 7,149 |
| 2025 | *STAR Kids MDCP | 21+ | 81 |
| 2025 | STAR Kids MDCP | 21- | 2,156 |
| 2025 | *STAR Kids Non-MDCP | 21+ | 176 |
| 2025 | STAR Kids Non-MDCP | 21- | 2,571 |

*The only members in STAR Kids who would be 21+ are members who are in their 21st birthday month. STAR Kids eligibility ends when a member turns 21 years old.

## All Waiver Services

**Waiver Utilization by Age Range**

**Date Range: 09/01/2023-02/28/2026**

| State FY | Service Group | Age Group | Clients |
|---|---|---|---|
| 2024 | Community Living Assistance and Support Services | 18- | 268 |
| 2024 | Community Living Assistance and Support Services | 18+ | 6,216 |
| **2024** | **Community Living Assistance and Support Services** | **Yearly Waiver Total** | **6,361** |
| 2024 | Deaf-Blind Multiple Disabilities | 18- | 88 |
| 2024 | Deaf-Blind Multiple Disabilities | 18+ | 236 |
| **2024** | **Deaf-Blind Multiple Disabilities** | **Yearly Waiver Total** | **317** |
| 2024 | Home and Community-Based Services | 18- | 829 |
| 2024 | Home and Community-Based Services | 18+ | 30,132 |
| **2024** | **Home and Community-Based Services** | **Yearly Waiver Total** | **30,790** |
| 2024 | STAR Kids MDCP | 21- | 6,332 |
| 2024 | STAR Kids MDCP | 21+ | 131 |
| **2024** | **STAR Kids MDCP** | **Yearly Waiver Total** | **6,332** |
| 2024 | STAR Kids Non-MDCP | 21- | 14,711 |
| 2024 | STAR Kids Non-MDCP | 21+ | 782 |
| **2024** | **STAR Kids Non-MDCP** | **Yearly Waiver Total** | **14,720** |
| 2024 | STAR Plus HCBS | 18+ | 72,502 |
| **2024** | **STAR Plus HCBS** | **Yearly Waiver Total** | **72,502** |
| 2024 | STAR Plus Non-HCBS | 18+ | 132,608 |
| **2024** | **STAR Plus Non-HCBS** | **Yearly Waiver Total** | **132,608** |
| 2024 | Texas Home Living Waiver | 18- | 152 |
| 2024 | Texas Home Living Waiver | 18+ | 3,126 |
| **2024** | **Texas Home Living Waiver** | **Yearly Waiver Total** | **3,206** |
| 2025 | Community Living Assistance and Support Services | 18- | 175 |
| 2025 | Community Living Assistance and Support Services | 18+ | 6,360 |
| **2025** | **Community Living Assistance and Support Services** | **Yearly Waiver Total** | **6,406** |
| 2025 | Deaf-Blind Multiple Disabilities | 18- | 117 |
| 2025 | Deaf-Blind Multiple Disabilities | 18+ | 261 |
| **2025** | **Deaf-Blind Multiple Disabilities** | **Yearly Waiver Total** | **369** |
| 2025 | Home and Community-Based Services | 18- | 829 |
| 2025 | Home and Community-Based Services | 18+ | 31,340 |
| **2025** | **Home and Community-Based Services** | **Yearly Waiver Total** | **31,994** |
| 2025 | STAR Kids MDCP | 21- | 6,718 |
| 2025 | STAR Kids MDCP | 21+ | 131 |
| **2025** | **STAR Kids MDCP** | **Yearly Waiver Total** | **6,723** |
| 2025 | STAR Kids Non-MDCP | 21- | 14,488 |
| 2025 | STAR Kids Non-MDCP | 21+ | 806 |
| **2025** | **STAR Kids Non-MDCP** | **Yearly Waiver Total** | **14,497** |
| 2025 | STAR Plus HCBS | 18+ | 72,864 |
| **2025** | **STAR Plus HCBS** | **Yearly Waiver Total** | **72,864** |
| 2025 | STAR Plus Non-HCBS | 18+ | 129,046 |
| **2025** | **STAR Plus Non-HCBS** | **Yearly Waiver Total** | **129,046** |
| 2025 | Texas Home Living Waiver | 18- | 100 |
| 2025 | Texas Home Living Waiver | 18+ | 3,426 |

**Behavioral Support Services**

| State FY | Service Group Cd | Service Group | Service Cd | Service Desc | Client Count |
|---|---|---|---|---|---|
| 2024 | 16 | Deaf-Blind Multiple Disabilities | 43A | Behavioral Support | # |
| **2024** | **16** | **Deaf-Blind Multiple Disabilities** | | **Waiver Total** | **#** |
| 2024 | 2 | Community Living Assistance and Support Services | 43A | Behavioral Support | 226 |
| **2024** | **2** | **Community Living Assistance and Support Services** | | **Waiver Total** | **226** |
| 2024 | 21 | Home and Community-Based Services | 43A | Behavioral Support | 7150 |
| **2024** | **21** | **Home and Community-Based Services** | | **Waiver Total** | **7150** |
| 2024 | 22 | Texas Home Living Waiver | 43A | Behavioral Support | # |
| 2024 | 22 | Texas Home Living Waiver | 43AV | Behavioral Support - CDS | # |
| **2024** | **22** | **Texas Home Living Waiver** | | **Waiver Total** | **132** |
| ***2024*** | | | | ***Yearly Total*** | ***7505*** |
| 2025 | 16 | Deaf-Blind Multiple Disabilities | 43A | Behavioral Support | # |
| **2025** | **16** | **Deaf-Blind Multiple Disabilities** | | **Waiver Total** | **#** |
| 2025 | 2 | Community Living Assistance and Support Services | 43A | Behavioral Support | 234 |
| **2025** | **2** | **Community Living Assistance and Support Services** | | **Waiver Total** | **234** |
| 2025 | 21 | Home and Community-Based Services | 43A | Behavioral Support | 7200 |
| **2025** | **21** | **Home and Community-Based Services** | | **Waiver Total** | **7200** |
| 2025 | 22 | Texas Home Living Waiver | 43A | Behavioral Support | # |
| 2025 | 22 | Texas Home Living Waiver | 43AV | Behavioral Support - CDS | # |
| **2025** | **22** | **Texas Home Living Waiver** | | **Waiver Total** | **144** |
| ***2025*** | | | | ***Yearly Total*** | ***7561*** |

**# Cannot share data due to the small number of users.**

## 4. Public comment. There was no public comment offered

## 5. Review of action items and agenda items for next meeting

**Next Meeting**: May 20th

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