TEXAS INSIGHT
HEALTHCARE INTELLIGENCE

Texas House of Representatives Committee on Human Services

May 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.

The committee heard invited testimony only on the following charges:

Monitoring: Monitor the implementation and associated rulemaking of all legislation passed by the Committee and enacted by the 89th Legislature to ensure that legislative purposes are properly implemented, including the following:

- HB 26, relating to authorizing Medicaid managed care organizations to offer nutrition support services in lieu of other state Medicaid plan services.
- HB 109, relating to the construction, expansion, and operation of certain inpatient mental health facilities and the designation of residential treatment facilities for certain juveniles.
- HB 136, relating to Medicaid coverage and reimbursement for lactation consultation services.
- SB 379, relating to prohibiting the purchase of sweetened drinks and candy under the supplemental nutrition assistance program.
- SB 513, relating to a rural community-based care pilot program.

Provision of Services for Texans With Intellectual and Developmental Disabilities: Evaluate the availability of services for Texans with intellectual and developmental disabilities, including service coordination, Home and Community-Based Services, and the functionality of the waiver interest list. Ensure vulnerable Texans are protected by the current regulatory landscape and make recommendations for improvements.

Preventing Fraud, Waste, and Abuse: Ensure government services provided by agencies under the committee's jurisdiction, including Medicaid and the Supplemental Nutrition Assistance Program, efficiently serve eligible Texans. Evaluate barriers to efficient service provision for both clients and the providers of services, particularly the enrollment and credentialing of Medicaid providers. Review current efforts to identify and prevent fraud, waste, and abuse, and consider additional measures to reduce costs to taxpayers.

Agency Oversight: Pursuant to the broad oversight responsibilities granted to the Committee under Section 301.014, Government Code, and the House Rules of Procedure, monitor the agencies under the Committee's jurisdiction, including for fraud,

waste, and abuse, where applicable. The jurisdiction of the Human Services Committee includes the following agencies:

The Health and Human Services Commission (HHSC)
The Department of Family and Protective Services (DFPS)
The Texas Behavioral Health Executive Council (BHEC)

Texas Behavioral Health Executive Council (BHEC): BHEC Presentation Materials

BHEC described steady growth of the regulated workforce, with a net gain of ~5,000 licensees per year and ~97,000 total licenses regulated (expecting ~100,000+ by next session). BHEC oversees the administrative functions supporting the marriage and family therapy, psychology, social work, and counseling boards.

A school psychologist retraining/certificate pathway was enabled by legislative flexibility to accept related degrees. BHEC partnered with ESC Region 20 and Abilene Christian University to close training gaps and move candidates toward licensure.

The agency flagged for potential legislative attention the rising complaint volume and growing backlog. Complaint volume trend described: historically saw 600/year that increased to 800 and is now projected to reach 1,000 this year;

Staffing issues were raised (12 investigators and 6 attorneys) and that the legal review is the main bottleneck. Potential solutions were discussed including a request for additional attorney funding through Appropriations/Senate Finance and adopt a professional reviewer model (similar to medical and nursing boards) to screen out non-meritorious complaints before legal review.

The most common complaint categories cited were standard of care violations, sexual misconduct, and unlicensed practice. BHEC commented on “life coaching” as a way some attempt to circumvent licensure requirements.

A question was raised about tracking whether sexual misconduct complaints involve minors; BHEC indicated the database may not track it but agreed it may be worth tracking and they would attempt to provide an estimate.

The Unicor lawsuit regarding denials under Occupations Code Chapter 108 (criminal history gatekeeping) involving social work applicants were discussed. The case is pending in the Fifteenth Court of Appeals after the trial court denied a plea.
BHEC described reliance on national licensure exams owned/controlled by national associations, limiting Texas's control over content and standards. They commented on the Psychology exam where a national association previously attempted to raise requirements and BHEC helped lead efforts to reverse changes. BHEC is studying creation of a new exam intended for multi-state use (not Texas-only) to support mobility and reduce future entry barriers. BHEC plans to issue a bid in the summer and return to the Legislature with estimated costs.

There was discussion regarding a Spanish-language social work exam. HHSC/BHEC made efforts to negotiate with the national exam owner but were unsuccessful; funds allocated for this have not been spent and may be returned.

There was discussion on multilingual exams, but psychometric advisors warned translation is not defensible unless the exam was built in the target language from the start; BHEC continues exploring options.

Strategic planning ideas included expanding the school psychology recertification concept by creating a program to certify university degrees as meeting licensure requirements (similar to nursing board practice). Customer service/operations need a modern online applicant dashboard and improved web interface because the legacy systems are failing and requires investment.

Department of Family and Protective Services. DFPS Presentation Materials

DFPS reviewed its updated mission/values that focus on empowering families and communities. DFPS core functions include Statewide Intake; Adult Protective Services; Child Protective Investigations (including licensed childcare provider investigations); Child Protective Services (in-home services, foster/kinship placements, permanency outcomes).

Operational metrics and staffing trends:

Statewide intake turnover has decreased, and call wait times continue meeting the LBB benchmark (7.4 minutes) despite increased report volume.

E-report volume is up ~30% over last year.

APS turnover has decreased with full implementation of "Training While Working," supporting performance timelines and quality.

CPI turnover has decreased from 47% in FY2022 but remains the highest due to job difficulty and safety risks; timeliness of contact and case closure metrics have improved.

CPS turnover has increased in areas approaching community-based care transitions (as workers seek other jobs); caseload levels in legacy areas remain stable.

Foster care population has significantly decreased since 2021 stabilizing in 2024–2026; DFPS emphasized increasing placements in home-like settings including kinship placements.

Family engagement initiative (started 1 year ago) aims to prevent removals when safe, increase kin placements, and improve reunification outcomes through earlier engagement and better service planning.

Kinship initiative:

- Phase 1: improve home assessment processes and training; address region-specific barriers.
- Phase 2: earlier engagement of specialized kinship staff, stronger kin finding, and faster financial support to kinship caregivers.
- "Rider 40" campaign that updated website/toolkit, resources, training/newsletters, video series, and social media to increase awareness of supports (e.g., WIC/TANF) and the benefits of becoming a verified kinship caregiver. The reimbursement now is comparable to basic foster family.

Family Team Meeting pilot launch is planned June 1 in Regions 1, 2, and 7 North. The focus is earlier family team meetings quickly after the safety assessment indicates a child is unsafe, to connect supports quickly and potentially prevent removal. The criteria is danger indication being present plus a known substance use issue. DFPS noted it

cannot resource this for all investigations, but a pilot will have results expected before session.
Service capacity challenges were reported in the sunset self-evaluation. These include: limited after-hours services, rural availability gaps, language accessibility, transportation barriers, and waitlists.

Health and Human Services Commission HHSC Presentation Materials

HHSC panel included Executive Commissioner Stephanie Muth, Medicaid/CHIP policy update by Michelle Irwin (substituting for Valerie Mays), and eligibility operations update by Rachel Patton.

HB 109 / Terrell Center for Youth:
HHSC was directed by rider to establish an RTC for up to 30 DFPS-conservatorship youth, including high-acuity youth with behavioral health/substance use/IDD needs. Hiring key leadership began in February and job fairs are planned; MOUs are also planned with Terrell ISD and DFPS. Admissions are expected to begin September 2026 with staggered admissions. The unit should be fully online by January 2027.

Rider 60: funding to contract with Spindletop (LMHA) to support a psychiatric residential youth treatment mental health respite facility and an educational opportunity center is progressing with the contract pending final LMHA approval.

HB 26 related to nutrition counseling as in-lieu services + high-risk pregnancy pilot, requires MCOs be allowed to offer nutrition counseling and/or instruction as in-lieu of services. It is optional for MCOs and voluntary for members. The services must be medically appropriate, cost-effective, evidence based.

A Pilot has been authorized for high-risk pregnancies to offer nutrition counseling, medically tailored meals, and other evidence-based supports. Implementation planning includes literature review, defining populations/services/providers, planning for new provider types and billing codes and managed care contract requirements, and engagement with the State Medicaid Managed Care Advisory Committee. Target implementation is September 2027. The pilot ends August 2030. There is an annual reporting requirement plus a one-time pilot report. HHSC stated it is not doing rulemaking for HB 26.

HB 136 lactation consultation as Medicaid benefit requires a new benefit policy, procedure codes, reimbursement/billing guidelines, provider certification requirements. It also requires Texas Administrative Code updates and federal approval via a Medicaid state plan amendment. The timeline includes stakeholder listening session (planned); informal comments on draft rules expected in coming months; draft policy/rules/rates for public comment in fall; CMS submission in winter. The benefit is targeted to be effective March 2027.

SB 379 SNAP Healthy Foods Waiver: prohibits purchase of sweetened drinks and candy with SNAP (with specified exclusions like medical-grade electrolyte drinks and milk-based/milk substitute products). Regarding the timeline, a waiver intent was announced in May, and the waiver was submitted June 25 and approved in August. The provision was implemented April 1 in Texas.

- Retailer/advocate workgroups, store walkthroughs, and biweekly retailer support used for implementation readiness.
- Client communications included March robocalls and mid-April text follow-ups; website guidance and retailer toolkit published.
- Evaluation required by USDA FNS: pre- and post-implementation surveys. The post-survey is open through May 31 with a report due at the end of September.

HHSC Fraud Prevention HHSC Presentation Materials on Fraud Waste and Abuse

Emily Zolkovsky, Rachel Patton, Raymond Winters, Susan Biles were presenters on behalf of the Texas Health and Human Services Commission (HHSC). HHSC presented how it embeds fraud, waste, and abuse (FWA) prevention in eligibility operations (SNAP/Medicaid/CHIP/TANF) and Medicaid operations.

HHSC emphasized it is the "front door" for preventing FWA via program design, administration, and oversight, not just downstream investigations by the Office of Inspector General (OIG). HHSC serves 7.5 million people across 200 programs; Medicaid and SNAP are two of the largest. Taxpayers invest $60B+ across Medicaid and SNAP (state + federal); HHSC programs and processes 6 million applications annually.

Prevention efforts were highlighted: early adoption of electronic visit verification (EVV) for certain Medicaid services; early adoption of a third-party data aggregator to help eligibility workers verify applicant information. Program design also provides checks

against fraud. For instance, Applied Behavioral Analysis (ABA) benefit controls included requiring an autism diagnosis, meaningful parental participation, licensed behavioral analyst leadership, and prior authorization/reauthorization at set intervals tied to treatment progress.

Medicaid integrity

HHSC described using a Medicaid/CHIP data analytics unit (created by the legislature) to detect trends/anomalies and refer suspected fraud to OIG. As an example: a 2023 referral involving a single mental health rehab/targeted case management provider that had higher-than-average costs and is now an active case at the federal level.

Managed care: Medicaid is delivered via managed care (MCOs/health plans) plus limited fee-for-service (e.g., some IDD waiver populations). Fraud controls include benefit limitations, diagnostic restrictions, prior authorization, and claims-system edits; EVV is used to confirm in-home service delivery before paying claims.
Provider Enrollment Management System(PEMS) was described and HHSC acknowledged challenges that are being addressed through a legislatively funded rebuild that is targeted for rollout by end of the biennium.

A Federal letter has been received requesting revalidation of highest-risk providers and improvements over two years; HHSC is preparing a response.

Provider screening efforts include business/tax checks, background checks, fingerprint checks for highest-risk providers, ownership checks, work authorization checks; expansion of SAVE use into provider enrollment which is planned as part of redesign.

Managed care requirements: MCOs must maintain Special Investigative Units (SIUs) and cooperate with HHSC/OIG/OAG; contracts allow immediate changes to requirements (e.g., prior auth) when fraud, waste or abuse is suspected. Managed care oversight includes utilization reviews and financial oversight. Fee-for-service and waiver provider monitoring follows 3,000 provider contracts through financial and programmatic oversight; corrective action plans, payment holds, and possible contract termination for noncompliance or egregious issues.

Program integrity: The 2024 Medicaid payment error rate was reported at 1.3% vs. national rate which is a little over 5%; In the past three cycles' errors reported were not due to fraud.

Eligibility/SNAP integrity operations

Eligibility operations: 6,000 staff; 6 million applications/year; 15M tasks/year including redeterminations and changes. Of the total recipients, 4.3 million are on Medicaid/CHIP, 3.2 million on SNAP, 24K on TANF.

Texas Integrated Eligibility Redesign System (TIERS) is used across programs and is a comprehensive verification required for identity, income, assets, and citizenship / immigration status.

There is a combined report pulling from 50+ data sources; examples highlighted: SAVE (immigration status) and PARIS (potential benefits in another state). SNAP interviews are used to probe and clarify questionable information.

Integrity Support Services (ISS) unit has 150 staff, and eligibility workers can escalate questionable cases for deeper review including additional data and social media review prior to certification. Post-certification monitoring is conducted by the Texas Workforce Commission that look at new hire and wage reporting, death and incarceration data; monitoring for anomalies like unreported income, lottery winnings, and out-of-state EBT usage patterns.

There is a plan to default SNAP recipients to opt-out of out-of-state purchasing (with ability to toggle on/off via mobile app), aimed at reducing skimming impacts. Out-of-state use is monitored alerting staff to consecutive out-of-state shopping for 30 days. This would flag and trigger residency validation issues. Border-area shopping patterns are considered.

Skimming Magstripe-only cards are more susceptible. Chip cards send one-time codes and can reduce (not eliminate) skimming. Future consideration includes exploring chip EBT card and mobile wallet options. It was noted that increased security can only occur with higher cost. There have been federal changes related to replacement benefits. After Dec 21, 2024, benefits stolen via skimming are no longer replaceable federally, raising concern about lack of recourse and potentially reduced reporting.

Seeking access to more data sources for identity verification, including DPS photo ID data; would require statutory change and likely some systems interface cost. Continuous improvement includes: strengthening policy (expungement rules; stronger verification for error-prone items like shelter expenses; opt-out for out-of-state purchases), increasing monitoring (increasing QC case samples; more onsite reviews; targeted screening for high allotment cases; PARIS integration into eligibility system), and system improvements (enhanced alerts; robotic process automation to reduce manual entry; stronger identity verification).

Member questions

Question regarding SNAP skimming solutions: HHSC reiterated magstripe vulnerability and chip card potential; noted chip card move would require funding and phased implementation; stated this would be brought forward for legislative discussion.

Disaster/out-of-state usage concern was raised: HHSC confirmed beneficiaries can still use cards out of state; feature would be user-toggled and there are interstate agreements that are required for out-of-state usability.

Question on COVID-era self-attestation and tip income: HHSC stated income must be validated for SNAP (e.g., verification via two pay periods), though some tip data may not appear in electronic sources.

Question on TANF/SNAP automatic eligibility: verification may be reused, but eligibility is not automatic across programs.

Question on skimming loss data: HHSC offered to prepare and send historical data on losses (especially when benefits were being replaced), noting current underreporting concerns since replacement ended.

Question on DPS data access difficulty and associated cost: HHSC said statutory change would be needed and systems modifications could create costs.

Question on non-emergency medical transportation (NEMT) policy review including pharmacy trips: HHSC confirmed the policy review includes prescription pickup. There

were concerns about multiple trips per day and there can be legitimate reasons these occur. HHSC will review the policy.
Question on mail-order prescriptions and 90-day vs 30-day supply: HHSC noted mail order exists but is optional; HHSC would follow up on whether 90-day supply is mandated and available.

Question on NEMT verification, especially for rural access: HHSC described modalities (Uber/Lyft, bus passes, airfare for rare out-of-state specialty care, friend/family driver) and checks such as matching transportation claims to medical claims and provider enrollment checks (including driver's license verification) for certain arrangements.

Office of Inspector General (OIG) OIG Presentation Materials

Texas HHS expenditures are over $53B annually (state + federal), with Medicaid the largest share at roughly $42B (about 25% of the state budget). The OIG is a 600-person agency attached to HHSC but operating independently to protect programs from fraud, waste, and abuse.

Medicaid is a public-private partnership involving HHSC administration, providers, pharmacies, labs, managed care plans with voluntary participation; all creating a responsibility to comply with program rules.

Pay and Chase: HHSC builds front-end guardrails, while OIG focuses on recovering dollars that are lost through mistakes, disputes, misrepresentations, or criminal activity. Recovery errors are described on a spectrum from innocent error, good-faith disputes, to knowingly misrepresent and outright criminal misconduct. The OIG investigates across the spectrum.

There are national estimates that up to 10% of the national HHS spend may be lost annually (implying $5.3 billion in Texas), and another estimate of 6.4% of a state's total budget (implying $11 billion for Texas).

The OIG pointed out enhanced statutory remedies from the last session that included: treble damages (3x recovery) for knowing misconduct, administrative penalties per violation, and exclusion from participation; criminal matters are referred to the Office of the Attorney General.

Coordination, tools, and examples

The OIG described program integrity as a "three-legged stool": OIG (administrative), OAG civil enforcement (Healthcare Program Enforcement Division), and OAG criminal enforcement (Medicaid Fraud Control Unit), with regular coordination. He highlighted multi-agency collaboration of APS/DFPS referral involving consumer-directed services where funds continued after an attendant stopped working. This was; referred to OAG and federal partners and resulted in a federal indictment and a 17-year sentence; Referral sources include HHSC, DFPS, managed care partners, public web portal, and hotline; OIG also generates leads via data analysis. Oversight tools include audits, investigations, inspections, clinical utilization reviews, and data-driven analytics.

In FY 25:

- $465M recovered (state + federal),
- With $410M from provider misconduct and
- $56M from client misconduct;
- 364 exclusions;
- ROI of $4.21 returned per $1 invested.

Governor directives and current initiatives

Governor Abbott's January directive (as described) included reviewing high-risk Medicaid services and taking actions to ensure Texas avoids issues seen in other states. The OIG reported it was already monitoring federally identified high-risk services and has since deepened analysis, referring providers of interest into the appropriate oversight pathway (investigation/audit/clinical review).

The OIG surveyed MCO Special Investigative Units and staffing;. Some plans reported not meeting certain contractual requirements for management/investigator credentials, and OIG is working through those issues.

Training efforts have included enhanced training in March (in addition to annual training) on high-risk services and fraud schemes.

Public fraud reporting improvements included a new, more user-friendly online reporting system (rolled out in December), increased website visibility, coordinated social media, and adding reporting links within the Your Texas Benefits website/app.

Common fraud schemes (Medicaid + SNAP) and policy recommendations

Provider misconduct included upcoding (billing higher-cost services than delivered), with a cited $1.7M settlement involving billing RN services when LVN services were provided. Another cited resolution involved a $4M settlement with Dallas-area dental providers related to illegal solicitation via third-party marketing companies under the Texas Anti-Kickback Statute; additional investigations are ongoing and coordinated with OAG.

SNAP fraud, waste, and abuse categories

- Client fraud (misreporting income/household), with an example of an influencer concealing income and being arrested/charged.
- Trafficking (exchanging benefits for cash), including examples involving restaurant/food truck operators and mobile vendors draining accounts.
- Benefits theft (skimming, data breaches, social engineering), with noted nationwide increase starting 2021 and a surge in Texas in 2022.

Provider enrollment screening : The OIG conducts federally required screenings (criminal history, exclusions and sanctions, licensure verification) for newly enrolling/re-enrolling providers. Regarding high-risk categories (e.g., nursing facilities, DME), and providers with concerning histories, the OIG recommends to HHSC whether to enroll.

There has been a significant provider screening backlog. FY25 saw 96 thousand screenings (15 thousand more than normal), and the first six months of FY26 saw 92 thousand. The cause included a TMHP backlog that was shifted to the OIG. This has, increased the complexity due to NPI enrollment (large systems pulled into “high-risk” screening), and more new provider enrollments. OIG ius addressing the backlog by hiring 8 staff, shifting vacancies, moving 4 internal staff, and implementing process changes. HHSC is providing 60-day extensions so providers with in-flight applications can continue billing.

Policy/program integrity recommendations

- Consider a one-to-one relationship between enrolling and billing entities (not feasible within the current PEMS upgrade; would require multi-year re-engineering).
- Create a personal care attendant registry to enable identifiers across agencies/EVV and improve detection of impossible hours, duplicate billing windows, solicitation, and "bad actors" moving between agencies (also described as a major systems/regulatory/staffing lift).
- Improve verification of IDs for client enrollment (limit/validate temporary IDs, out-of-state documents, third-party birth certificates), noting some constraints are federal; explore DPS-based verification.
- Add chip technology to SNAP cards and enable multi-factor authentication for PIN changes to reduce skimming and account takeover.
- Improve cross-state and federal data sharing for investigations; seek clearer federal authority/guidance and access to databases like T-MSIS to identify multi-state enrollment/claims patterns and emerging schemes.

Committee member Q&A

The Chair asked about TMHP performance on enrollment oversight; HHSC stated it oversees the contracts (now split between tech and provider-facing/process vendors), monitors KPIs, and addresses performance issues through contract mechanisms, noting complexity and provider back-and-forth contributes to delays.

OIG stated it will request additional staffing via an exceptional item next session and is working to fund temporary staff beyond the fiscal year.

The Chair asked about statutory flexibility in benefit design; OIG emphasized the need to balance guardrails with timely access, noting fraud evolves as loopholes close.

There was discussion on upcoding trends (including AI concerns). No specific metrics were cited but there was agreement that upcoding has long existed and the system will remain imperfect.

The Chair asked about diagnostic/procedure codes related to child abuse and potential triggers for review. OIG noted that claims data alone doesn't identify whether services were part of a child abuse investigation, but codes/factors could be explored as indicators, likely requiring expert clinical review.

The Vice Chair asked how overpayments are recovered. The OIG stated recoveries come from the entity that received the improper payment (even if innocent), and payment plans can be used when reasonable.

The Chair called Jamie Dudensing (Texas Association of Health Plans) and David Smith (HHAeXchange)

Ms. Dudensing commented on the core tension in Medicaid: maintaining access for vulnerable Texans (children, pregnant women, elderly, disabled) while managing high-FWA-risk service areas (e.g., DME, attendant services).

Texas was an early adopter of Medicaid managed care with statewide expansion occurring in 2011. Ninety eight percent (98%) of Medicaid clients are now in managed care (acute care plus long-term care for elderly/disabled).

The state pays MCOs a per-member-per-month premium, and the plans are financially at risk for costs and are incentivized to avoid improper payments; Texas shares profits/savings back to the state while capping administration and profits.

There are "Four buckets" of managed-care FWA activities:

- Pre-payment controls ("pay right the first time"): provider credentialing, network contracting, negotiating reimbursement rates, prior authorizations, front-end automated claim edits, and payer-of-last-resort recovery.
- Post-payment review: utilization review after payment (plans must pay within 30 days), identifying improper billing (e.g., adult dental), double-billing, and other anomalies; recoupments pursued via full recovery, payment plans, or offsets against future payments.
- SIU investigations: when patterns suggest a bad actor (beyond error), MCO special investigation units conduct record reviews and build evidence; Ms. Dudensing noted investigations become administratively expensive and it's cheaper to prevent errors up front.
- Referral to OIG: SIU packages are referred to OIG; OIG has ~10 days to indicate whether it will take the case; often plans are directed to pursue dollars.

Benefit design was highlighted as critical to prevention (guardrails like Prior Authorization, clinical criteria, caps). Ms. Dudensing cited an independent study finding $13.9B saved (2009–2017) versus fee-for-service.

Examples of benefit/rate vulnerabilities and guardrails:

- ABA/autism therapy: Texas has avoided some other states' issues due to careful benefit design (PAs, clinical criteria, caps).
- Behavioral health rehab/skills training: high historical rates and unlicensed service delivery created a "get rich quick" vulnerability. MCOs responded by tightening network and payment approaches. Example of non-clinical billing included "life skills" as teaching basketball dribbling.
- Transportation: MCOs match transportation claims with same-day medical claims to flag likely improper billing.
- EVV was described as a "clock in/clock out" tool. There were pandemic-era grace periods reduced enforcement. EVV is now seen as an opportunity to expand/strengthen verification.

Ms. Dudensing made some policy recommendations:

- Study options for stronger prepayment prevention/investigations and potential prepayment holds (beyond today's prepayment denials) and align with emerging CMS guidance.
- Require fiscal and FWA analysis for HHSC benefit design/policy changes that do not go through rulemaking and are not directed by the legislature or federal government.
- Create an HHSC stakeholder/committee process focused specifically on FWA guardrails (including topics like EVV enhancements) to tee up ideas for legislative consideration.
- Move toward "day one managed care" (immediate enrollment in managed care rather than up to 45 days of fee-for-service exposure); CHIP already operates this way.

Committee Members Discussion

Ms. Dudensing explained that benefit design changes often occur via policy processes (not always rulemaking), so fiscal analysis requirements don't always apply.

Upcoding: longstanding issues, ER severity code shifts.; There are newer AI-related trends that add more diagnosis codes, increasing severity/acuity and reimbursement without more services.

Plans use thousands of automated triggers for review (ER severity patterns, diagnosis-code mismatches, therapy time-unit patterns) and request medical records to validate services.
With child abuse related billing, there are no procedure codes identified, but diagnosis codes exist for suspected/confirmed abuse.

Linkage across providers and pattern detection may be limited. Broader pattern analysis is possible across claims and diagnosis coding.

Prepayment hold concept was discussed. Ms. Dudensing recommended studying safeguards to avoid penalizing non-bad actors. A possible model is holding payment until a records review is completed.

David Smith (HHAeXchange) described EVV as a federal mandate under the 21st Century Cures Act, requiring six data elements: who provided care, who received care, where, date, start/end time, and what services were delivered. HHAeXchange provides Texas's state-sponsored EVV solution (providers may use other vendors) and the EVV data flows to HHSC's aggregator to support claim validation.

EVV strengthens front-end controls and shifts from self-attestation toward verified time/location; supports claim validation, program integrity, SIU investigations, audits, and legislative review. Key Texas strengths include statewide EVV across fee-for-service and managed care, strong provider adoption/compliance, CMS-certified system, and linkage between verified visits, claims, and authorizations.

Mr. Smith's recommended next steps (moving "from compliance to insights"):

- Cross-plan EVV data sharing to detect caregiver conflicts/double-booking across MCOs (example: New York).
- Workflow insights for real-time flagging, documenting outreach, and enabling corrective actions before claim payment.
- Consistent statewide unique provider ID for caregivers (not necessarily NPI-level) to improve identification and reduce "abrasion."

Member Q&A focused on geolocation: Texas EVV already captures time/place. Validation methods include app (most secure), IVR tied to member phone, and fob/token method which is being phased out. The App has the benefit of storing location offline and upload later.

HHSC IDD services and waiver structure HHSC Presentation Materials on IDD

IDD is defined as chronic, lifelong conditions affecting cognitive and adaptive functioning with diverse causes (genetic, prenatal, delivery complications, postnatal injury/exposure). Functional impacts include language, mobility, learning/problem solving, self-care, independent living, and potential need for support up to 24/7.

Service continuum:

- Facility-based: Intermediate Care Facilities (ICFs) and state-supported living centers (SSLCs).
- Community-based: attendant care, habilitation, residential options, therapies, skills training/socialization, crisis services, etc.

Commissioner Muth noted an internal organizational change to strengthen continuum-of-care leadership by aligning facility- and community-based services under a single leader (Jordan Dixon).

Medicaid HCBS waivers for IDD: CLASS, DBMD, HCS, Texas Home Living (TxHmL). HCS is the only one with residential options (group home/host home companion care). Waivers are capped and must be cost neutral (average waiver cost cannot exceed institutional cost). All waivers must be approved by CMS.

HHSC defines services and policies, obtains federal approvals; contracts, trains, supports providers and LIDDAs; manages some interest lists (HHSC for CLASS/DBMD; LIDDAs for HCS/TxHmL), determines functional and financial eligibility.

Oversight is provided through contract management, financial oversight, utilization review, and regulatory oversight.

Regulation

HCS/TxHmL providers are regulated via Medicaid contract certification standards; surveys/complaint investigations by long-term care regulatory team with enforcement by regulatory enforcement teams. HCS providers are surveyed within 120 days of first placement and annually thereafter.

Abuse/neglect/exploitation (A/N/E) is investigated by HHSC. The intake function (presently at DFPS, moves to HHSC on 9/1/2027 under HB 4696 (88th Legislature). Enforcement tools that are available include: corrective action, administrative penalties, decertification; A/N/E perpetrators may be placed on Employee Misconduct Registry after due process.

Regarding the backlog, HHSC reduced the backlog by 57% over the last 13 months and expects to eliminate it by end of year due to added resources from last session.

CLASS/DBMD provider oversight: licensed as HCSSAs; surveyed at initial readiness and every 3 years; complaints received/investigated by HHSC; violations can lead to corrective action and license revocation.

LIDDAs are the community entry point for navigating the IDD system. Key delegated functions include information/referrals, service navigation, interest list management (HCS/TxHmL), eligibility testing/psychological evaluations (HCS/TxHmL), and service coordination/monitoring post-enrollment.

Interest lists

- Anyone can join; no upfront eligibility; first-come/first-served; individuals may be on multiple lists.
- Reserved capacity exists for certain crises/institution transitions.
- Eligibility is determined when slots are available (functional level of care + financial eligibility), then the individual chooses provider and receives assessment/service plan.
- Slot release depends on appropriations, attrition, uptake/decline, and cost growth.
- Uptake rates vary): HCS 41.7%; CLASS/TxHmL 16–17%; DBMD 11%.

Addressing Legislative Mandates:

STAR+PLUS IDD pilot (SB 7, 83rd; revisited HB 4533, 86th) did not proceed due to lack of funding.

Interest list questionnaire (HB 3720, 87th) implemented Aug 2023; 105,774 unduplicated questionnaires were received Aug 2023–Mar 2025. There were limitations that include issues with self-reported data and incomplete responses. Questionnaire

highlights: 48% reported needing help with daily activities; 25% reported transportation or financial barriers; a little over half expected to need services within 3 months. Some states prioritize by urgency rather than first-come/first-served; some enroll at lower service levels first. Waiver structures vary.

HHSC summarized system challenges that include fragmented waiver structure, difficult navigation, mismatch between waiver and individual needs, increasing co-occurring behavioral health needs. Nearly half of new SSLC admissions in FY25 came from people previously in community HCS slots and moving due to inability to get needed supports. 988 individuals received HCS crisis diversion slots in FY24–FY25.

Oversight HHSC stated there are limited statutory/regulatory tools for HCS group homes (annual survey for 3–4 bed facilities; administrative penalties; lack of suspension/revocation tools; complaint structure largely limited to A/N/E). HHSC suggested a continuum of options between current approach and full licensure.

Committee discussion:

Rep. Rose asked who manages the lists and about very long wait times. HHSC stated LIDDAs manage HCS/TxHmL lists with contact every two years; HHSC releases slots typically monthly when resources allow.

Members asked about additional supports while waiting. LIDDAs can connect individuals to state GR-funded community services (behavioral supports, day habilitation, respite).

Rep. Noble asked for population estimates (IDD adults and IDD children who will become IDD adults); HHSC agreed to get that information for the committee.

Data reported included the following: 2,450 people released and enrolled from interest list during the biennium as of 8/31/2025; nearly 15,000 were denied, declined or withdrew in the same period; unduplicated interest list across six lists was 198,321 (this includes two non-IDD waivers and HHSC agreed to provide the IDD-specific number.

Vice Chair Manuel asked for an estimate of the cost to “fully fund” serving eligible people on all interest lists. HHSC indicated they can estimate but costs are ongoing and

depend on eligibility/uptake, staffing capacity (HHSC/LIDDA), and provider workforce capacity.
There was discussion about sharing school-based assessment data (TEA) with HHSC/LIDDAs to improve planning. HHSC said they can start with conversations with TEA and noted school qualification and referral does not equal waiver eligibility.

Chair noted ongoing interim work, including ensuring individuals in SSLCs can receive prescriptions under the Compassionate Use Program in light of new federal changes.

Jenny Good, Betty Hardwick Center and Texas Council of Community Centers described LIDDAs as units of local government under contract with HHSC, performing intake/access, crisis response, limited safety-net services, and transitions in/out of high-need settings. Ms. Good highlighted resource imbalance with IDD services being a smaller share of state/local resources than mental health. Less than 20% of local expenditures go to IDD and the share has declined over 15 years.

Workforce Recent wage investments for direct support professionals were felt more in physical disability programs. Group-home IDD staff remain below market, driving vacancies, turnover, reduced capacity, and quality risks.

There is strain on the system with increasing SSLC admissions and census for the first time in a decade and more people with IDD are in state hospitals. Local authorities scaled back nursing supports and day habilitation as flexible family support funds were eliminated in 2011 alongside a $65 million GR reduction for IDD community services.

Additional waitlist: 16,000 Texans are on GR-funded service waiting lists and due to limited resources they cannot receive services from the LIDDAs. Ms. Good noted that the targeted case management rate hasn't increased in 17 years, producing $40 million annual loss systemwide.

Scott Daigle, Texas Council for Developmental Disabilities shared council-member-driven issues:

- Caregiver workforce issues-- inadequate staffing/backup, burnout. He recommended including higher pay/benefits, training and certification pathways, and a deep-dive study on caregiving realities.

- ISS (individualized skills and socialization) programs replacing day habilitation need better continuity after public education ends at age 22. Funding needs include supplies, training, facility maintenance and expansion.
- **IDD Strategic Plan** (released Jan 2022) has had little follow-through. He urged updating it for the next five years and moving recommendations forward.

Carol Smith, Private Providers Association of Texas and Sandy Batton, Providers Alliance for Community Services of Texas focused on capacity, regulation, and practical solutions

- There is unused residential capacity but constrained by staffing. There are: 15,000+ HCS group-home certified beds with 5,300 of them unoccupied;4,700 ICF licensed beds with 565 unoccupied.
- They emphasized that a bed is not usable without qualified staff. Staffing shortages and overworked staff risk safety.
- Regarding regulation there are survey backlogs and reduced survey coverage for host homes (20% sample) with quarterly provider visits.

Recommendations were grouped into three areas:

- Remove barriers to use existing resources: remove 24/7 awake-staff requirement in 4-bed group homes (allow sleep staff similar to 6-bed ICFs) and enable flexible staffing.
- "Technology-first" allowing remote supports and monitoring, assistive technology (e.g., sensors/alarms/cameras with consent), telemedicine options, modernize billing rules for common tech usage (e.g., tablets for communication), promote electronic documentation and reduce wet-signature and non-interoperable reporting burdens.
- Refocus oversight where risk is highest. Clear the A/N/E backlog and improve survey processes using electronic records. Revisit host home requirements and reduce unnecessary administrative burden for parent host homes.
- Fix the front door-- publish real-time provider/vacancy information and regulatory history (noting older tools once existed) and improve transparency about which providers actually offer group homes. Ensure better enrollment timelines and place Medicaid eligibility specialists at LIDDAs.

Sabrina Gonzalez Salcedo The Arc of Texas stressed individualized needs be addressed and the massive scale of the interest lists (198,321 across six lists as of March 2026), and the practical effect of 17–18 year waits.

Ms. Salcedo highlighted budgeting mechanics citing if the legislature funds interest-list reduction but not base cost growth, funds intended for new slots may be diverted to cover existing caseload cost growth.

She recommended stabilizing supports while waiting, including greater awareness and use, including targeted expansion, of Community First Choice (CFC) and strengthen Texas Home Living (TxHmL) as a lower-needs entry point.

Discussion also touched on criminal justice involvement for people with IDD. Ms. Salcedo emphasized prevention and stabilizing services before crisis occurs. Carol Smith added that there is limited access to behavioral health providers (psychiatrists/psychologists/therapists) and short ED "stabilize and discharge" cycles which exacerbate the problems.

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