Health and Human Services

Department of State Health Services

Public Health Funding and Policy Committee

April 8, 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.

Public Health Funding and Policy Committee defines what core public health services a local health entity should provide in a county or municipality; evaluates public health in the state and identifies initiatives for areas that need improvement; identifies funding sources available to local health entities; and establishes public health policy priorities.

Texas Health and Safety Code Chapter 117 established the Public Health Funding and Policy Committee (PHFPC). This committee consists of nine public health professionals. The DSHS Commissioner appoints three local health entity directors, two local health authorities, two deans from schools of public health, and two DSHS Public Health Region medical directors to serve on the committee. DSHS also provides a staff member who supports the committee and coordinates communication between the agency and the committee. DSHS is charged with responding to recommendations made by PHFPC. The committee shall:

1. Define the core public health services a local health entity should provide in a county or municipality.
2. Evaluate public health in this state and identify initiatives for areas that need improvement.
3. Identify all funding sources available for use by local health entities to perform core public health functions.
4. Establish public health policy priorities for this state; and
5. At least annually, make formal recommendations to the department regarding:
    a. The use and allocation of funds available exclusively to local health entities to perform core public health functions.
    b. Tab
    c. Ways to improve the overall public health of citizens in this state.
    d. Methods for transitioning from a contractual relationship between the department and the local health entities to a cooperative-agreement relationship between the department and the local health entities; and
    e. Methods for fostering a continuous collaborative relationship between the department and the local health entities.

Recommendations made under Subsection (a)(5)(A) must be based on the latest epidemiological evidence and take into account the specific needs of different geographic areas and populations. They should incorporate best practices and evidence-based interventions appropriate for the populations being served.

1604 SAN ANTONIO, AUSTIN, TEXAS 78701 TEL: 512-944-8994 WWW.TXINSIGHT.COM

Additionally, these recommendations must comply with state and federal laws and meet federal funding requirements.

1. Call to Order/Welcome. The meeting was convened by Katherine Wells, Chair. A quorum was present.

2. February 11, 2026 Meeting Minutes. The minutes were approved as drafted.

3. Federal Funding Update.

Resource: Grant Development Center | Texas DSHS

Imelda Garcia (Chief Deputy Commissioner, DSHS) reported federal grants are currently coming in routinely with no new disruptions. The President's proposed federal budget (FFY27, starting Oct this year) includes changes across HRSA/CDC/HHS, but DSHS expects a long congressional process with clearer direction likely later in the summer. Regarding the Public Health Infrastructure Grant (PHIF). There have been no official changes communicated to date and the current grant runs through Nov 2027. The President's budget proposes a PHIG reduction of about $100M nationally (not specific to Texas).

4. Public Health Provider - **Charity Care Program Update (PHP-CCP)**

Hank Morris (HHSC) provided a timeline and operational updates for PHPCCP. The FFY26 reporting period is 10/1/2025–9/30/2026. DSHS is transitioning cost reporting from the legacy system to the new platform STEPS; This is the first year. receiving cost reports through STEPS.

Participation updates were provided (FFY25 cost reports). There are 5 new local health departments/public health districts that submitted with 6 returning LHDs/PHDs; and 40 returning community centers/LMHAs/LBHAs.

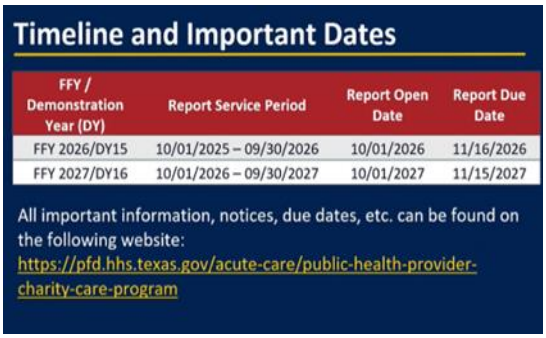
Regarding the FFY25 results the total settlement was $691M vs federally imposed cap ~ $499.193M. There is a proportional reduction of 72.26% applied to all providers; with the net amount to providers after match of just under $300M.

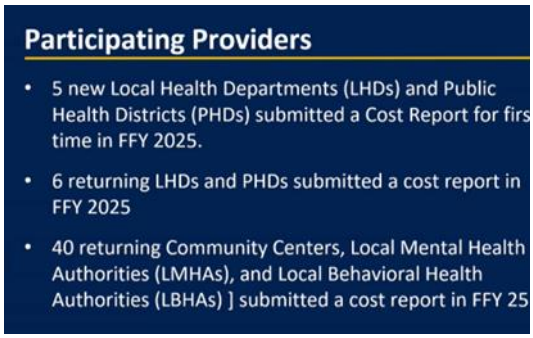
Training will shift from live webinars to on-demand training embedded in STEPS. The program cap was approved through Demonstration Year 17 (2028), and the program is approved through 2030. HHSC plans to start rebasing in 2028 (using FFY27 data);

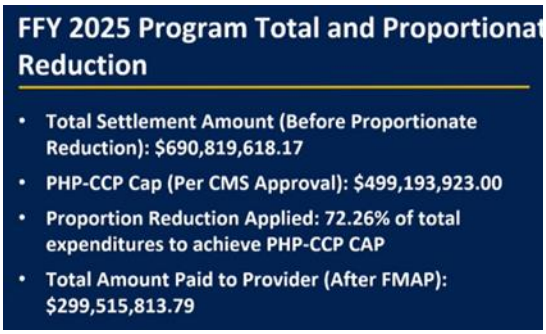
Members expressed concern that growing participation and the static cap reduces reimbursement percentages. They requested exploration of increasing cap and/or considering carve-outs for public health vs behavioral health.

Committee shared examples of how charity care funds are being used locally (HIV care with high viral suppression, hepatitis C treatment, HPV vaccination, cancer screening planning, adding physician coverage), and offered to provide community impact stories.

Presentation Materials







5. DSHS Legislative Appropriations Request Process/Timeline.

Summary DSHS legislative appropriations request (LAR) process will involve a public hearing for stakeholder input scheduled for April 30 (available online, with options for in-person/virtual/written comments). Austin Hood (Deputy Director, Government Affairs, DSHS) outlined LAR/Exceptional Item (EI) workflow and timeline. He explained that EIs are above baseline requests and historically total ~$40–$80M (last biennium was an outlier due to lab building request).

In the prior biennium about "five and a half" of the EIs were funded (some partially). The Committee discussed aligning EIs with interim charges (e.g., AI in healthcare, public health prevention trends, infant mortality prevention). There was a strong emphasis from members that funding must support local implementation ("boots on the ground"), noting locals have minimal flexibility and small cuts can mean layoffs. Concerns were raised about flat core public health funding (immunizations, TB, preparedness) not keeping up with inflation for 15–20 years, making sustainability difficult for locals. DSHS noted regional staffing increases have often relied on time-limited funds (e.g., COVID/workforce/PHIG) rather than increased base immunization funding, and agency has had to cut other line items (media, admin, conferences) to maintain core functions.

Discussion

How many EIs were funded? 5 were funded. Some not in the full amount

Will the hearing be online? DSHS answered in the affirmative

Interim Charges are out and do these align with the DSHS EIs? DSHS stated that the interim charges inform the process of EI development.

This body has recommended expansion of local funding and there is hope that those recommendations would be considered.

DSHS stated that there are topical themes and those drive the funding impact for local health departments. Legislative leadership makes the decision about what gets funded.

Immunization funding has been the same amount for 15-20 years. They have been sitting in the same place for at least ten years. This makes charity care really important to make up the variance. This level funding is unsustainable in small local health departments.

How does the agency keep the immunizations program going? DSHS stated that the additional positions in the regions were funded with COVID dollars and other non-immunization funds. There is a little bit of flex in the immunization funds, but those dollars are used primarily for vaccines. Programs have a mix of state and local funds with separate mandates that must be addressed.

The field is absorbing all the new efforts that go unfunded. The local governments are putting in more and more money and the legislature is not.

6. Emerging and Infectious Diseases Update.

Summary. DSHS provided updates on measles, New World screwworm, and the 2025–2026 respiratory season (data noted as preliminary and subject to change).

Measles (Americas/US/Texas):

- PAHO (3/14): 10,571 confirmed measles cases in 2026 in the Americas vs 14,751 in all of 2025.
- US (as of 4/2): 1,671 cases across 17 outbreaks and 5% were hospitalized; 92% were unvaccinated or unknown. There were no deaths reported in 2026 (vs 3 deaths in 2025).
- Texas (as of 4/1) had 175 confirmed cases in 2026 vs 762 in 2025. Weekly updates are now posted on DSHS website by county and likely origin. Measles | Texas DSHS
- Most Texas cases categorized as "unknown/other" largely tied to infections in federal detention facilities.

- DSHS reported ongoing communication with federal authorities; some staff exposures have occurred but have not led to sustained community spread.

New World screwworm: not present in the US; Mexico reports significant animal burden, with attention on northern spread near the border.
The USDA sterile fly dispersal strategy continues and DSHS indicated the spread appears to have held relatively stable (no major northward advance), and a dispersal facility opened in Edinburgh, TX to improve logistics.

Respiratory season: ED visits and hospitalizations for influenza and RSV have been declining while RSV stayed elevated into March. Based on elevated RSV activity, Texas VFC providers may continue ordering RSV monoclonal antibody through April 17 and may administer through April 30 (DSHS communication April 1); providers were advised to use clinical judgment and shared decision-making and check expiration dates.

Immunization policy concerns: members asked about potential anti-vaccine legislation; DSHS has not heard specific Texas drafts yet (bill filing begins in November).

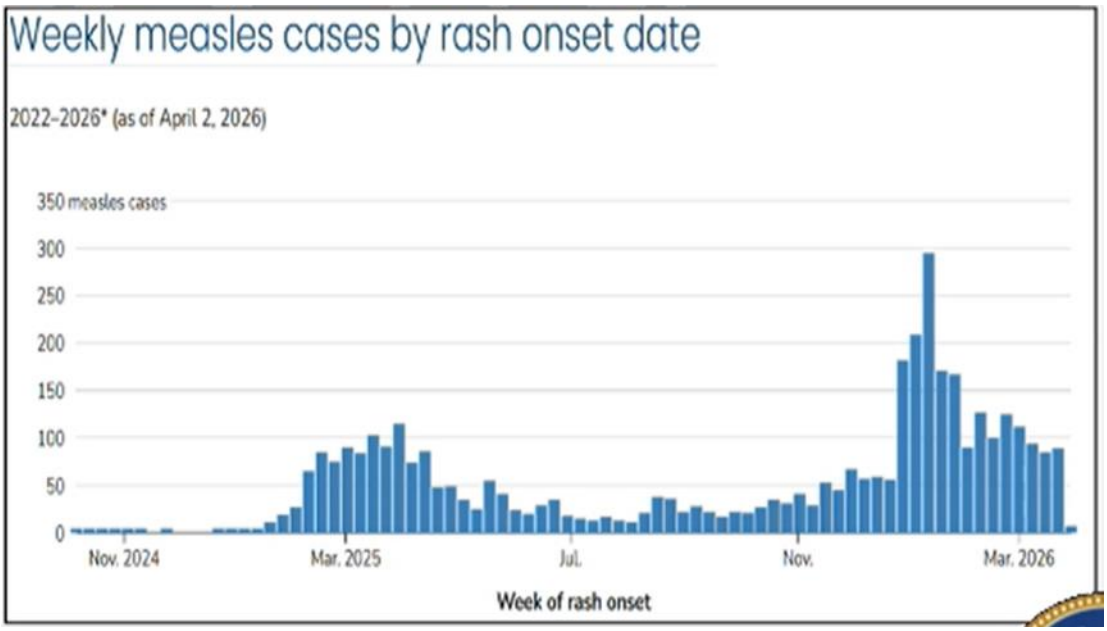
Exemption tracking: after last legislative change allowing online download of exemption forms, DSHS lost prior visibility based on form issuance; DSHS can still monitor immunization uptake via the registry and annual school district reporting but that is at the (district-level and not the campus-level). A challenge was noted related to unregistered private/home school settings with reduced visibility in some areas.

Presentation Materials

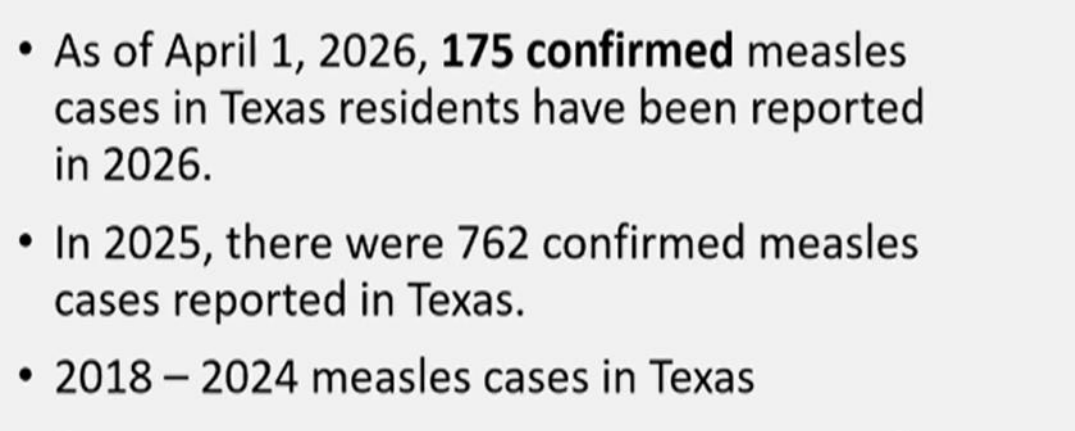
Measles

Measles in the United States

United States	2026 (as of April 2, 2026)	2025 (Full year)
Total Cases	**1,671**	2,285
Total Outbreaks	17 new outbreaks (94% of the total cases are outbreak associated)	48 outbreaks (90% of the total cases are outbreak associated)
Total Hospitalized	5% (91 or 1,671 cases)	11% (242 of 2,285 cases)
Vaccination Status	92% unvaccinated or unknown	93% unvaccinated or unknown
Total Deaths	0	3



Texas Measles Cases



There have been employees of facilities where measles was found reporting that they had contracted the disease.

New World Screwworm

New World screwworm (NWS), or *Cochliomyia hominivorax*, is species of parasitic fly that completes part of its lifecycle by feeding on the tissue or flesh of warm-blooded animals and people. NWS flies are attracted to wounds and body openings like the nose, eyes, ears, and mouth, where they lay eggs. The eggs hatch into maggots (larvae) that eat live tissue, causing a worsening, often painful and foul-smelling wound.

NWS is typically found in South America and parts of the Caribbean. However, the fly has steadily moved northward from South America through every country in Central America and Mexico since 2023.

NWS infestations (presence of maggots on or in the body) do not regularly occur in the United States, but cases have occurred in travelers returning from areas where flies are present. If you travel to these areas, have an open wound and spend a lot of time outdoors, you may be at greater risk of becoming infested with NWS.

Symptoms can include

- Feeling maggots (larvae) move or seeing maggots within a skin wound or sore, or in the ears, nose, eyes, or mouth.
- Painful skin wounds or sores that worsen within a few days.
- A foul-smelling odor from the site of the infestation.

- Bleeding from open sores.

Bacteria can also infect wounds where NWS maggots are present and may cause infection that can lead to symptoms like fever or chills.

Current Status of the NWS

- Currently, the New World screwworm (NWS) fly is not present in the United States and there are no cases of NWS in the United States.
- As of April 2nd, there are 1,433 currently active animal cases and 19,278 total cumulative in Mexico.
  - Tamaulipas has had 111 animal cases.
  - Additionally, cases are reported towards the west of Tamaulipas to include 106 active cases in San Luis Potosi and 2 active cases in southern Neuvo Lean.

Available at: Current Status of New World Screwworm | Screwworm.gov, accessed on April 7, 2026. 9

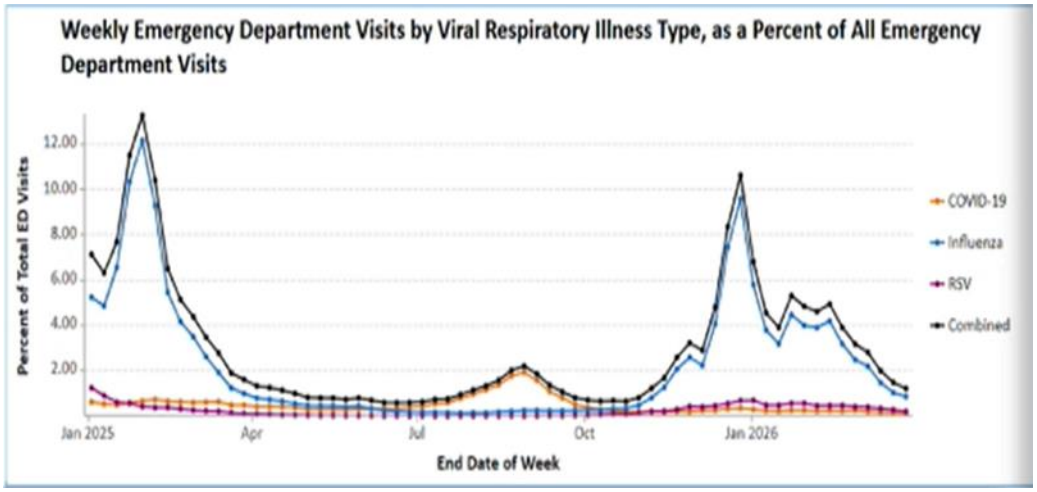
It is not present in the US.

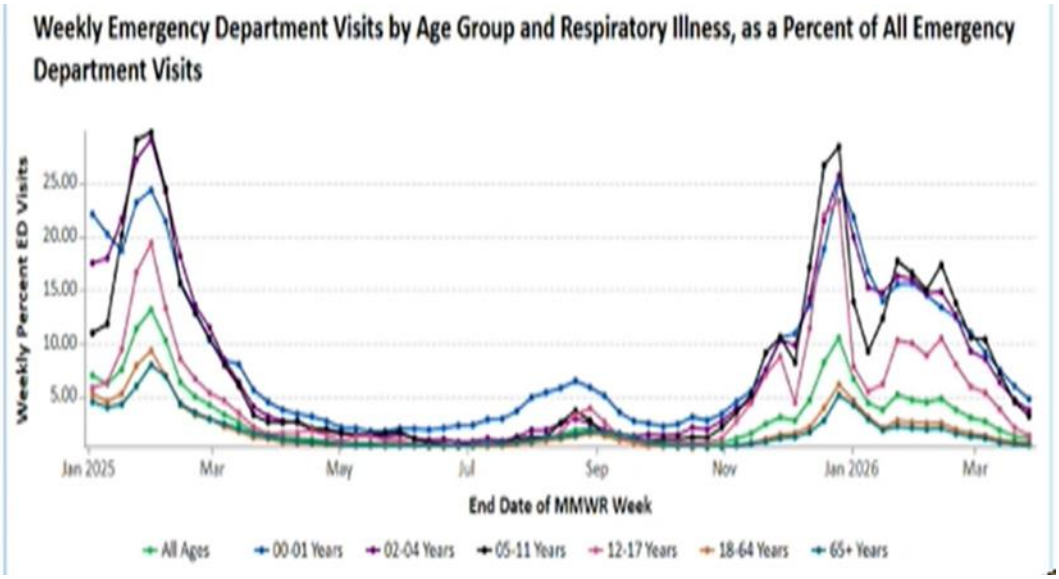
Preparation and Coordination

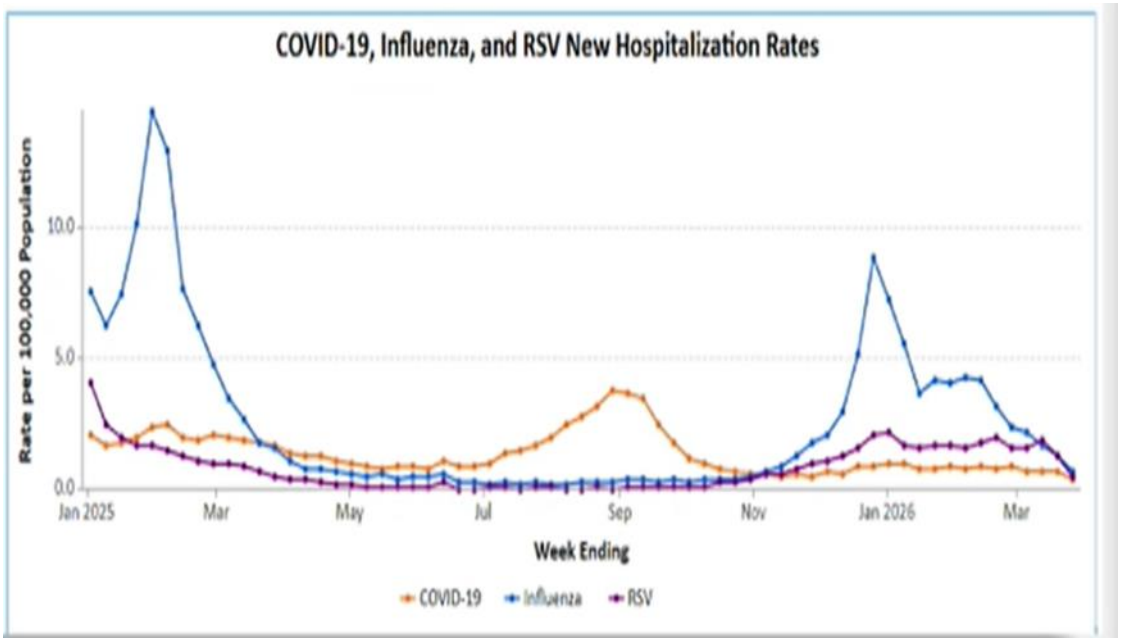
- One Health approach
- Ensure collection of appropriate specimens and establish submission process
- Ensure appropriate disposal of all larvae
- Case reporting and investigation
- Communication planning
- Education and training

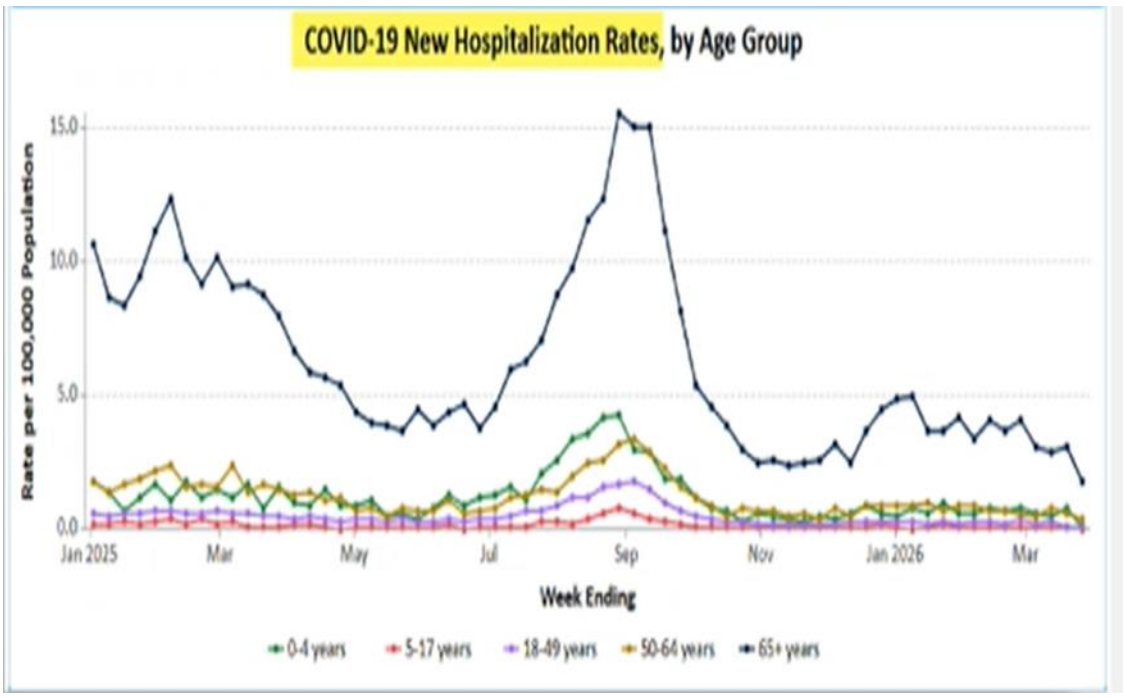
What has been the impact of the sterile flies? DSHS stated that there has been a leveling out of the cases. There is activity outside the zone where the sterile flies were introduced. Activity has been several hundred miles from the border.

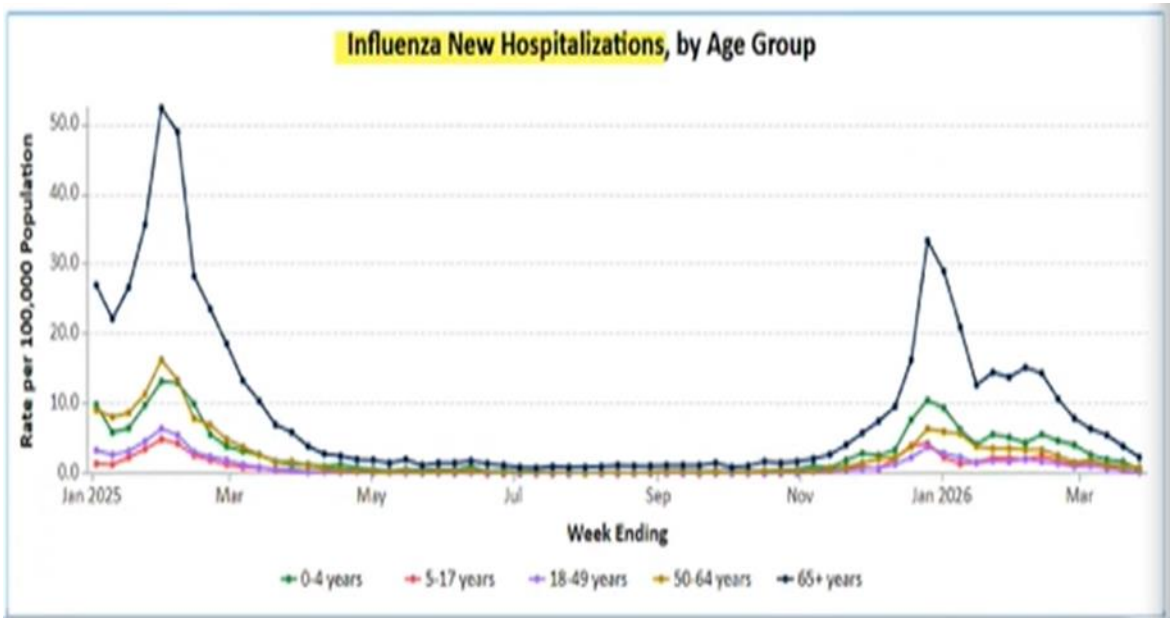
Texas Respiratory Virus

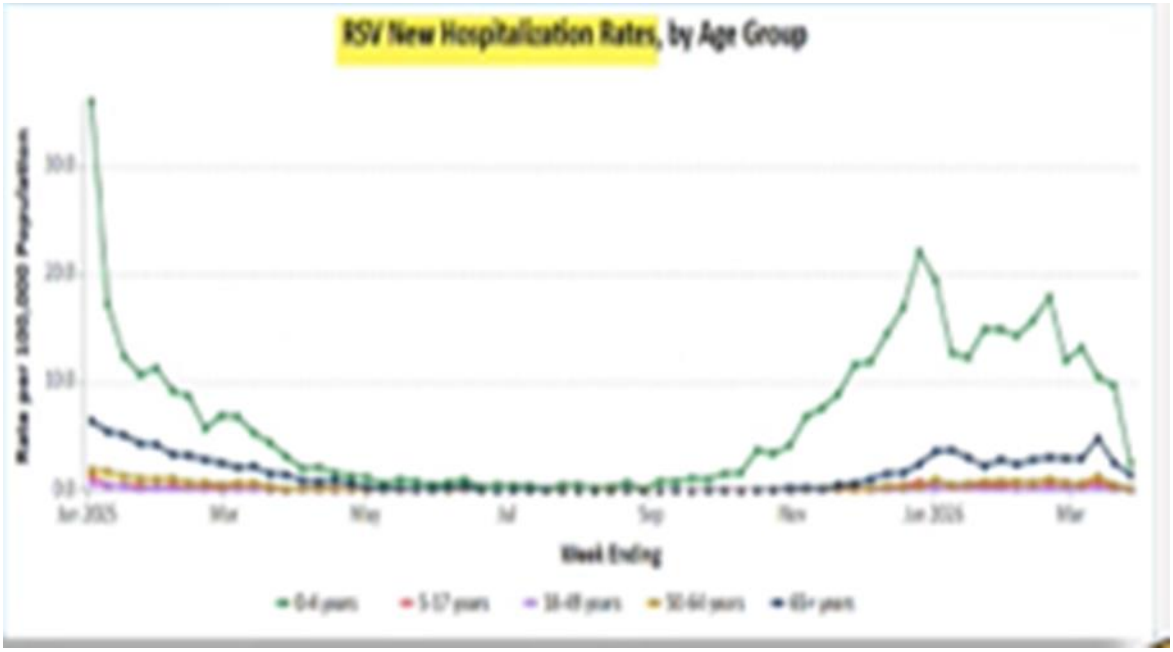


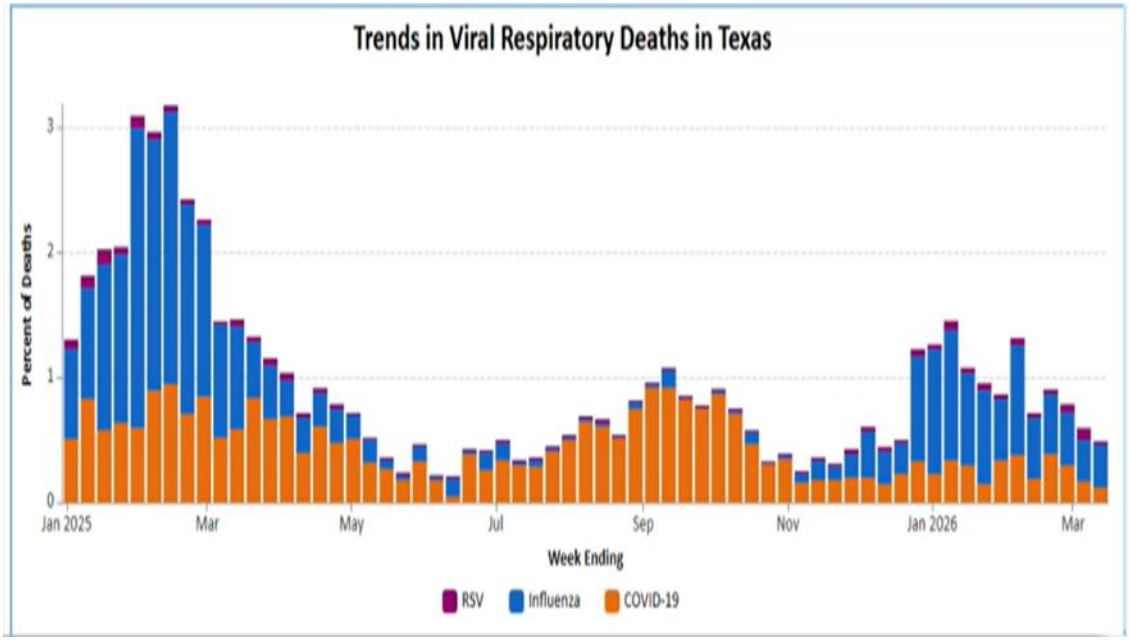



COVID-19, Influenza, and RSV New Hospitalization Rates
Rate per 100,000 Population
10.0
5.0
0.0
Jan 2025
Mar
May
Jul
Sep
Nov
Jan 2026
Mar
Week Ending
COVID-19
Influenza
RSV


COVID-19 New Hospitalization Rates, by Age Group
Rate per 100,000 Population
15.0
10.0
5.0
0.0
Jan 2025
Mar
May
Jul
Sep
Nov
Jan 2026
Mar
Week Ending
0-4 years
5-17 years
18-49 years
50-64 years
65+ years

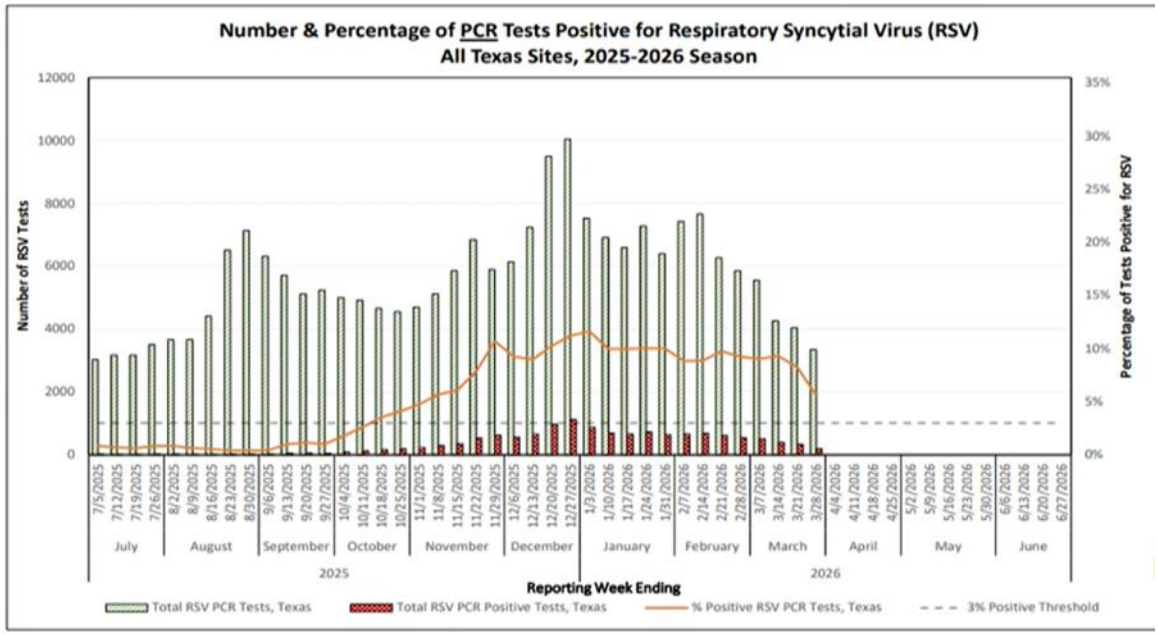

Influenza New Hospitalizations, by Age Group
Rate per 100,000 Population
50.0
40.0
30.0
20.0
10.0
0.0
Jan 2025
Mar
May
Jul
Sep
Nov
Jan 2026
Mar
Week Ending
0-4 years
5-17 years
18-49 years
50-64 years
65+ years


RSV New Hospitalization Rates, by Age Group
Week Ending



Texas Respiratory Syncytial Virus (RSV) Surveillance

Figure 7: Number and Percent of PCR Tests Positive for Respiratory Syncytial Virus in the State of Texas, 2025-2026 Season



Immunization Products Ordering

- Texas Vaccine for Children providers may continue ordering the two RSV immunization products [Beyfortus® (nirsevimab) and ENFLONSIA™ (clesrovimab)] in the Vaccine Allocation and Ordering System through **April 17, 2026.**
- Providers should review expiration dates of immunization products currently in stock and prioritize the use of doses with shorter expiration dates.
- Providers, exercising clinical judgment and using shared clinical decision making, may continue to administer RSV infant immunizations through April 30, 2026.

Regarding immunizations and the federal changes (anti-vax). What is the impact in Texas. DSHS stated they have not seen any draft legislation here in Texas, but pre-filing does not occur until November.

Last session opting out was made easier (vaccinations). The requirements and forms have changed. This has impacted the ability to track optouts. (Forms can be accessed online).

Can the School annual report be used to track optout and vaccinated students. DSHS stated that the data is school district level and not on a school by school basis. There is the Conscientious Objection Report (historical). The Annual School District Report is online but at the district level.

The unregistered private schools do not report.

7. Data Modernization/Public Health Data Sharing Update.

Data Modernization for Public Health | Data Modernization | CDC

Summary DSHS presented a status update on electronic case reporting (automated case report generation from EHRs/hospitals to public health), in place at DSHS central office since 2022 (started with COVID-19).

- Texas has 129 conditions in production; 69 infectious conditions in NEDSS (NEDS) and 60 in SHARP.

- Texas reported leading nationally in number of conditions in production, including non-infectious programs (birth defects, newborn screening, environmental conditions) and infectious conditions.
- Work is underway to establish "manual release criteria" to reduce parallel/manual reporting burden; infectious disease partners completed a pilot with 3 local health departments and one regional partner.

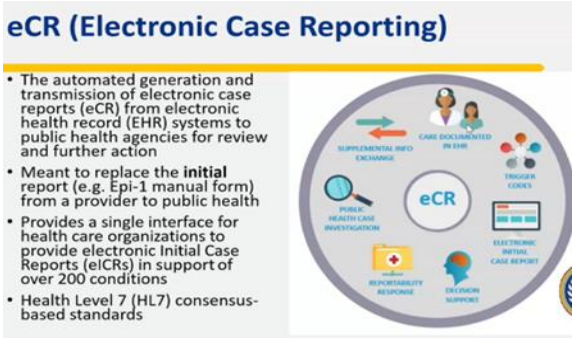
Next step: Bring pilot lessons to a broader central-office workgroup (including non-infectious programs) and seek statewide consensus. The target for sharing proposed minimal criteria is mid-year and then get local feedback.

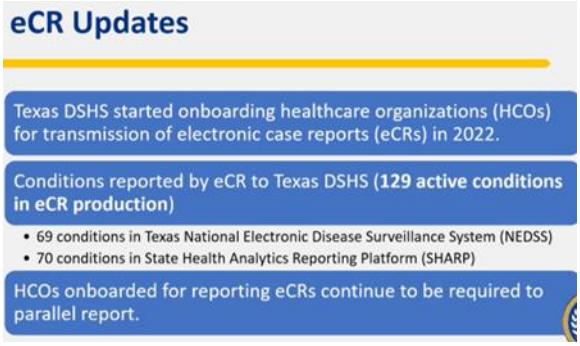
RCKMS update: Release 15 includes 50 updates to existing conditions; 262 conditions available (94 nationally notifiable; 168 non-notifiable); new conditions include COVID-19–associated pediatric mortality and soil-transmitted helminths.
There are 1,600+ facilities in production, with growth beyond metropolitan areas into West and South Texas.

Local partners (notably Dallas/ Parkland) offered to pilot and share what they have learned, including a closed-LLM pilot to extract travel/occupation/pregnancy status and a TEFCA pilot for data access.

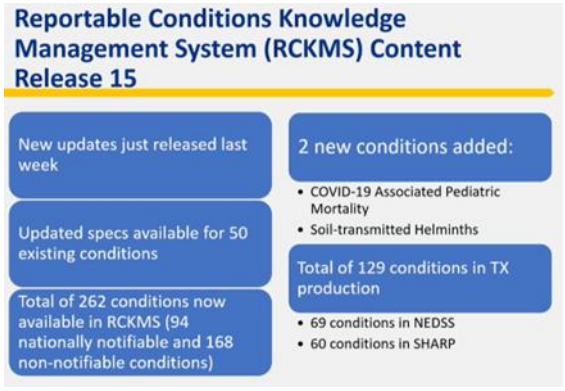
eCR data marts: NEDS contains variables such as pregnancy, occupation, medications; expansion to additional v3.1 variables underway with more detailed pregnancy fields (target end of summer). SHARP data mart also is being expanded. Regarding CSV/bulk upload into NEDS: DSHS anticipates an update by the end of this summer with the goal being to cover all conditions that currently have placeholders and begin piloting with locals

Presentation Materials

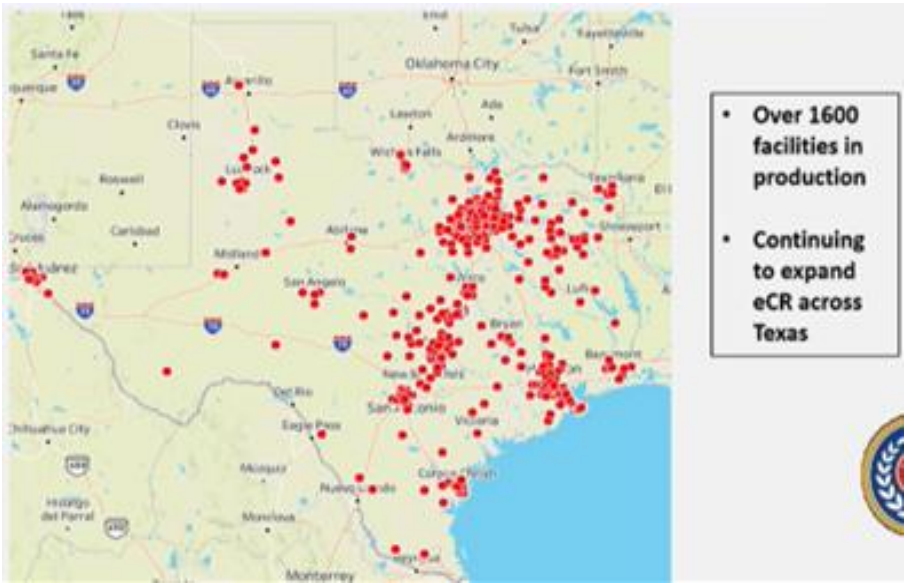




Error in the slide 2: 60 not 70 conditions in SHARP



Healthcare Facilities in eCR Production



Discussion

There should be local health department engagement on the RKCMS development. DSHS stated that local variables have been included in NEDS and are being expanded in eCR. Detailed pregnancy data will be available by the end of the summer.

Some EHRs are better reporting than others.

All conditions that have a page folder will be included and local health departments will be engaged in the development.

8. House Bill 2844 (HB02844F.pdf) (89th Legislature, Regular Session) Implementation Update. phfpc-hb-2844-overview-10.08.2025.pdf

Resource: Retail Food Establishments | Texas DSHS

House Bill 2844 amends the Health and Safety Code to provide for the licensing, regulation, and inspection of mobile food vending operations by the Department of State Health Services (DSHS). The bill sets out general provisions, including provisions providing for the bill's preemption of a local authority's power and, effective September 1, 2025, for the authority of the executive commissioner of the Health and Human Services Commission to adopt rules to implement the bill's provisions regarding mobile food vendors.

House Bill 2844 requires a person to obtain a mobile food vendor license from DSHS to operate as a mobile food vendor in Texas and sets out provisions regarding the application for and issuance and renewal of such a license, including certain health inspection requirements for an applicant's food vending vehicles. The bill requires DSHS to develop a guide on the mobile food vendor licensing procedures and to establish and maintain a mobile food vendor database. With respect to mobile food vendor operations, the bill sets out provisions regarding compliance with state and local law, food vending vehicle driver requirements, operational standards, and food safety.

House Bill 2844 requires the executive commissioner by rule to establish certain classifications of mobile food vendors for purposes of conducting health inspections and provides for the authority of DSHS or a local authority to investigate a mobile food vendor on reasonable suspicion the vendor is violating the law or on receipt of a health or safety complaint. Subsequently, the bill provides for the enforcement by DSHS of the bill's provisions regarding mobile food vendor operations, including by providing for license denial, suspension, or revocation and for an administrative penalty.

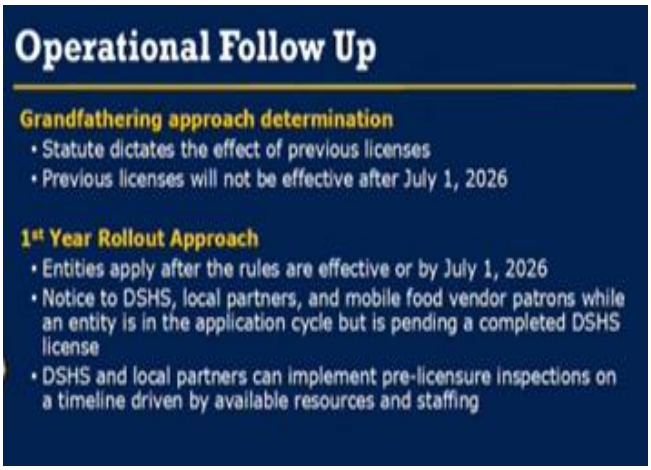
House Bill 2844 also includes provisions setting out certain small-scale food business permit exemptions and repeals the provision that provides for a required permit for the operation of a mobile food service establishment issued by Dallas, Harris, or Tarrant County.

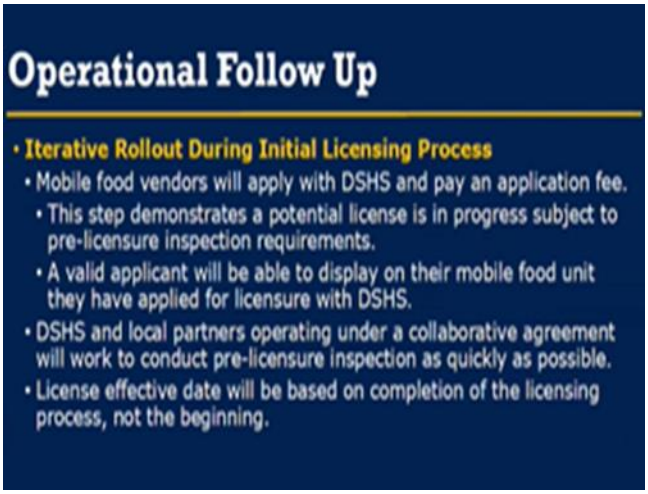
Summary Ken Vela (DSHS Consumer Protection/Retail Food Safety) provided implementation update for HB 2844 (statewide mobile food vendor permitting).

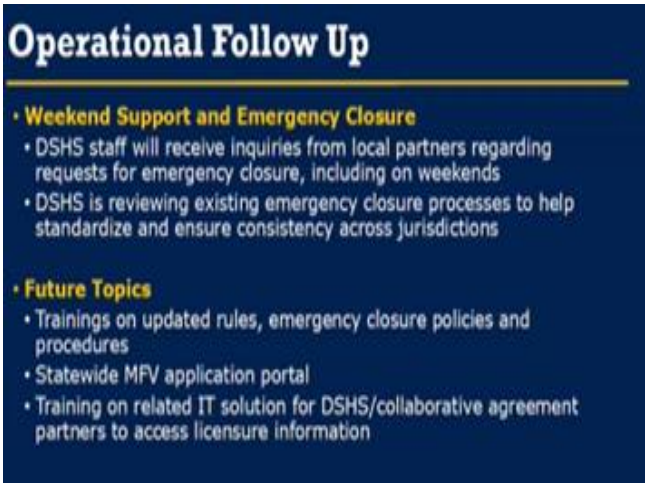
- Rulemaking: public comment period ended March 23 with 20 submissions and 101 comments. The rules are still slated to take effect May 31.
- Implementation work includes SOP development, funding/resource identification (no appropriations provided), contract development for collaborative agreement partners, internal reorganization, and IT buildout.
- Collaborative agreements: letters of intent were sent at the end of February (deadline March 10); contract management drafting and rolling out contracts has goal of early April distribution with time to allow local approval processes.
- Local health department workgroup meets weekly (Fridays) and the SOPs to be shared with workgroup members by end of the week for feedback.
- Grandfathering constraint: local permits will not be honored beyond July 1 (statutory requirement).
- Planned rollout: applications may open in June after rules are effective; vendors apply to DSHS and pay pre-licensing fees.
- Transition approach: previously licensed vendors can operate while pending using proof/receipt of application ("golden ticket" concept) while pre-licensing inspection is completed.
- New/unlicensed vendors will be prioritized for inspection and generally cannot operate until they pass the pre-licensing inspection.
- DSHS is developing weekend/on-call support and standardized emergency closure procedures.
- Training: May is expected to be a major training month for partners and inspection teams given the timing of the rollout.
- IT: application portal and required public database are under development; licensing "drive-through" run-through was tested in Region 1 and generated operational feedback.
- Local concerns included communication gaps and need for clearer public-facing website guidance; DSHS aims to post updated licensing/rollout information within 2 weeks.
- Contract funding concerns: local partners flagged "do not exceed" amounts may not cover total workload; DSHS will monitor contract spending and escalate if nearing limits; DSHS remains responsible for complaints/compliance inspections if locals cannot.

- Refund/fee transition was suggested: locals expect vendor frustration due to overlapping payments; one LHD described planning partial rebates tied to re-inspection/reimbursement mechanics.

Presentation Materials







Discussion

LHDs are getting a lot of questions. They are trying to find a way to say that the information is not available yet without damaging credibility with LHDs or state-level staff. DSHS stated that they have received feedback on this and are going through a process to update the website with rollout process information.

When we are looking at the blanket operation until they come up on re-inspection. DSHS stated that the application will dictate the process. If they have been licensed, they can continue to operate. For those who have never operated before, there is a priority system to address them.

There is a do not exceed number on the contract. This number is too low. Is there a contingency to continue if they run out of funds? DSHS stated they are working actively to find additional resources. They will be tracking the contracts and those approaching the upper limit. Protocols will be developed to address this issue. They are limited by the total amount of funding made available.

The rough estimation of the contract completion with one LHD was 90%. DSHS stated they would continue to be responsible for completing those inspections and will stay in contact with LHDs.

Is there flexibility in enforcement as the process is rolled out? DSHS stated that there will be growing pains and they are approaching this with education. There is some flexibility in the permitting. There will be some adaptation allowed in the SOPs and risk based approach. These have to be compliant with the statute like a requirement for a permit in order to operate by July 1.

Operators will be mad because when they got their permit, they thought it would last longer. DSHS stated that once they apply (and pay fee) and have a screening receipt they will get an allowance to continue to operate. This achieves continued operation without "grandfathering". The key is for them to apply and answer the screening requirements. Those who have not been operating will have to be addressed quickly.

Some LHDs are giving a rebate on their previous inspection fees paid. There are some food trucks that will choose to not operate because of the permit costs. DSHS stated that in order to operate they must collect the fees. It is a fee based program. Those conversations about rebates will be discussed within DSHS.

9. 2026 PHFPC Annual Report Preparation.

Report is due November 30th. A draft should be developed by August first. Previous annual reports were provided:

Annual Reports

- 2025 PHFPC Annual Report (159 kb, PDF)
- 2024 PHFPC Annual Report (133 kb, PDF)
- 2023 PHFPC Annual Report (254 kb, PDF)

The impact of the reports and recommendations was requested. DSHS stated that they will have an update. The recommendations have been used year after year. The response to the reports follows.

DSHS Responses to PHFPC Annual Report Recommendations

- DSHS Response to 2025 PHFPC Annual Report Recommendations (288 kb, PDF)
- DSHS Response to 2024 PHFPC Annual Report Recommendations (330 kb, PDF)
- DSHS Response to 2023 PHFPC Annual Report Recommendations (332 kb, PDF)

Looking at the local health issues and addressing those through formal meetings across the state would be a good approach.

Voting on Recommendations at the June meeting will be necessary to meet the timelines.

10. Public Comment. No public comment was offered

11. Timelines, Next Steps, Announcements, and Future Meetings.
Next meeting June 10; 9:00 am

12. Adjourn/Thank you. There being no further business, the meeting was adjourned.