



Health and Human Services

Policy Council for Children and Families

May 14, 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.





[Policy Council for Children and Families](#) works to improve the coordination, quality, efficiency and outcomes of services provided to children with disabilities and their families through the state's health, education and human services systems. Members:

Dr. Ebony Beaudoin

Physician Representative
Houston

Lawanda Brown

Family Representative
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Dr. Thelma Green

Family Representative
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Dr. Shailen Singh

Family Representative
Jarrell

Stephanie Tower

Advocacy Organization Representative
for Autism Spectrum Disorder
Houston

Elizabeth Tucker

Advocacy Organization Representative
Austin

1. Welcome, call to order, roll call, and introductions. The meeting was convened by Elizabeth Tucker, presiding officer.

2. Consideration of March 12, 2026, draft meeting minutes

The minutes were approved as drafted

3. Presentation: Attendant Reimbursement Rates and Average Wage



Summary. HHSC Provider Finance presented changes effective Sept 1, 2025 implementing new attendant service rates across multiple LTSS programs per Rider 23. Rider 23 rate assumptions included an average attendant wage of \$13/hour plus 14% (community) or 15% (residential) for payroll taxes/benefits, and an added \$0.24/hour administrative component. The prior base wage requirement of \$10.60/hour ended Aug 31, 2025 and rules were amended accordingly.

The new requirement states that at least 90% of attendant service revenue must be spent on attendant and attendant-like compensation. No minimum base wage is required, and providers may use wages, overtime, and bonuses. HHSC will calculate the 90% threshold using biennial cost reports (with pre-populated revenue/units and provider-entered attendant expenses) and report annually by Nov 1 on providers below 90% to state leadership and via public posting.

HHSC plans to align “direct care worker” definitions with CMS access rule guidance and is modifying cost reports to allow clinical supervision reporting but rates won’t be adjusted until impacts can be evaluated.

Costs excluded from the attendant cost center for the 90% ratio included required training, travel/mileage, etc.

Presentation

On September 1, 2025:

- HHSC implemented new rates for attendant services effective for dates of service on or after September 1, 2025.
- HHSC updated reimbursement methodologies for certain services, including attendant services under Rider 23.

Establishment of Average Hourly Wage [The 2026-27 General Appropriations Act \(GAA\), Senate Bill 1, 89th Legislature, Regular Session, 2025 \(Article II, Rider 23\)](#) Effective September 1, 2025:

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



- Establish direct care wage and benefits expense ratio.

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

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

How will HHSC determine the expense ratio? Rider 23(c) requires HHSC to calculate for each provider:

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

HHSC will use the following calculation to determine if the 90 percent spending threshold is met:

$$\frac{\text{Total Attendant Care Expenses}}{\text{Total Attendant Care Revenue}} \geq 90\%$$

Clinical Supervision Cost It is HHSC’s intention to align the definition of the attendant cost component with the Centers for Medicare & Medicaid Services (CMS) Final Rule, relating to Ensuring Access to Medicaid Services. (CMS revised 42 Code of Federal Regulation (CFR) Section 441.302(k)(1)(ii) and noted that clinical supervisors, including “nurses or other staff who provide clinical oversight and training for direct care workers participate in activities directly related to beneficiary care (such as completing or reviewing documentation of care), are qualified to provide services directly to beneficiaries, and periodically interact with beneficiaries should be included in the definition of direct care workers.” (89 Federal Register 40542, 40628 (May 10, 2024))

HHSC is modifying Medicaid cost reports for providers to report clinical supervision costs, which will be included in the attendant cost center.



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

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

Cost Reporting Requirements

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

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

References

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

IL 2025-25: Rider 23: Texas Administrative Code Rule Amendments, Personal Attendant Base Wage Discontinuation, Rate Enhancement Discontinuation, Established Average Hourly Wage Assumed in Methodology, and Established Direct Care Wage and Benefits Expense Ratio, effective September 1, 2025 (.pdf) [il2025-25.pdf](#)

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



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

[Transition to the State of Texas Electronic Provider System | Provider Finance Department](#)

[PFD Cost Report Information | Provider Finance Department](#)

Discussion

Regarding the legislative reports you stated that you identify providers who do not meet the attendant care expense to revenue threshold. What do you do with that information? Do you notify the providers? Are there any, um, opportunities there to let them know, or how do you, how do you carry that information forward?

HHSC stated that they intend to notify providers after the financial examination process is completed on the cost report. Once a cost report is submitted, it goes to HHSC staff who do an examination of the report to make sure that, that the report is accurate and that includes allowable costs, then providers will be notified. When they get what we call the notification of adjustments on their cost report, they will have an opportunity to, to review that information and then to engage in an informal review process. So, there is an inherent review and appeal process. Once the report is finalized it is HHSC's intention to just identify the providers that are not meeting that 90% requirement and put that in a report to the legislative offices and the governor's office, as well as publishing that information on HHSC's reports page. The providers will, will only be notified through the cost report notification processes.

When HHSC developed the rates, did you all develop those with a thought toward the fact that clinical supervision was going to be placed in the attendant compensation portion of the rate? HHSC stated they did not

When do you anticipate that you will be able to make an informed decision about whether or not the rate needs to be adjusted based on the inclusion of clinical supervision in the attendant compensation portion? HHSC stated that the change was made so that providers can report clinical supervision separately on the 2025 report



that is open for collection now. It is there those reports will go through an examination process that does not include all the attendant programs. HHSC is hoping that the '25, fiscal year data will help inform some initial evaluation of the impacts for that change.

I think that everyone was very pleased to see that the legislature made an attempt to increase attendant care rates and were very disappointed when it came out with an average wage as opposed to the base rate. I think some of us fear that the average is going to result in people receiving less than the previous base rate of 10.60 an hour. Are you all watching that, or do you have any way to query the providers to see what's happening as a result of the average being inserted into this?

HHSC stated that beyond the cost-reporting process or feedback that providers give to us anecdotally we don't really have a systematic way to query the providers.

Is there any other way besides provider self-reporting through the cost reports to actively monitor whether or not this wage increase is being implemented across the board for attendants, both in the CDS space and in the agency space?
HHSC stated he did not think so but they will take that back and see if there's any other parts of the agency that be looking into that question.

This is more of a self-reporting process that you're counting on, having the providers self-report to you all regarding their cost reporting and where those costs are being categorized, and how this average wage is being implemented. There's not any additional oversight or accountability process?

HHSC stated it is self-reporting, but providers provide supporting documentation so HHSC can validate the reported costs. So, it's not pure self-reporting, because there is a requirement that they substantiate what they put on the cost report.

4. Presentation: Pathways to Employment: Empowering Individuals with Disabilities Through Employment (Professional Contract Services, Inc.)

Summary Vanessa Ferguson (PCSI SVP, Workforce Development) described PCSI as a nationwide nonprofit focused on employing individuals with significant disabilities, with robust workforce development infrastructure.



PCSI serves 2,042 employees and 80.4% of direct labor hours are worked by people with significant disabilities. They have operations in 15 states and heavy a presence in Texas. The PCSI model includes recruitment, job suitability assessment, placement, training, supported employment, and benefits counseling; partnerships with 650+ companies.

The programs discussed included community employment program, internal vocational rehabilitation services, benefits counseling, Pre-ETS, Project SEARCH sites, and Summer Earn and Learn (supporting earlier transition engagement).

Key barriers/opportunities identified in Texas include low DSP pay and turnover, limited transition youth services, rural access challenges, late/insufficient family support, fragmented waivers/waitlists, and inconsistent case management.

Presentation

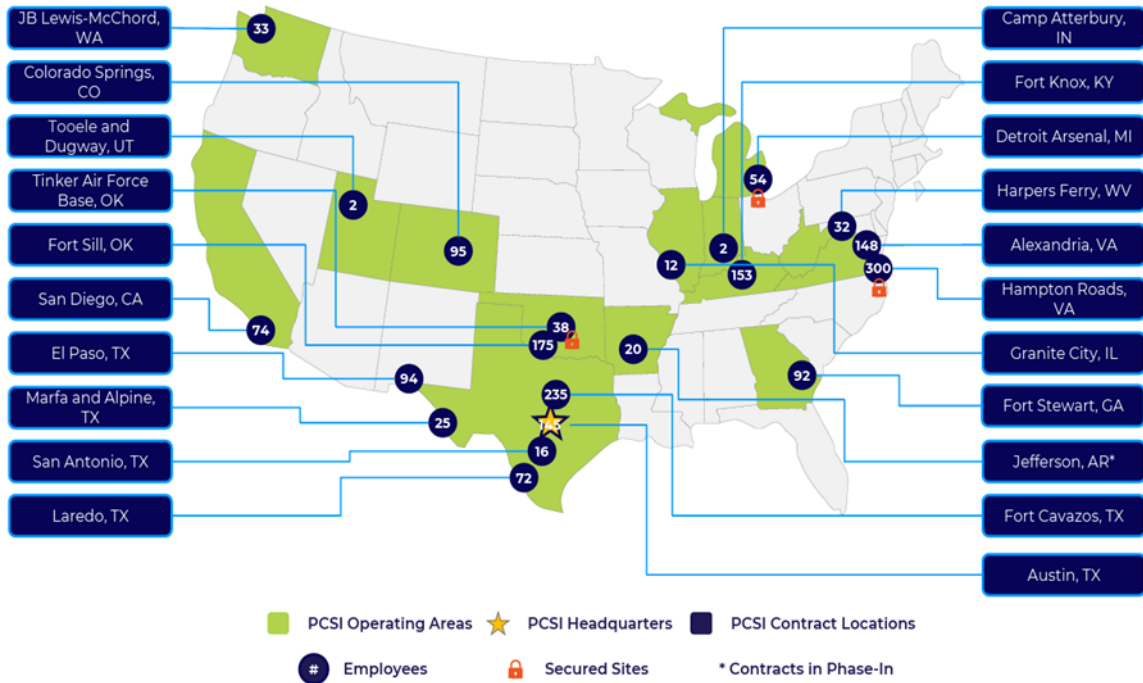
We are a socially responsible nationwide non-profit whose purpose is to improve the lives of all people with disabilities through employment. We vet, prepare, lead, and sustain a skilled workforce that provides top-tier services at job sites across the country. Total facilities management, hospital environmental services, fleet maintenance, and food service are a few examples.

We also vet, prepare, place, and support individuals from our distinctive population, enabling them to find and pursue meaningful work and careers . As champions of fairness and experts on law and policy assist other organizations in hiring for full inclusion.

Our bottom line is jobs — and offering the dignity and empowerment that comes with them.

Mission Enhance the lives of people with disabilities through employment, advocacy, and partnerships.

Where We Currently Work



PCSI's Workforce Development: Overview

PCSI provides meaningful employment opportunities for individuals with disabilities.

Careers at PCSI

Our team recruits, trains, and supports employees throughout their careers at PCSI. We provide accommodations that empower people with disabilities to participate in the workforce, achieve career goals, and gain independence.

Community Employment Program & Vocational Rehabilitation Services

Our team provides vocational and enhanced services to help job seekers prepare for, obtain, and grow in meaningful careers outside of PCSI. Through our expertise and strong community ties, we help individuals with disabilities secure rewarding employment and build successful careers.

Benefits Counseling Services

We provide benefits counseling to help individuals with disabilities understand how employment and life decisions may affect their benefits and healthcare. Through person-centered guidance, we empower participants to pursue work and financial goals with confidence and clarity.

To provide these services, it is essential for us to stay abreast of regulatory and compliance changes related to disability employment. As such, our Workforce Development department is equipped to monitor, analyze, and respond to these changes utilizing our subject matter expertise.

The CEP provides a structured approach that enables our organization to:



Our Business Model



Expanding Employment Access Across Texas



In addition to employment opportunities at PCSI contract locations statewide, PCSI's five Community Employment Program (CEP) locations in Texas support individuals seeking employment beyond PCSI.

CEP extends PCSI's workforce impact by connecting job seekers to competitive, integrated employment in local communities, including rural and underserved areas where access to employment supports is often limited.

Through employer partnerships and individualized job development, CEP ensures statewide reach, creating pathways to employment regardless of geography.

Texas Disability Services: Opportunities for Improvement

| ISSUES IDENTIFIED | OTHERS APPROACH | PCSI'S RESPONSE |
|--|--|--|
| <p>Low DSP Pay Drives Turnover and Service Disruptions</p> <p>Low DSP wages contribute to chronic turnover, which reduces provider capacity and disrupts service quality, particularly in rural and high-need areas.</p> | <p>Centralized Systems Reduce the Impact of Turnover</p> <p>Although DSP turnover is high nationwide, Virginia provides higher baseline wages which has shown to reduce turnover. Additionally, centralized service models have shown to help reduce the operational impact of turnover.</p> | <p>PCSI's Investment in Staff Stability Strengthens Workforce Participation</p> <p>PCSI pays Vocational Employment Specialists a livable wage with benefits, supporting low turnover, service stability, and increased workforce participation for clients.</p> |
| <p>Limited Services for Transitioning Youth</p> <p>The lack of resources dedicated to transition resources leads to service gaps during the school-to-adult transition, which weakens long-term employment outcomes.</p> | <p>Earlier Service Access Strengthens Transition-to-Work Pipelines</p> <p>Oklahoma and Virginia offer earlier access to services, which enables employment planning to begin closer to school exit, strengthening workforce outcomes.</p> | <p>Pre-Employment & Transition Services</p> <p>PCSI delivers transition-focused services, including Project SEARCH and Summer Earn and Learn, and Pre-ETS, helping youth and young adults build early work experience. We also partner closely with Independent School Districts to ensure seamless service delivery.</p> |

Limited Access in Rural and Underserved Areas

Provider shortages, transportation barriers, and regional variability **significantly limit access** for rural families even when eligibility is met.



Centralized Planning Provides Equitable Access and Coordination

Centralized systems, such as Oklahoma's DDS and Virginia's Community Services Boards, enable statewide planning and coordination, **increasing access in rural regions**.



Community-Based Services, Regional Partnerships, & Specialized Training

PCSI provides services to rural locations and underserved populations by **leveraging our 5 statewide CEP offices**, regional partnerships, and by providing services to **meet direct needs such as Transportation Training**.

Families Receive Too Little Support Too Late

Families often **lack timely education** on navigating services, benefits, and long-term planning, **increasing stress, delays, and burnout**.



Early, Structured Guidance Reduces Family Burden

Virginia's Community Services Boards **engage families early** (often before waiver enrollment) by coordinating eligibility, providing case management, and **connecting families to interim supports and planning resources**.



PCSI's Parent & Caregivers Bootcamp

PCSI offers a Parent & Caregivers Boot Camp, which educates families on PCSI services, goal development, and how we work together to achieve those goals, while preparing them for what to expect when navigating disability services in Texas and building self-advocacy skills.

Decade-Long Waitlists Leave Eligible and Medically-Fragile Texans Without Support

Texas' system results in **decade-long waits for services, with little to no interim support** for eligible individuals while they wait.



Active Waitlist Management With Earlier Access and Interim Supports

Oklahoma made targeted changes to actively reduce its waitlist, **cutting average wait times from approximately 13 years to 1 year**.

Fragmented Waivers Create Barriers to Access

Multiple waivers with different rules and processes create a fragmented system that is **difficult to navigate and leads to inequitable access**.



Centralized Entry Points Simplify Access

Oklahoma uses a **single entry system** and Virginia uses **Community Services Boards** to provide centralized front door access to services.

Inconsistent Case Management Limits Service Coordination

Case management varies significantly by region and waiver, resulting in **inconsistent coordination of services and supports**.



Early and Consistent Case Management Across Services

Both Oklahoma and Virginia assign case managers earlier and more consistently, improving continuity and person-centered planning.

Texas Disability Services: Strengths & Constraints

| | STRENGTHS | CONSTRAINTS |
|--|---|--|
| Specialized Program Variety vs. System Complexity | <p><u>Comprehensive Waiver Portfolio:</u></p> <ul style="list-style-type: none"> Allows for specialized supports for diverse needs Ability to tailor services | <p><u>System Complexity and Access Barriers:</u></p> <ul style="list-style-type: none"> Multiple waivers with different rules Difficult navigation for families Long interest lists and uneven availability |
| Community-Based Vision vs. Delayed Access | <p><u>Commitment to Community-Based Services:</u></p> <ul style="list-style-type: none"> Home- and community-based supports Independent living focus Alignment with national Home and Community Based Services (HCBS) best practices | <p><u>Delayed Realization of Benefits:</u></p> <ul style="list-style-type: none"> Extended waitlists delay entry Community integration postponed Critical life stages missed |

| | | |
|--|--|---|
| Innovation & Flexibility vs. Limited Reach | <u>Flexibility and Innovation in Service Design:</u> <ul style="list-style-type: none"> • Non-traditional / innovative therapies • Person-centered approaches | <u>Limited Reach of Flexible Options:</u> <ul style="list-style-type: none"> • Flexibility only after access • Years-long waits delay utilization |
| Strong Provider Infrastructure vs. Capacity Constraints | <u>Robust Provider and Employment Infrastructure:</u> <ul style="list-style-type: none"> • Large provider network • Employment & workforce development programs • Nonprofit and employer partnerships | <u>Capacity and Workforce Constraints:</u> <ul style="list-style-type: none"> • Workforce instability • Inconsistent case management • Employment pipelines bottlenecked |

Discussion

There is opportunity to work with the education subcommittee.

Regarding support for transportation, how do you work with families and employers regarding transportation? The speaker stated they have large contracts and sometimes provide vans for transportation. They have worked with local officials and have had bus routes changed. They also provide transportation training and have developed a voucher program.

How do you all navigate remote working? The speaker stated that they have service contracts, so you have to be present to provide the service. On the community development side, if the person has a goal to work from home, will they work with that? The business development team develops different opportunities. They have a contract with NASA that is all remote.

Getting people involved early is critical.

5. Election of Chair and Vice-Chair . The standard advisory committee election process was adopted, and Dr. Shailen Singh was elected chair, and Patricia Longoria was elected Vice Chair.

6. Consideration of draft recommendations for the 2026 PCCF Legislative Report, as required by 1 TAC Section 351.815(d)(2)



Early Childhood/Childcare

A. Childcare: Inclusive Access and Workforce Quality

A.1 Revise childcare licensing minimum standards to require that provider operational policies include notice to families of ADA obligations; and information on Texas ECI and how to request a screening

A.2 Enhance childcare subsidy reimbursement rates for providers whose employees attend training on serving children with disabilities, early childhood mental health, and inclusive caregiving practices

B· Early Childhood Intervention (ECI)

B.1 Increase funding for Early Childhood Intervention (ECI) programs to reflect increased demand, rising service costs, and ongoing needs for staff recruitment and retention

C · Pre-K and Early Childhood Special Education

C.1 Make full day pre-K programs an option for children who are or may be eligible for Early Childhood Special Education (ECSE) services, by adding an eligibility category to existing pre-K rules

Education, Post-Secondary Education, and Transition

A. Special Education Funding

A.1 Invest in non-formula based special education funding by adopting mechanisms that supports students with disabilities in their least restrictive environment

B· Family Engagement and Access to Supports

B.1 Review classroom camera access and monitoring laws to strengthen transparency around recording access, ensuring parents of students with disabilities can obtain footage when needed to safeguard their child's health and safety and secure appropriate supports.



B.2 Improve education, awareness and access to non-educational funds for children at risk of residential placement to support community-based services, improved service benchmarks for LEAs, and increased school-based funding to provide respite for families in need.

C· Postsecondary Opportunities and Meaningful Days Post-School.

C.1 Improve data sharing between TEA and THECB;

C.2 Promote awareness of postsecondary opportunities for students with disabilities through interagency coordination and stakeholder involvement

C.3 Appropriate funds to increase the amount provided to districts for students with disabilities who graduate College, Career, and Military Ready (CCMR)

C.4 Add off-site Individualized Skills and Socialization (ISS) to all applicable waivers; ensure adequate funding for high medical and behavioral support needs post-school;

C.5. Improve access to and remove barriers to supported employment

Child, Parent and Family Support

A· Supporting Parents and Family Caregivers

A.1 Ensure families have access to medically necessary home care services and respite delivered flexibly, reliably, and without administrative barriers.

A.2 Require all eligibility determinations, service assessments, and service delivery models are fair and equitable to working families

A.3 Restore and expand flexible respite funding modeled on the In-Home and Family Support Program (IH/FSP)

A.4 Amend Medicaid waivers to expand in-home respite; set rates sufficient to sustain a viable provider network



A.5 Allow family members and household members to be paid providers of attendant services, habilitation, and respite through a kinship care model

A.6 Designate caregiving as a statewide workforce priority, leveraging coordination with existing state resources including DPRIT

A.7 Create clearer, simpler pathways for parents to access and use in-home services funding, ensuring appropriated dollars reach intended beneficiaries

B- Preventing Out-of-Home Placement: Waiver Access and Interest List Reform

B.1 Align TxHmL waiver eligibility with other HCBS waivers; remove IQ-below-75 restriction for related conditions

B.2 Allow children with SSI meeting MDCP functional criteria to enroll without waiting.

B.3 Provide dedicated funding to reduce HCBS interest lists, prioritizing children at imminent risk of nursing facility admission

B.4 Adequately fund LIDDAs for waiver eligibility assessments; allow flexibility in tools, qualifications, and frequency

B.5 Increase funding for crisis intervention specialists and crisis respite at LIDDAs to ensure children with IDD do not end up in more restrictive and expensive settings

B.6 Increase funding for SMCOT and YCOT for individuals with IDD; ensure each LIDDA has a YCOT with full statewide coverage including rural areas

B.7. Mandate specialized training for all Texas DFPS investigators and personnel who work with children and families with autism spectrum disorder and other intellectual and developmental disabilities (IDD), including communication differences, sensory and behavioral presentations, adaptive functioning challenges and trauma-informed, disability-responsive approaches to family interactions

B.8. Enhance and expand Transition Support Teams at the LIDDAs and create a referral pathway to the TST by DFPS investigators



C• Moving Children from Institutional to Family-Based Settings

C.1 Provide waiver funding to support children to move from or be diverted from institutional settings — including nursing facilities, ICFs, and state-operated programs — to live in families

C.2 Create reserved TxHmL waiver slots for young adults graduating high school

C.3 Provide legislative direction for HHSC to amend the HCS, CLASS and DMBD waivers to add Private Duty Nursing (PDN) and allow adults with intense medical fragility to access Level of Need 9 services as an alternative to institutionalization

D• Strengthening the In-Home Workforce

D.1 Increase wages for community attendants to stabilize the workforce and achieve parity with SSLCs

D.2 Amend 1915(c) HCBS waivers, 1915(k) Community First Choice, and 1115 waivers to allow and fund kinship care-type programs

D.3 Amend the Texas Medicaid State Plan and applicable waiver programs to add Licensed Health Aides (LHA), including parents as LHAs, for children and adults with medical complexities

Healthcare

A• Integrated Health Homes and Whole-Child Continuum of Care

A.1 Provide base funding for comprehensive care clinics, structured as Texas medical school partnerships

A.2 Incentivize value-based payment: reimburse care coordination and care plan development as billable activities

A.3 Provide differential reimbursement for providers serving children with medical complexity, IDD, and serious mental illness; reduce administrative barriers to collaborative care models

B. Health Insurance Access

B.1 Align the Texas Medicaid Buy-In for Children program to the full Family Opportunity Act limit (300% FPL after income disregards)

Medicaid Buy-In for Children allows families who meet income requirements to buy Medicaid coverage for children age 18 or younger with disabilities or special health care needs. [Medicaid Buy-In for Children with Disabilities | Navigate Life Texas](#)

B.2 Implement a TEFRA (Katie Beckett) option for children who meet an institutional level of care but live at home

Katie Beckett Medicaid — also called the TEFRA option — is a special Medicaid eligibility pathway that allows children with severe disabilities or complex medical needs to qualify for Medicaid based only on the child's own income, not the parents'. This means a child from a high-income family can qualify for full Medicaid benefits that would otherwise be blocked by the family's earnings.

Without this program, many children with serious medical needs would be forced into institutional care simply to access Medicaid coverage. Katie Beckett keeps these children at home with their [families](#), where care is both more appropriate and typically less expensive.

[Katie Beckett Medicaid \(TEFRA\): What It Is, Who Qualifies & How to Apply](#)

B.3 Require HHSC to thoroughly explore all available Medicaid eligibility categories before terminating coverage for individuals who no longer meet SSI eligibility requirements

C. Healthcare Data Infrastructure

C.1 Fund development of a centralized statewide registry for children with medical complexity

D. Provider Network Adequacy and Healthcare Transitions

D.1 Address the pediatric-to-adult transition gap: increase adult provider capacity and strengthen handoff protocols in areas of documented network shortage



D.2 Improve network adequacy and continuity of care: increase the number of primary and specialty care providers available to young adults with medical complexities aging out of pediatric care

D.3 Fund health care transition (HCT) coordination for medically complex youth as a distinct, reimbursed service

D.4 Require physician CME on health care transition planning as a condition of Texas Medical Board license renewal

D.5 Adopt service fulfillment network adequacy standards for LTSS in Medicaid Managed Care using existing Electronic Visit Verification infrastructure

E. Autism Services

E.1 Require HHSC to establish an autism services advisory board with access, utilization, and network adequacy reporting

E.2 Extend ABA diagnostic evaluation timelines beyond 3 years

E.3 Increase funding for the Children's Autism Program at HHSC

E.4 Require Department of Family and Protective Services Investigators to have training on autism.

E.5 Require schools receiving public funds to allow private and publicly funded ABA providers to deliver medically necessary behavioral health services to students at school

E.6 Direct HHSC to reduce the backlog of providers in the TMHP Provider Enrollment Management System (PEMS), specifically those delayed at the OIG approval stage

E.7 Require consistent standards for authorization and delivery of ABA services across all Medicaid Managed Care Organizations

F. A System of Care for Children with Behavioral Health Needs



- F.1 Strengthen the operation of one integrated continuum of care for all children and youth: prenatal through 21, with centralized access and navigation
- F.2 Embed navigators across schools, pediatric practices, ECI, and community health workers
- F.3 Remove single-diagnosis funding restrictions; enable blended funding and wrap-around team approaches
- F.4 Full continuum of respite matched to child acuity and family need
- F.5 Create and fund short term diagnostic and stabilization centers for children with IDD and complex behavioral support needs embedded in local communities.
- F.6 Develop community-based, small-scale emergency therapeutic living options for children in acute crisis
- F.7 Amend the Texas Medicaid State Plan to cover Residential Treatment for all children meeting clinical criteria, not only those in conservatorship
- F.8 Make Treatment Foster Care (TFC) a Medicaid benefit for all clinically appropriate children regardless of conservatorship
- F.9 Fund transitional respite for children leaving residential treatment centers
- F.10 Develop and fund Pediatric Intensive Psychiatric Rehabilitation in Texas

Community and Housing

A• Juvenile Justice Diversion and Community Supports

- A1. Require specialized training for organizations and entities that interact with youth at risk of juvenile justice involvement
- A2. Establish a grant or pilot program to support community-based diversion and mentorship programs for youth with disabilities at risk of juvenile justice involvement

B. Strengthen Coordinated Mental Health & Community-Based Re-entry

B.1 Strengthen coordinated mental health and community-based re-entry services for justice-involved youth with disabilities through strengthened Individual Success Plans (ISPs) for youth exiting TJJJD

C. Increase Utilization of Peer Support Specialists

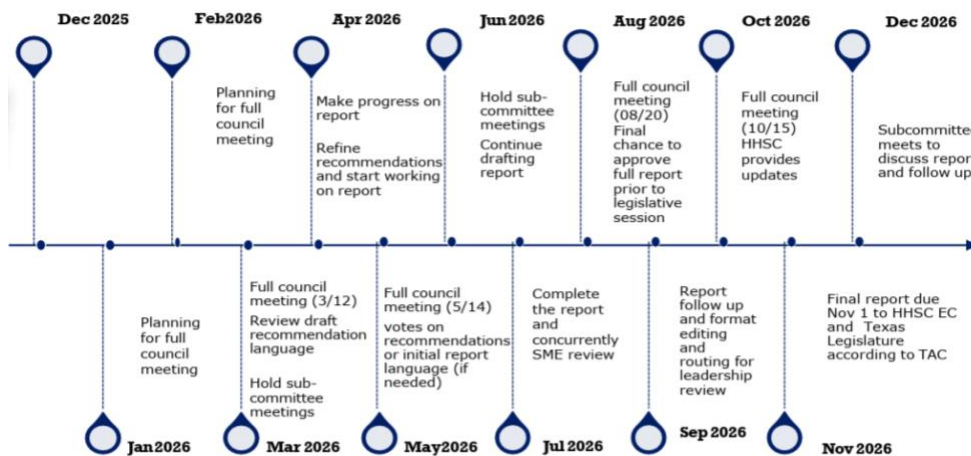
C.1 Increase utilization of peer support specialists for justice-involved youth and young adults; establish a peer support benefit for individuals with disabilities in special populations

D. Crisis Response and Pre-Arrest Diversion

D.1 Expand crisis systems of care and pre-arrest diversion strategies for youth with disabilities, including coordinated mental health response; develop a statewide resource hub on diversion programs, crisis response models, re-entry supports, and community-based services (as a resource: [Tailoring Crisis Response and Pre-arrest Diversion Models for Rural Communities](#))

MOTION: Approve the draft recommendations received unanimous vote from those present but failed due to the absence of a quorum. (Some members had dropped off the call)

7. 2026 Legislative report planning and next steps



8. Public comment. No public comment was offered

9. [Action items for staff and member follow-up](#)

2026 PCCF remaining full council meetings:

- August 20, 2026
- October 15, 2026

PCCF Advisory Council Legislative Report Timeline

| Milestones | Due Date |
|--|------------|
| PCCF Committees provide preliminary recommendations to full Council | 5/14/2026 |
| Preliminary Draft Report submitted by PCCF members to council liaison | 7/20/2026 |
| Draft report prepared for review by council liaison and sent to HHSC SMEs | 7/27/2026 |
| HHSC SMEs complete content review and feedback (5 days). Draft Report routed to committee. | 8/3/2026 |
| Draft Report finalized by PCCF committee members and submitted to council liaison | 8/10/2026 |
| Draft Report reviewed by QDAR Director/ VBI Manager and returned to liaison | 8/14/2026 |
| Draft Report reviewed and finalized by committee members for distribution before full council meeting. | 8/18/2026 |
| Draft report approved by PCCF members at full council meeting | 8/20/2026 |
| Draft sent to DAC for review (5-7 days) | 8/21/2026 |
| Draft sent to DEC for review (5days) | 9/3/2026 |
| Draft sent to SMD for review (20 business days) | 9/21/2026 |
| Draft sent to EC (10 business days) | 10/19/2026 |
| Report published and posted to website | 11/1/2026 |

Subcommittee meetings will be less frequent.



It was brought to the Committee's attention that during the adoption of the recommendations vote, the committee had lost a quorum and so had to reconsider the vote. After waiting, a quorum was never re-established so it was agreed the recommendations could move forward as drafts to be adopted at a later date after editing.

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

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