TEXAS
Health and Human Services

Consolidated Budget Request
2018 - 2019 Biennium

Health and Human Services Commission

Department of Family and Protective Services

Department of State Health Services

February 2017

Updated to Include Revised Rate Tables

Table of Contents

I. EXECUTIVE SUMMARY

With the consolidation of HHS system agencies required by Sunset legislation passed by the 84th Legislature, the transformed Texas Health and Human Services system will consist of three agencies in the 2018-19 biennium, the Health and Human Services Commission, the Department of Family and Protective Services, and the Department of State Health Services. Two agencies which were part of the HHS system since 2005, the Department of Assistive and Rehabilitative Services and the Department of Aging and Disability, will be fully consolidated by the end of the current biennium. A portion of the Department of Assistive and Rehabilitative Services transferred to the Texas Workforce Commission to improve employment outcomes for persons with disabilities. As a result, three Legislative Appropriations Requests (LARs) were submitted for the two-year budget period for the 2018-2019 biennium providing strategy level detail, sources of funding, anticipated performance, and base and exceptional item requests. To strengthen these requests, the Consolidated Budget Request for 2018-2019 biennium:

- Summarizes the requests for legislative appropriations for the three Texas health and human services agencies.
- Highlights critical funding needs across the agencies and categorizes the requests to help decision makers and the public analyze the service and operational needs throughout the state's health and human services system.
- Provides supporting information on elements contributing to funding needs.
- Identifies major federal funding issues.
- Describes provider rate methodologies and changes for legislative consideration.
- Provides supplemental information for legislative consideration.
- Fulfills several statutory reporting requirements.

Summary of the HHS System LARs

HHS system agencies have requested a total of $87.4 billion from all fund sources for the 2018-2019 biennium, an increase of $6.8 billion (8.5 percent) over the 2016-2017 biennium amounts. The general revenue (GR) portion of the 2018-2019 biennium request totals $37.5 billion, an increase of $4 billion (12 percent). These amounts assume a $1.3 billion general revenue supplemental appropriation in fiscal year 2017. This estimate will be updated for the Legislative Session.

Base Request and Critical Funding Needs

For the 2018-2019 biennium all agencies were required to submit base requests of 96 percent of the current general revenue funding levels with some exceptions, such as Medicaid entitlement services, Child Protective Services and Behavioral Health Services. This 4 percent reduction in

the base amounts to $219 million in general revenue, which is detailed in **Chapter II**. In addition to the "base" level of funding, prepared according to required budget guidance, the Consolidated Budget Request highlights agency exceptional item requests above the base budget totaling $6.6 billion All Funds ($3.4 billion general revenue), including exceptional items to restore funding to a portion of the 4 percent reduction.

Supporting Information on Factors Contributing to Funding Needs

Chapter III provides information on the key drivers of the increased need for resources such as forecasts for caseload, trends in the cost of services, and federal fund matching percentages. Other key drivers such as infrastructure for both state-operated facilities and critical information technology are further described in **Chapter IV**.

HHS System Initiatives

Chapter IV highlights exceptional item requests addressing critical needs crossing multiple HHS agencies and program areas, such as increasing community services to reduce waiting/interest lists, supporting information technology efforts system-wide, recruiting and retaining critical staff, supporting state operated facilities, and improving mental health services.

Select Medicaid Initiatives

Chapter V provides information on recent cost containment efforts undertaken by HHS agencies and status of the Healthcare Transformation and Quality Improvement waiver. The waiver funds payments for uncompensated hospital care and allows Texas to support the development and maintenance of a coordinated care delivery system through the creation of Regional Healthcare Partnerships, transition to a quality-based payment system across managed care and hospitals, and improved coordination in the current indigent care system.

Major Federal Funding Issues

Federal funding and policy issues are contained in several chapters including **Chapter VI**, which highlights areas with potential fiscal impact, such as passage of federal appropriations bills and pending reauthorizations.

Provider Rates

While agency LARs generally do not include provider rate increases, **Chapter VII** of the Consolidated Budget Request addresses the cost of various rate changes by identifying funding required to fully fund the service per methodology the funding impact for each 1 percent increase or decrease in the rates, as well as identifying previous rate increases or decreases. This provides legislators a tool to estimate costs for rate changes considered during the appropriations process.

Other Supplemental Information Provided (Appendices)

Finally, the document provides additional detailed information in appendices related to reducing interest/waiting lists for services, rate schedules, including more detailed methodology information, and the state's Long-Term Care Plan **(see Chapter VIII)**.

Statutory Requirements Fulfilled

Submission of the Consolidated Budget Request fulfills several statutory requirements including:

- The Biennial Consolidated Budget Request for the HHS system, Section 531.026, Government Code;
- The Annual Federal Funds Report, Section 531.0271-531.028, Government Code (**Chapter VI**); and
- The Long-term Care Plan for Individuals with Intellectual Disabilities and Related Conditions (**Appendix A**).

HHS Agency LARs are located here:
https://hhs.texas.gov/about-hhs/budget-planning

II. CONSOLIDATED BUDGET REQUEST OVERVIEW

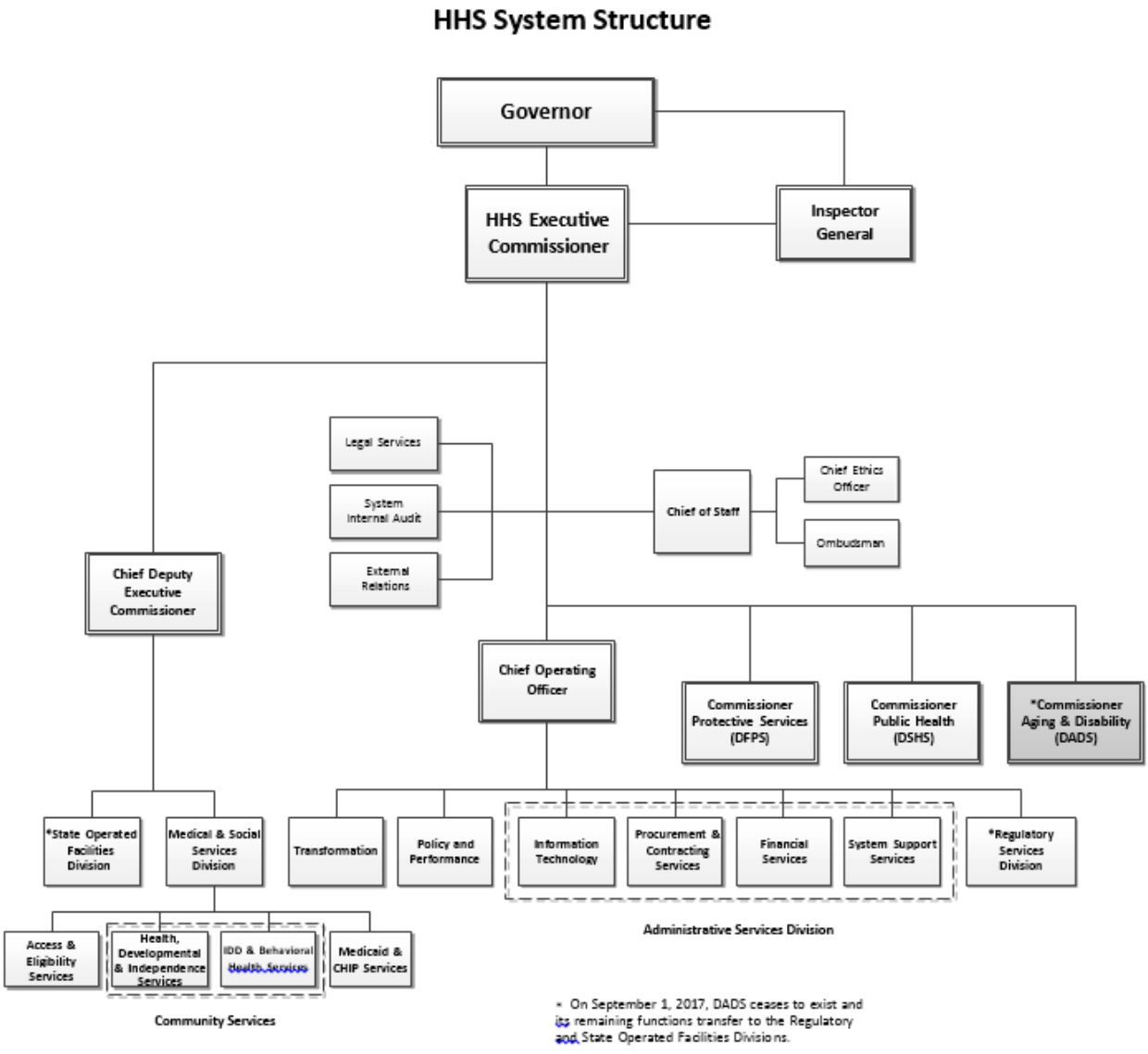
Health and Human Services System Overview

The Texas Health and Human Services (HHS) system is dedicated to developing client-focused program and policy initiatives that are solution-oriented and fiscally responsible. The findings and recommendations of the Sunset review formed the basis for the 84th Texas Legislature's directive to transform today's HHS system. Reflecting a unified approach to delivering health and human services, with the passage of Sunset legislation, the HHS system was given an opportunity to develop a more streamlined, efficient organization that provides services and benefits more effectively. Senate Bill 200 outlined a phased approach to this restructuring. The first phase transfers the following programs and functions to the Health and Human Services Commission (HHSC) by September 1, 2016: client services other than vocational rehabilitation-related programs from the Department of Assistive and Rehabilitative Services (DARS), client services from the Department of Aging and Disability Services (DADS) and the Department of State Health Services (DSHS), and administrative services that support those respective client services of the HHS system. As a result of this transfer and the transfer of other programs to the Texas Workforce Commission (TWC), DARS no longer exists as a separate agency as of September 1, 2016. Additionally, effective May 1, 2016, the Nurse Family Partnership and Texas Home Visiting programs transferred from HHSC to the Department of Family and Protective Services (DFPS), which will continue its focus on protecting children, older adults, and people with disabilities, and preventing child abuse and neglect.

In the second phase, regulatory programs as well as management of the operations for state supported living centers and state hospitals will transfer to HHSC by September 1, 2017, and DADS will be fully consolidated into HHSC. Based on current statute, Child Care Licensing and Adult Protective Services provider investigations from DFPS will be part of HHSC's regulatory services functions. After these transfers, DSHS' streamlined structure will focus on its core public health functions**. Figure II.1** depicts the HHS system organizational structure in fiscal year 2017 and identifies services provided by the HHS agencies.

The full HHS system Transition Plan is here: https://hhs.texas.gov/about-hhs/hhs-transformation

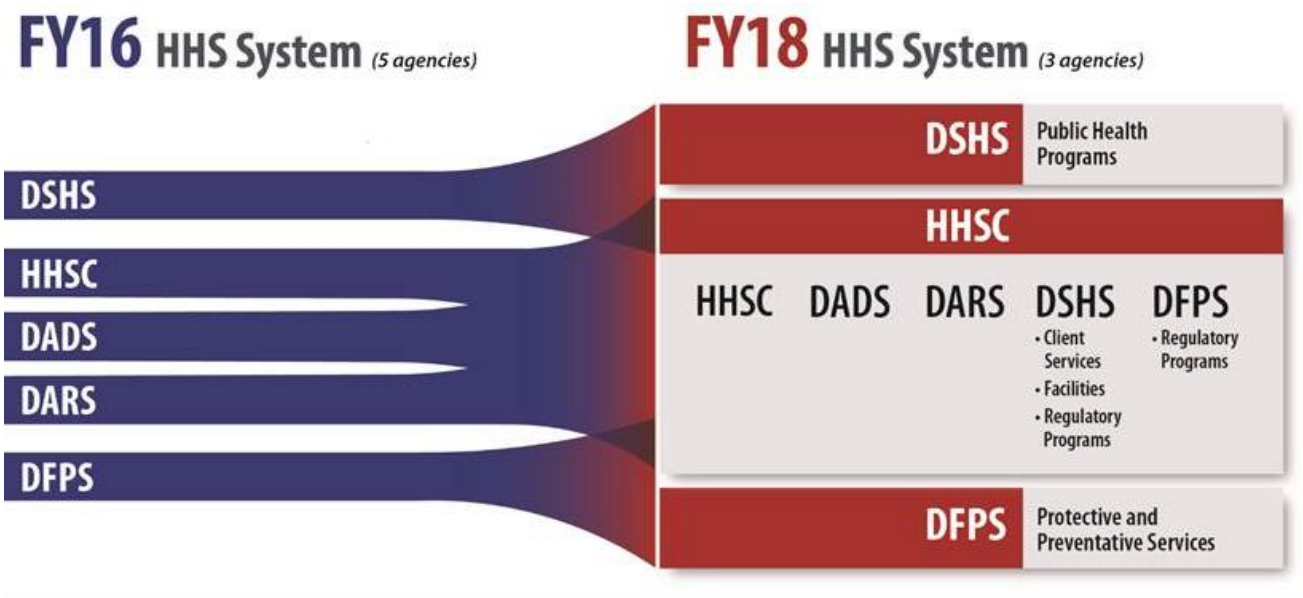
Figure II.1


HHS System Structure
Governor
HHS Executive Commissioner
Inspector General
Legal Services
System Internal Audit
External Relations
Chief of Staff
Chief Ethics Officer
Ombudsman
Chief Deputy Executive Commissioner
Chief Operating Officer
Commissioner Protective Services (DFPS)
Commissioner Public Health (DSHS)
*Commissioner Aging & Disability (DADS)
*State Operated Facilities Division
Medical & Social Services Division
Transformation
Policy and Performance
Information Technology
Procurement & Contracting Services
Financial Services
System Support Services
*Regulatory Services Division
Administrative Services Division
Access & Eligibility Services
Health, Developmental & Independence Services
IDD & Behavioral Health Services
Medicaid & CHIP Services
Community Services
* On September 1, 2017, DADS ceases to exist and its remaining functions transfer to the Regulatory and State Operated Facilities Divisions.

By September 1, 2017, the new HHSC will have grown by more than 28,000 staff (includes client and administrative services) and approximately 200 programs or programmatic functions. With the consolidation of three agencies into one, and the transfer of client services and regulatory programs from an additional two agencies, the HHS system financial and appropriations structure is substantially different from previous biennia.

In the 2018-2019 biennium, HHSC will have appropriations distributed through strategies A-L. These strategies will contain all Medicaid and CHIP programs and services, all mental health services, all women's health services, and all centralized administrative functions delivered by the Health and Human Services system. **Figure II.2** shows programs and services that will have been transformed through fiscal year 2018.

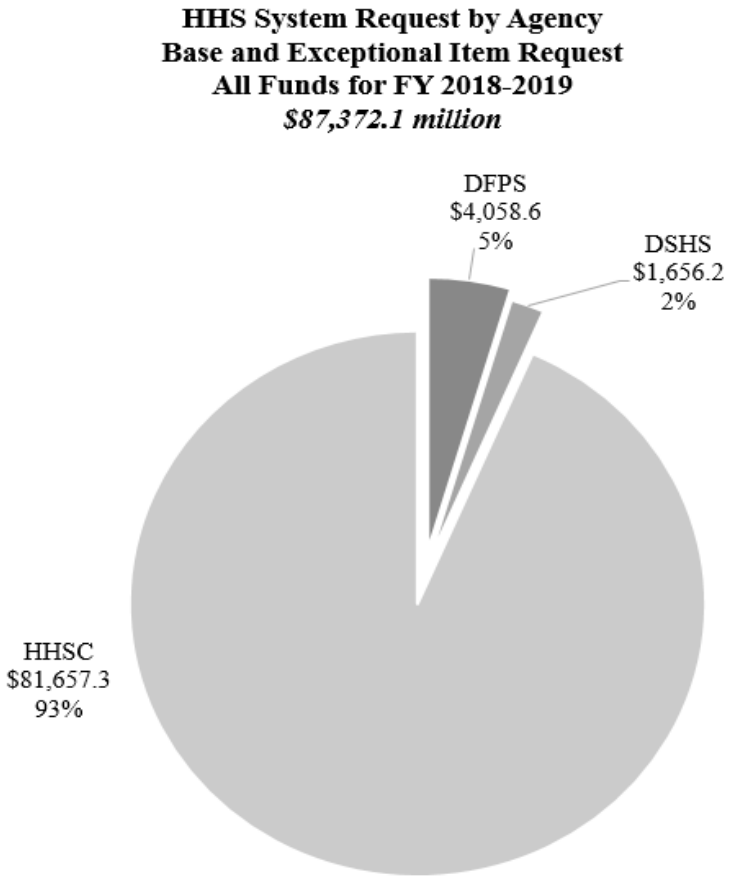
Figure II.2



HHS System Fiscal Year 2018-2019 Legislative Appropriations Request

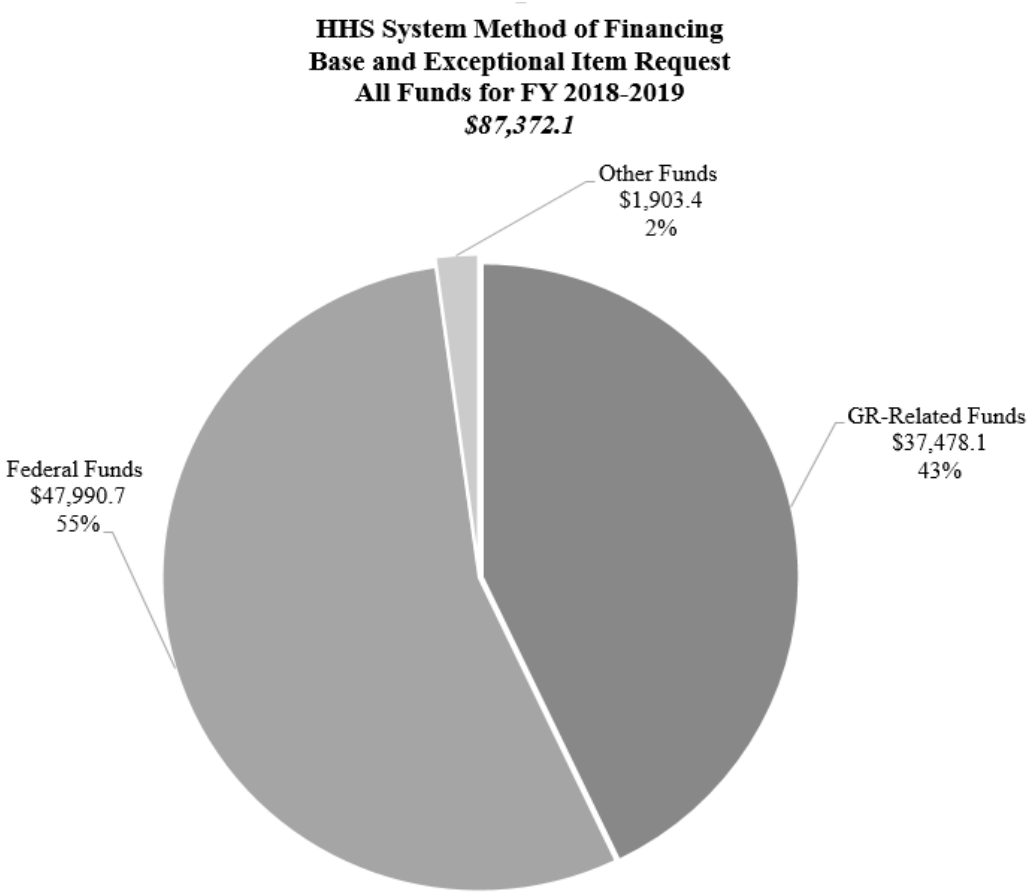
The Legislative Appropriations Request (LAR) base request for the 2018-2019 biennium combined with the exceptional items for HHS agencies totals $87.4 billion, an increase of $6.8 billion all funds from the 2016-2017 biennium (8.5 percent increase). Note that the 2016-2017 biennial estimate assumes a $1.3 billion general revenue supplemental appropriation. This estimate will be updated for the Legislative Session. **Figure II.3** presents the allocation of requested funds among HHS agencies.

Figure II.3



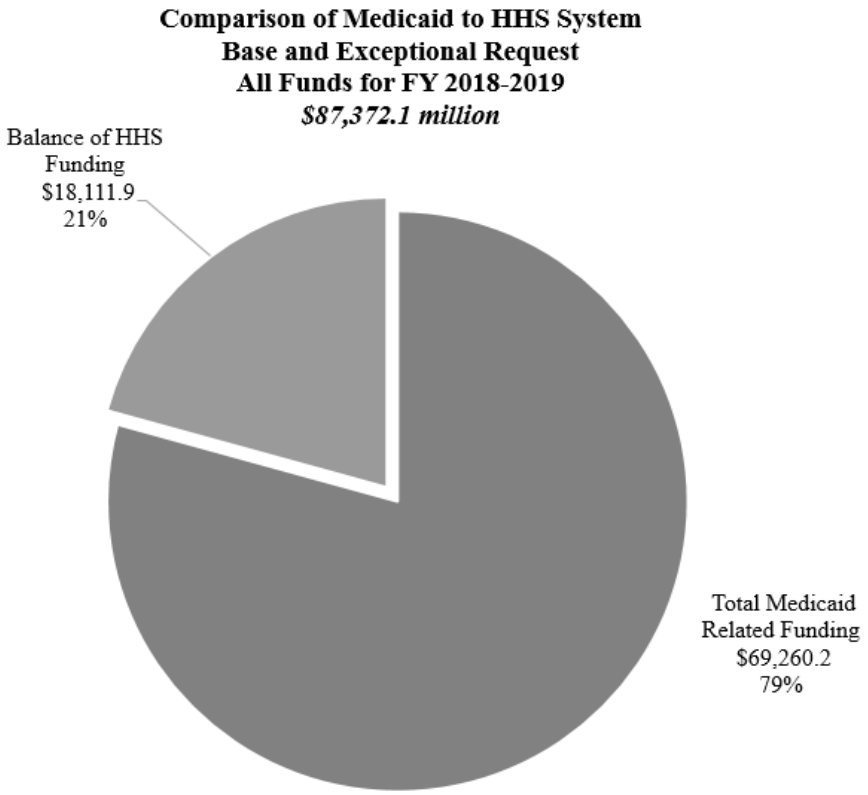
As reflected in the following chart, the general revenue-related base and exceptional item request for all HHS agencies for the 2018-2019 biennium totals $37.5 billion, representing a $4 billion increase (12 percent) from the 2016-2017 biennium. Total requested federal funds for the base and exceptional items for the HHS system for the biennium is $48 billion (55 percent). **Figure II.4** presents the comparison of funding sources for the HHS system.

Figure II.4



As the chart below indicates, Medicaid related funding accounts for $69.3 billion, or 79 percent, of the total HHS funding requested in the 2018-2019 biennium. Using state and federal funding, Texas' Medicaid program provides acute care and long-term services and supports to millions of low income Texans each year (see **Chapter III** for Medicaid caseload forecasts). **Figure II.5** presents the comparison of Medicaid to the HHS system.

Figure II.5



Legislative Appropriation Request: Guidance and Funding Request

Base Request Policy

On June 30, 2016, the Governor's Office of Budget, Policy, and Planning and the Legislative Budget Board (LBB) jointly issued LAR instructions for the 2018-2019 biennium. The general revenue and general revenue-related base request must be reduced by 4 percent as a starting point for budget deliberations. Exceptions to the base limitation include amounts necessary to maintain funding for behavioral health services and Child Protective Services. In addition, benefits and eligibility in the Medicaid program, the Children's Health Insurance Program, the foster care program, the adoption subsidies program, and the permanency care assistance program are also exempt from the 4 percent reduction, Base requests for these programs may also include amounts sufficient for caseload growth.

Funding requests for other purposes that exceed the base spending level, including cost growth in programs above the 2017 level, may not be included in the base request but may be submitted as exceptional items. Agencies must also submit a supplemental schedule detailing how they would reduce the base request by 10 percent in general revenue funding (S**ee Appendix B**). A summary of each agency's request is provided below.

Agency Funding Requests

The following section highlights the three HHS agency requests in terms of overall base and exceptional items. The chapters that follow offer additional detail explaining critical issues related to these requests, such as key budget drivers, system-wide initiatives, federal funding considerations and provider rates considerations. (See **Figure II.6** for a recap of the HHS agency funding requests for the 2018-2019 biennium).

The **Health and Human Services Commission (HHSC)** 2018-2019 biennium base request totals $75.6 billion in all funds ($31.6 billion general revenue-related). This request represents an increase of $4.3 billion in all funds and an increase of $2.9 billion general revenue or a 6.1 percent and 10.2 percent increase respectively. These amounts include program transfers to HHSC from the Department of Aging and Disability Services, Department of Assistive and Rehabilitative Services, and Department of State Health Services required by Sunset legislation.

HHSC exceptional items, totaling $6 billion all funds ($2.8 billion general revenue-related), include 60 items (including Texas Civil Commitment Office), with the majority of the request for maintaining Medicaid, CHIP, and other client services. Exceptional items also expand certain community and behavioral health services, and address critical information technology and operational needs.

The **Department of Family and Protective Services (DFPS)** 2018-2019 biennium base request totals $3.5 billion in all funds ($1.9 billion general revenue-related). This level of funding is a decrease of $64.1 million all funds from the 2016-2017 biennium and a $17.6 million or 0.9 percent decrease of general revenue-related funds.

DFPS exceptional items total $534 million all funds ($498.1 million general revenue-related) and build on recent improvements, and focus on improving the state's Child Protective Services system. Multiple initiatives are included to ensure DFPS staff have the resources needed to keep children safe throughout the system. In addition, new efforts aim to build high-quality capacity in the foster care system, reduce staff turnover, and retain a high-performing workforce.

The DFPS request addresses the critical and unprecedented challenges facing the system overall. The cost-per-foster-care-child FTE, the decline in federal Title IV-E financial participation, and capacity demands on foster care significantly impact the system. The agency request will help to fortify the health, safety, and welfare infrastructure affecting the child welfare system.

The **Department of State Health Services (DSHS)** 2018-2019 biennium base request totals $1.6 billion in all funds ($625.9 million general revenue-related). This is a $4.1 billion all funds decrease from the 2016-2017 biennium and a $2.2 billion or 72.1 percent decrease in general revenue-related funds. The reduction reflects program transfers to HHSC, the Texas Department of Licensing and Regulation, and the Texas Medical Board required by Sunset legislation, to focus the agency solely on public health services.

DSHS exceptional items, totaling $89.4 million in All Funds ($89.4 million general revenue-related), address critical public health needs across the state. The request supports the EMS/Trauma System, local public health services and emergency preparedness while also strengthening the state public health laboratory. DSHS seeks to further help local health departments address service gaps where disease outbreaks are increasing and where local health departments have closed or reduced services.

Figure II.6 Summary Tables Fiscal Years 2018-2019 Requests ($ in millions)

Comparison of FY 2016-2017 to Total Request for FY 2018-2019

Agency	FY 16 Estimated-17 Budgeted		FY 18-19 Total Request		Biennial Change		Percent Change	
	GR/GRD	All Funds	GR/GRD	All Funds	GR/GRD	All Funds	GR/GRD	All Funds
DFPS	$1,952.7	$3,588.7	$2,433.2	$4,058.6	$480.5	$469.9	25%	13%
DSHS	$2,865.3	$5,622.0	$715.2	$1,656.2	-$2,150.1	-$3,965.8	-75%	-71%
HHSC	$28,623.8	$71,319.6	$34,329.6	$81,657.3	$5,705.8	$10,337.7	20%	14%
HHS Total	**$33,441.8**	**$80,530.3**	**$37,478.1**	**$87,372.1**	**$4,036.3**	**$6,841.8**	**12%**	**8%**

Base and Exceptional Item Request (Total Request) FY 2018-2019

Agency	FY 18-19 Base Request		FY 18-19 Exceptional Item Request		FY 18-19 Total Request	
	GR/GRD	All Funds	GR/GRD	All Funds	GR/GRD	All Funds
DFPS	$1,935.1	$3,524.6	$498.1	$534.0	$2,433.2	$4,058.6
DSHS	$625.9	$1,566.8	$89.4	$89.4	$715.2	$1,656.2
HHSC	$31,552.7	$75,643.4	$2,776.9	$6,014.0	$34,329.6	$81,657.3
HHS Total	**$34,113.6**	**$80,734.8**	**$3,364.5**	**$6,637.3**	**$37,478.1**	**$87,372.1**

Full-Time Equivalents FY 2016-2017 to FY 2018-2019

Agency	FY 16 Estimated-17 Budgeted		FY 18-19 Total Request		Biennial Change		Percent Change	
	2016	2017	2018	2019	2018	2019	2018	2019
DFPS	12,201	12,875	13,753	13,872	1,552	998	13%	8%
DSHS	11,938	11,669	3,295	3,295	(8,643)	(8,375)	-72%	-72%
HHSC	31,151	31,405	41,721	41,883	10,570	10,478	34%	33%
HHS Total	**55,289**	**55,949**	**58,768**	**59,050**	**3,479**	**3,101**	**6%**	**6%**

Additional Information:

- Change from FY 2016-2017 Base to FY 2018-2019 Base Request is $671.8M (2%) GR and $204.5M (.25%) AF.
- HHSC LAR reflects an estimated $1,246.0 M supplemental need for FY 2017.
- DFPS LAR reflects an estimated $45.3M supplemental need for FY 2017.
- The FY 2016-2017 estimate will be revised in December 2016/January 2017 for consideration of supplemental appropriations.
- HHSC amounts include Texas Civil Commitment Office.

Summary of HHS System Exceptional Item Request

HHS agencies request 75 exceptional items totaling $3.4 billion in general revenue and $6.6 billion in all funds. **Figures II.7-II.9** divide the exceptional items into groups following the major agency functions in the restructured HHS system, with HHSC functions, protective services and public health in separate categories. In addition, the information below highlights the portion of the request that can be characterized as necessary to continue existing services levels, as compared to items addressing previously unmet or emerging needs.

Maintaining Current Services

More than half of the exceptional item request is needed to continue current service levels, with the largest portion attributed to the Medicaid program. In addition, Child and Adult Protective Services and Public Health funding to support existing service levels are also highlighted below along with items related to restoring a portion of the 4 percent general revenue reductions taken in the base request. These items total $2.1 billion general revenue and $4.2 billion all funds collectively.

Medicaid and non-Medicaid clients service program at HHSC ($1.746 billion GR/$3.876 billion AF) (Figure II.7)

These exceptional items continue the current level of services provided in the Medicaid program by funding increased costs in acute care and long-term care. Additional non-Medicaid client services which will be fully consolidated at HHSC in the 2018-2019 biennium, are also included in this grouping.

- Maintain services at FY 2017 levels for:
  - Medicaid waivers for individuals with disabilities ($29.9 million GR/$70.2 million AF)
  - Mental health community services programs ($4.7 million GR/$4.7 million AF)
  - Early Childhood Intervention caseload ($41.9 million GR/$44.8 million AF)
- Sustain enhanced community coordination services and transition support teams when the Money Follows the Person federal grant funding ends after FY 2017 ($13.0 million GR/$13.0 million AF)
- Maintain the state's psychiatric bed capacity ($121.0 million GR/$121.0 million AF)
- Maintain critical direct delivery staff in state hospitals and state supported living centers ($68.8 million GR/$96.0 million AF)
- Maintain critical operational supports for Child Care Licensing (CCL) and Adult Protective Services (APS) provider investigations ($5.1 million GR/$6.0 million AF)

Child and Adult Protective Services at DFPS ($323.6 million GR/$352.1 million AF) (Figure II.8)

The following two exceptional items and the initiatives included therein support a level of service required to meet existing targets and goals in several critical service areas.

- Exceptional Item 1-Increase Funding to Meet the Needs of the Growing Number of Vulnerable Children, Adults, and Their Families ($75 million GR/ $76.6 million AF)
- Exceptional Item 2-Increase Staff Resources to Achieve Better Outcomes for Vulnerable Children, Adults, and Their Families ($248.7 million GR/ $275.5 million AF)
- For a full breakdown of DFPS exceptional items see **Appendix C**.

Maintain Current Public Health Services at DSHS ($15.2 million GR/$15.2 million AF) (Figure II.9)

Two exceptional items are requested to maintain the state's public health infrastructure and services.

- Exceptional Item 1- Restore Four Percent GR Reduction to Chronic Disease Programs ($5 million GR/$5 million AF)
- Exceptional Item 2-Maintain Critical Public Health Capacity and Tobacco Prevention/Control ($10.3 million GR/$10.3 million AF)

Addressing critical needs in client services and agency operations

The remainder of the exceptional items, totaling $1.3 billion general revenue and $2.4 billion all funds in HHS agencies' LARs improve services provided by HHS agencies in a number of ways, both in direct client services and in improved operations and infrastructure to support client care.

Examples of major efforts to improve and enhance services include supporting our mental health system through several avenues of treatment and services, reducing interest and waiting lists in community care program for clients with intellectual and developmental disabilities, expanding Medicaid services for clients with autism, strengthening our state's lab and public health infrastructure, and setting a course for the future of our child protective services system **(See Chapter V** for more details**)**.

Included is funding to make critical repairs and renovations to aging state facilities and to provide equipment to maintain our state's mental health hospitals and State Supported Living Centers. These repairs are needed to ensure the safety and well-being of the facilities' residents. Likewise, maintaining and upgrading mission-critical information technology systems is necessary each biennium. These exceptional items address information technology needs that will enable HHS programs to provide client services in the most efficient manner possible (**See Chapter V** for more details).

The following HHSC exceptional items, **Figure II.7**, include requests for client services, system administration, and critical operations funding. For the 2018-2019 biennium the exceptional item requests total $2.8 billion general revenue and $6 billion all funds. The total for the HHS system request in exceptional items is $3.4 billion general revenue and $6.6 billion all funds for the biennium.

Figure II.7 HHSC Client Service and System Administration Fiscal Year 2018-2019
Exceptional Items ($ in millions)

EI #	Exceptional Item	GR/GRD	All Funds
Maintain Current Funding for Client Services		**$1,746.2**	**$3,875.7**
1	Maintain Medicaid Entitlement Program Cost Growth	$1,414.1	$3,347.0
2	Maintain CHIP Non-Entitlement Program Cost Growth	$8.1	$106.4
3	Maintain Medicaid Non-Entitlement Cost Growth	$21.2	$48.4
4	Maintain Medicaid Waiver Programs at FY 2017 Levels	$29.9	$70.2
5	Maintain Mental Health Community Services Programs	$4.7	$4.7
6	Maintain Early Childhood Intervention Caseload	$41.9	$44.8
7	Funding to Sustain Enhanced Community Coordination	$13.0	$13.0
8	Maintain Psychiatric Bed Capacity in the State	$121.0	$121.0
9	Maintain Critical Direct Delivery Staffing	$68.8	$96.0
10	Maintain Critical Operations & Support of Direct Delivery Staff (Adult Protecitve Services(APS)/Child Care Licensing (CCL))	$5.1	$6.0
11	Maintain Biennial Funding for Senate Bill 208 (Art. II, Special Provision 57)	$18.3	$18.3
Restore Selected Four-Percent Reductions		**$3.1**	**$3.1**
12	Restore Client Service 4% Reductions (Blindness Education Screening and Treatment (BEST) and Comprehensive Rehabilitation Services (CCR))	$1.3	$1.3
13	Restore Client Service 4% Reductions for APS/CCL	$1.7	$1.7
Provide Transition to Community Services		**$50.3**	**$114.5**
14	Promoting Independence Slots	$50.3	$114.5
Reduce Community Program Interest Lists		**$364.9**	**$822.0**
15	Reducing Community Program Interest Lists	$346.3	$803.4
16	Community Mental Health Waitlist	$8.2	$8.2
17	DARS Waitlists (CCR and Independent Living Services)	$10.4	$10.4
Provide Essential Repairs for State Operated Facilities		**$21.1**	**$209.7**
18	Facilities Repair and Renovation	$.0	$188.6
19	Other Facility Upkeep/Repairs	$5.4	$5.4
20	Fleet Operations	$15.8	$15.8
21	New Construction	TBD	TBD

EI #	Exceptional Item	GR/GRD	All Funds
Increase Capacity to Meet the Growing Need for Psychiatric Treatment		**$100.7**	**$100.7**
22	Expand Psychiatric Bed Capacity in the State	$100.7	$100.7
Offer Acute, Long-Term, and Behavioral Health Treatment		**$119.5**	**$160.4**
23	Family Planning Services	$20.0	$20.0
24	Family Violence Program Increase Services	$3.0	$3.0
25	Court Appointed Special Advocates (CASA) and Children's Advocacy Centers (CAC) Increase Capacity	$8.0	$8.0
26	Intensive Behavioral Intervention (for Autism Spectrum Disorder)	$14.3	$32.8
27	Hepatitis C Treatment at State Hospitals	$19.8	$19.8
28	Enhance Community Services	$44.5	$44.5
29	SSLC Services to the Community	$3.5	$19.3
30	Increase Aging and Disability Resource Centers Supports for Veterans	$1.3	$1.3
31	Program of All-Inclusive Elderly Care (PACE) Full Funding Adjustment	$5.1	$11.6
Ensure Quality System Oversight and Client Service Delivery		**$237.7**	**$511.5**
32	Contract Management/Quality Monitoring for Intermediate CareFacilities for Individuals with Intellectual Disabilities (ICF/IID)	$6.8	$13.7
33	Maintaining Regulatory Timeframes Amid Increased Workload	$3.9	$5.8
34	Ensure Compliance with Federal Child Care Licensing Requirements	$11.9	$12.1
35	Increase Staff Resources to Achieve Better Outcomes for Vulnerable Children, Adults, Families	$14.8	$17.4
36	Litigation Support & Legal Assistance	$3.1	$3.2
37	Quality Improvement in Community Intellectual and Developmental Disabilities (IDD) Programs	$1.7	$3.5
38	Attendant Wage Increase, $8.00 to $8.50	$156.3	$364.4
39	Increased Wage Enhancement Funding for IDD Programs	$8.5	$21.5
40	Community Day Habilitation Programs	$30.6	$70.0

EI #	Exceptional Item	GR/GRD	All Funds
Provide Critical Information Technology Infrastructure and Support		**$114.8**	**$179.4**
41	Community Critical Incident Reporting	$1.3	$2.5
42	Quality Reporting System Updates	$.6	$1.2
43	Preadmission Screening and Resident Review (PASSR) for Long Term Care (LTC) Online Portal Quality Improvements	$4.1	$16.5
44	ReHabWorks Replacement Solution	$3.3	$3.3
45	Avatar Support	$6.1	$6.1
46	Hospital Life-Record at Rio Grande State Center	$2.0	$2.0
47	Hospital Infrastructure	$2.0	$2.0
48	Texas Integrated Eligibility Redesign System (TIERS)	$4.2	$12.1
49	Social Security Number Removal Initiative	$.7	$7.1
50	HHS Electronic Discovery Solution	$6.1	$8.3
51	HHS Cybersecurity Project	$3.5	$4.8
52	DIR Data Center Services	$38.2	$59.7
53	Legacy System Modernization - Non-Data Center Services (DCS) IT Infrastructure	$33.7	$43.6
54	Seat Management Services	$7.1	$7.4
55	Enterprise Identity & Access Management Expansion	$2.0	$2.7
Office of Inspector General		**$9.4**	**$27.9**
56	Additional Inspection Staff	$1.3	$1.8
57	Medicaid Fraud and Abuse Detection System (MFADS)	$5.0	$20.0
58	Case Management System	$2.5	$5.0
59	Provider Enrollment Background Check Staff	$.5	$1.1
Texas Civil Commitment Office		**$9.2**	**$9.2**
HHSC Client Service & System Administration Exceptional Items		**$2,776.9**	**$6,014.0**

The DFPS exceptional item request, **Figure II.8**, totals $498.1 million general revenue and $534 million all funds for the biennium. The items focus on client services and staff needs. Additional detail of the DFPS items can be found in **Appendix C**.

Figure II.8. DFPS Protective Services Fiscal Year 2018-2019 Exceptional Items ($ in millions)

EI #	Exceptional Item	GR/GRD	All Funds
1	Increase Funding to Meet the Needs of the Growing Number of Vulnerable Children, Adults, and Their Families	$75.0	$76.6
2	Increase Staff Resources to Achieve Better Outcomes for Vulnerable Children, Adults, and Their Families	$248.7	$275.5
3	Enhance CPS Investigation Capacity to Improve Caseworker Decision Making	$8.6	$9.2
4	Strengthen and Expand High-Quality Capacity and Systems in the Foster Care System	$110.8	$114.5
5	Increase Safety, Permanency, and Well-Being for Children and Youth Through Sustaining CPS Transformation and Engaging Community Partners	$28.5	$31.5
6	Expand and Strengthen Community-Based Prevention and Early Intervention Programs	$26.7	$26.7
7	Further Improve High Quality Care for Children in Foster and Kinship Care	TBD	TBD
8	Increase Funding to Retain High Performing Workforce	TBD	TBD
	DFPS EI Subtotal	**$498.1**	**$534.0**

The DSHS exceptional item requests, as seen in **Figure II.9** total $89.4 million general revenue and $89.4 million all funds for the 2018-2019 biennium. The requested funding focuses on public health initiatives and recruitment and retention needs.

Figure II.9 DSHS Public Health Fiscal Year 2018-2019 Exceptional Items ($ in millions)

EI #	Exceptional Item	GR/GRD	All Funds
1	**Restore Four Percent GR Reduction to Chronic Disease Programs**	**$5.0**	**$5.0**
	a. Love Kidneys (End Stage Renal Disease Prevention Program)	$.5	$.5
	b. Lone Star Stroke (LSS) Research Consortium	$3.0	$3.0
	c. STEMI (Texas Heart Attach and Stroke Data Collection Initiative)	$1.5	$1.5
2	**Maintain Critical Public Health Capacity and Tobacco Prevention/Control**	**$10.3**	**$10.3**
	a. Restore 4% Tobacco General Revenue Reductions	$2.0	$2.0
	b. Tobacco Prevention and Control	$4.1	$4.1
	c. Emergency Medical Services and Trauma	$2.1	$2.1
	d. Public Health Preparedness	$2.1	$2.1
3	**Support Regional and Local Public Health**	**$6.3**	**$6.3**
	a. Addressing Service Gaps	$3.0	$3.0
	b. Public Health Workforce	$3.3	$3.3
4	**Strengthen the State Public Health Lab**	**$27.5**	**$27.5**
	a. Staff Recruitment	$3.0	$3.0
	b. Cost Public Health Testing	$11.1	$11.1
	c. Building Infrastructure	$13.4	$13.4
5	**Improve Tuberculosis Detection and Control Capacity**	**$24.7**	**$24.7**
6	**Secure and Preserve Vital Records**	**$3.9**	**$3.9**
7	**Ensure Continued Operation of Public Health Information Technology**	**$11.8**	**$11.8**
	a. Blood Lead Registry (CABLES)	$2.9	$2.9
	b. Public Health Pharmacy (ITEAMS)	$8.8	$8.8
	DSHS EI Subtotal	**$89.4**	**$89.4**
	Total HHS Exceptional Item Request	**$3,364.5**	**$6,637.3**

Legislative Appropriation Base Request: 4 Percent Reduction

The 4 percent reductions in the base request for the HHS system are detailed below in **Figure II.10**. Based on the allowed exemptions the approach for each agency to achieve a 4 percent reduction is similar. Each agency targeted administrative activities, one-time projects from the previous budget, and limited impacts to clients or the number of clients served.

Figure II.10 HHS System 4 Percent Base Reduction Fiscal Year 2018-2019 ($ in millions)

Items Reduced	GR Amount
Departement of Family and Protective Services	
Reduction for one-time expenditure for Information Management Protecting Adults and Children in Texas (IMPACT) System	$ 4.2
Limit pay down of overtime to agency staff (CPS, APS and Statewide Intake)	$ 4.2
Eliminate sub-acute in-patient treatment program in Foster Care	$ 6.0
DFPS 4% Reduction Total	**$ 14.4**
Department of State Health Services	
Chronic Disease Prevention	$ 7.0
Tobacco Prevention and Control	$ 2.0
Reduction in administrative activities and one-time projects	$ 16.0
DSHS 4% Reduction Total	**$ 25.0**
Health and Human Services Commission	
In-Home Family Support Program	$ 10.0
Lifespan Respite Program	$ 1.0
Elimination of relocation specialist function	$ 5.0
Child Care Licensing and Adult Protective Services Investigations	$ 1.7
Blindness, Education, Screening, and Treatement (BEST) and Comprehensive Rehabilitation Services (CRS)	$ 3.0
Administrative Areas	$ 51.0
Indigent Health Care Reimbursement	$ 9.8
WIC program formula rebates	$ 18.0
Converting to cash-based payment for client services provided after 09/01/17 (DADS legacy)	$ 54.0
Reduce provider rates for the Medicaid and CHIP dental program	$ 26.4
HHSC 4% Reduction Total	**$ 179.9**
HHS System 4% Reduction Total	**$ 219.3**

III. MAJOR FACTORS CONTRIBUTING TO FUNDING NEEDS

Fiscal Years 2017 Supplemental Needs

HHSC and DFPS will require supplemental funding for entitlement programs currently estimated to be $1.3 billion in general revenue funds for the 2016-2017 biennium. Of that total, $1.2 billion in general revenue funds is Medicaid related. (**See Figure III.1**).

Health and Human Services Commission

- The estimated shortfall in Medicaid is largely due to medical cost growth that was not funded in the GAA in the current biennium. Other significant factors contributing to the shortfall include a less favorable fiscal year 2017 federal match rate than assumed in the GAA, Medicare Part B rate increases, higher drug costs, unrealized savings from Medicaid costs containment efforts (including delays due to litigation) and the dual-eligible demonstration project.
- Of the total supplemental funding need, $8.2 million is related to disaster funding. Since no funds were appropriated for disasters in the 2016-2017 biennium, the Commission transferred $8.2 million from eligibility determination to disasters. If the funds had not been needed for disasters, the funds could have been used to decrease the supplemental funding need.

Department of Family and Protective Services

- Current caseload forecasts for foster care, adoption subsidy/permanency care assistance, and day care services combined with a decline in federal Title IV-E funding create a supplemental appropriations need for DFPS.

In addition to the amounts listed below HHS agencies are currently projecting additional funding needs in fiscal year 2017 in state mental health hospitals, State Supported Living Centers, and Child Protective Services. These needs will be presented along with updates to the Medicaid and DFPS shortfalls by the beginning of the legislative session.

Figure III.1

HHS System Estimated FY 2016-2017 Funding Needs (General Revenue - $ in millions)	
Health and Human Services Commission	
Medicaid	(1,136.8)
Nursing Facilities (NF)	(63.4)
Hospice	(19.3)
Community Attendant Services (CAS)	(19.5)
Day Activity & Health Services (DAHS)	(0.2)
Texas Home Living	(6.8)
Total HHSC	**($1,246.0)**
Department of Family and Protective Services	
Foster Care	(42.7)
Adoption/Permanency Care Assistance (PCA)	(2.6)
Relative Caregiver Payments	0.3
Foster, Protective, and Relative Day Care	(13.9)
Total DFPS	**($58.9)**
Department of State Health Services/ Department of Aging and Disability Services	
State Mental Health Hospitals/ State Supported Living Centers	TBD
Total DSHS/ DADS	**TBD**
Total HHS System	**($1,304.8)**

Caseloads and Cost

Caseloads and health care cost increases are drivers in appropriations requests in several key areas. The Medicaid acute and long term care (waiver and entitlement), foster care, adoption subsidy, child protective services daycare, and Early Childhood Intervention programs are all projecting continued growth in the number of clients that will need services in the next biennium. In addition, funding to address rising health care costs, federal regulation and required additional client service coverages, are requested in agency exceptional items.

Medicaid Acute Care

Medicaid acute care caseloads are projected to average more than 4.2 million by fiscal year 2019, with an average of almost 3.1 million in the children's risk groups (all non-disability related children). Caseload impacts attributable to the Affordable Care Act (ACA) are now fully realized and growth trends have returned to levels expected absent of policy impact. In forecasting the Medicaid program for the 2018-2019 biennium LAR, the following assumptions were used:

- The caseload growth trend is estimated to be 1.9 percent by fiscal year 2019.
- Caseload growth under current eligibility criteria is included in the base request. There are caseload increases in fiscal year 2018 and fiscal year 2019 attributable to current population growth and historical Medicaid growth trends absent of policy impacts.
- The base forecast held costs at the fiscal year 2017 level. Cost growth is projected through the end of the 2018-2019 biennium and is included in HHSC's first exceptional item request.

Both caseload and cost trends are determined by time-series analyses of historical data, with consideration of external factors such as policy or demographic impacts. **Figure III.2** shows the Medicaid caseloads over a four-year period.

Figure III.2 Medicaid Acute Care Caseload

Caseload by Group	Estimated FY 2016	Projected FY 2017	Projected FY 2018	Projected FY 2019
Total Medicaid	**4,058,515**	**4,115,803**	**4,144,246**	**4,214,516**
Aged & Disability-Related	**802,188**	**814,461**	**811,844**	**824,398**
Aged & Medicare-Related	*374,028*	*378,372*	*379,962*	*385,892*
Disability-Related (including Children)	*428,160*	*436,089*	*431,882*	*438,506*
Other Adults, Non-Aged/Disability-Related	**285,824**	**288,925**	**288,086**	**293,361**
Pregnant Women	*139,739*	*141,569*	*138,092*	*140,424*
Adults, including Non-Cash and Breast and Cervical Cancer Clients	*146,085*	*147,356*	*149,994*	*152,937*
Medicaid Children Ages 0-20, Non-Disabled	**2,970,503**	**3,012,417**	**3,044,316**	**3,096,757**
Newborns	*266,446*	*268,168*	*268,987*	*271,447*
Age 1-5	*889,826*	*900,847*	*902,616*	*917,429*
Age 6-14	*1,371,735*	*1,391,185*	*1,405,499*	*1,440,342*
Age 15+	*411,654*	*421,062*	*435,116*	*435,116*
Star Health Foster Care	*30,843*	*31,155*	*32,098*	*32,423*

Source: Legislative Appropriations Request Forecast, HHSC Financial Services

Children's Health Insurance Program (CHIP)

CHIP program caseloads are projected to average more than 445,000 in fiscal year 2019. Excluding the Perinate caseload of 35,000, the estimated CHIP caseload is just over 410,000 in fiscal year 2019. The total CHIP program caseload trend is projected to be 4 percent by fiscal year 2019. Overall, there is a cost growth exceptional item of $8.1 million in GR for CHIP. **Figure III.3** shows the CHIP caseloads over a four-year period.

Figure III.3

CHIP Caseload				
Group	**Estimated FY 2016**	**Projected FY 2017**	**Projected FY 2018**	**Projected FY 2019**
**Traditional CHIP Children	360,541	382,138	393,126	410,293
***CHIP Perinatal Clients	34,855	33,550	34,941	35,019
Group Total, No Perinates	**360,541**	**382,138**	**393,126**	**410,293**
Group Total, With Perinates	**395,396**	**415,688**	**428,066**	**445,312**

Source: Legislative Appropriations Request Forecast, HHSC Financial Services
**Traditional CHIP contains Teacher Retirement System, legal immigrant, and federally funded children since all 3 groups are now federally funded as of Sept. 2010
***CHIP Perinate provides prenatal care for the unborn children of low-income women who do not qualify for Medicaid. Once born, the child will receive Medicaid or CHIP benefits depending on their income.

Long-Term Support Services (LTSS)

Long-Term Services and Supports caseloads in entitlement and waiver programs have changed considerably as many services have been carved-in to the overall managed care of the client. This results in a medical home and continuity of care that encompasses the total client need as well as staff support. Long-term services for children with significant needs will be carved-in to STAR Kids managed care in fiscal year 2017 (November 1, 2016). A subset of children will still receive waiver services outside of managed care. The caseload presented in **Figures III.4 and III.5** shows clients receiving Long-Term entitlement and waiver program services via fee-for-service (FFS).

Figure III.4 shows those clients who receive long term services through a fee-for-service model in the following general categories (note that declines in caseload result from service carve-ins to managed care):

- Residential Long-Term Services and Supports - caseload from the Nursing Facility (NF), Hospice, Skilled Nursing Facility (SNF), Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/IID), and State Supported Living Center (SSLC) programs.
- Community Care - entitlement and non-entitlement programs:
  - Community Care Entitlement includes caseload from the Primary Home Care (PHC), Community Attendant Services (CAS), Day Activity and Health Services (DAHS) Title XIX programs.
  - Community Care Non-Entitlement includes caseload from Home and Community Based Services (HCS), Community Living Assistance and Support Services

(CLASS), Deaf-Blind Multiple Disability (DBMD), Medically Dependent Children (pre-Nov 2016), Texas Home Living waiver programs and PACE (PACE program offers coordinated care).

- Promoting Independence - caseload for clients moving from institutional settings into the community care waivers, CLASS and Medically Dependent Children's Program (MDCP pre-Nov 2016).

Figure III.4

Long-Term Services and Supports Waiver & Entitlement Program Caseloads						
Group	**Estimated FY 2016**	**Projected FY 2017**	**Projected FY 2018 Base**	**Projected FY 2019 Base**	**Projected FY 2018 Full**	**Projected FY 2019 Full**
Residential LTSS	23,326	23,428	23,696	23,827	23,696	23,827
Promoting Independence	3,082	554	44	44	44	44
Community Care	96,971	99,157	99,929	101,739	100,782	102,592

Source: Legislative Appropriations Request Forecast, HHSC Financial Services

Figure III.5 provides further detail on caseloads for Long-Term Services and Supports programs described above, illustrating the remaining Long-Term Care fee-for-service programs. Some important caseload notes include:

- Caseloads for the fee-for-service Nursing Facility and Skilled Nursing Facility programs are comprised of residents of State Veteran's Homes and Truman Smith Care Centers as well as the impact related to eligibility of clients entering and exiting nursing facilities.
- The Community-Based Alternatives waiver was carved-in to managed care in September 2014 and with the rollout of the STAR Kids program in November 2016, the Medically Dependent Children's Program will be carved-in to managed care. These programs have caseload in both the Community Care and Promoting Independence rows of the chart.

Figure III.5

Long Term Services & Supports LAR Full Caseload Forecast (July 2017)				
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**
Residential LTSS				
Hospice	*7,097*	*7,415*	*7,269*	*7,394*
Skilled Nursing Facility	*1,716*	*1,631*	*1,797*	*1,797*
Nursing Facility	*6,359*	*6,318*	*6,661*	*6,661*
Intermediate Care Facility for Individuals with Intellectual Disability	*5,029*	*5,046*	*5,004*	*5,010*
State Supported Living Center	*3,125*	*3,018*	*2,965*	*2,965*
Subtotal	*23,326*	*23,428*	*23,696*	*23,827*
Promoting Independence*				
Rider Community Based Alternatives	-	-	-	-
Rider Community Living Assistance & Support Services	*48*	*48*	*44*	*44*
Rider Medically Dependent Children Program	*3,034*	*506*	-	-
Subtotal	*3,082*	*554*	*44*	*44*
Community Care				
Primary Home Care	*1,257*	*1,316*	*1,284*	*1,333*
Community Attendant Services	*54,743*	*56,590*	*57,761*	*59,523*
Day Activity & Health Services	*1,264*	*1,288*	*1,334*	*1,333*
Community Based Alternatives	-	-	-	-
Home & Community-based Services	*24,880*	*26,853*	*28,091*	*28,091*
Community Living Assistance & Support Services	*5,067*	*5,663*	*5,770*	*5,770*
Deaf Blind with Multiple Disabilities	*254*	*293*	*305*	*305*
Medically Dependent Children Program	*2,479*	*430*	-	-
Texas Home Living Program	*5,816*	*5,383*	*4,896*	*4,896*
Program of All-Inclusive Care for Elderly	*1,211*	*1,341*	*1,341*	*1,341*
Subtotal	*96,971*	*99,157*	*100,782*	*102,592*
Total	**123,379**	**123,139**	**124,522**	**126,463**

Excludes LTSS provided under managed care.
*Initiative supporting client movement out of institutional setting and into the listed community care waivers.

Other Key HHS Caseloads

DFPS - Based on the DFPS LAR submission, Foster Care caseloads are projected to increase approximately 2.1 percent in fiscal year 2017, followed by a decline of approximately 1.2 percent in fiscal year 2018, before returning to growth at 1.2 percent in fiscal year 2019. Adoption Subsidy/Permanency Care Assistance clients have been increasing steadily and are projected to increase approximately 6.2 percent in fiscal year 2017, followed by projected increases of 5.9 percent in fiscal year 2018 and 5.2 percent in fiscal year 2019. Total daycare caseloads (Foster, Protective and Relative combined) are projected to increase by an

estimated 3.3 percent in fiscal year 2017, followed by an approximately 11.5 percent increase in fiscal year 2018 and 1.3 percent increase in fiscal year 2019. **Figure III.6** below contains the base reconciliation forecast for 2016 and 2017.

HHSC - Early Childhood Intervention (ECI) caseload increases approximately 2.3 percent in fiscal year 2017 and by 1.9 and 1.6 percent in fiscal years 2018 and 2019, respectively.

HHSC - Temporary Assistance for Needy Families (TANF) is projected to see a decrease of about 6 percent in fiscal year 2017, continuing a similar trend of declining caseloads since fiscal year 2010. However, TANF caseload is expected to stabilize around 60,000 in fiscal year 2018, and slightly increase to 61,000 in fiscal year 2019.

Figure III.6

Other Key HHS Caseloads						
Agency/Program	**Estimated FY 2016**	**Projected FY 2017**	**Projected FY 2018 Base**	**Projected FY 2019 Base**	**Projected FY 2018 Full**	**Projected FY 2019 Full**
Department of Family and Protective Services						
Foster Care	*16,079*	*16,419*	*16,216*	*16,415*	*16,216*	*16,415*
Adoption Subsidy & Permanency Care Assistance	*49,357*	*52,401*	*55,510*	*58,376*	*55,510*	*58,376*
Total Day Care Days	*209,122*	*216,049*	*194,799*	*191,942*	*240,826*	*243,967*
Health and Human Services Commission						
Early Childhood Intervention	*27,228*	*27,854*	*24,981*	*24,073*	*28,384*	*28,840*
Temporary Assistance for Needy Families	*62,119*	*59,207*	59,939	61,136	59,939	61,136

Source: Legislative Appropriations Request Forecast, HHSC Financial Services

Notes:

(1) Foster Care caseload includes forecasted caseload for Home and Community Based Services (HCS), Relative Foster Care and Supervised Independent Living (SIL).

(2) Total Day Care Days represent the Average Monthly Days of Day Care received for Foster, Protective and Relative combined.

(3) ECI Caseload presented is representative of the Average Monthly Number of Children Served in Comprehensive Services.

FMAP Adjustment

The federal match or federal medical assistance percentage (FMAP) is the share of state Medicaid services costs paid by the federal government. It also represents the federal share of Title IV-E foster care and adoption assistance maintenance payments. The FMAP is effective for each federal fiscal year, October 1 to September 30. For the Texas fiscal year, September 1 to August 31, a one-month adjustment is made for budget planning and reporting purposes.

The FMAP is calculated based on a three-year average of state per capita personal income relative to the national average and is affected both by income and population. The March 2016 release of 2015 state personal income and per capita personal income data permitted projection of the fiscal year 2018 FMAP rate which is based on the per capita personal incomes for calendar years 2013-2015. Recent economic and demographic growth in Texas in comparison to the national average has resulted in a declining federal share to Texas.

The LARs submitted by health and human services agencies assumed the federal match or FMAP for direct care services in Medicaid and Title IV-E at 56.24 percent for state fiscal year 2018 and 56.25 percent for state fiscal year 2019. The final FMAP rates for fiscal year 2019 will be published in the fall of 2017. Subsequent to the LAR submissions, the final FMAPs for fiscal year 2018 were published October 2016 and the revised FMAP is 56.82 percent for state fiscal year 2018, which is more favorable to the state by decreasing the state share by 0.6 percent, and is noted below. The updated FMAP will be used during the legislative session and will increase the federal share of the Medicaid program and the federal Title IV-E foster care and adoption payments. When the federal match rate increases, it decreases the state share of the expenses resulting in a savings to General Revenue funds. **See Figure III.7**.

Figure III.7 LAR Estimated Federal Matching Rates (FMAP)
State Fiscal Years 2007 and 2016-2019

State Fiscal Year	Estimated FMAP	Revised FMAP
2007	N/A	60.77%
2016	N/A	57.21%
2017	N/A	56.26%
2018	56.24%	56.82%
2019*	56.25%	56.88%

** Projected*

The Children's Health Insurance Program (CHIP) uses an enhanced FMAP rate calculated by reducing each state's Medicaid share by 30 percent. In fiscal years 2016 through 2019, the Affordable Care Act increases the enhanced FMAP by an additional 23 percentage points. **Figure III.8**

Figure III.8 LAR Estimated Enhanced Federal Matching Rates (EFMAP) State Fiscal Years 2007 and 2016-2019

State Fiscal Year	Estimated EFMAP	Revised EFMAP
2007	N/A	72.54%
2016*	N/A	91.13%
2017*	N/A	92.39%
2018*	92.38%	92.78%
2019**	92.38%	92.82%

** Includes additional 23% enhanced match*

*** Projected, includes additional 23% enhanced match*

IV. HHS System Initiatives

HHS agencies are requesting a number of exceptional items that address critical needs across agencies and program areas. The items (described below) include increasing capacity of the community-based services programs, enhancing information technology, addressing retention and recruitment of selected direct care and other critical staff at HHS agencies, meeting the needs of aging and deteriorating infrastructure of state-operated facilities, supporting behavioral health services, and enhancing women's health care.

Behavioral Health

Behavioral health initiatives are a high priority for HHS system exceptional item requests. HHS are requesting 15 items totaling $332.1 million in General Revenue and $431.8 million in All Funds for the 2018-2019 biennium. A comprehensive report detailing behavioral health funding requests throughout all state agencies will be available for legislators and the public in the Consolidated Behavioral Health Schedule and Exceptional Item Review report provided by the HHSC Office of Mental Health Coordination and is available here: https://hhs.texas.gov/services/health/mental-health-substance-abuse/office-mental-health-coordination. Many of these exceptional items are part of larger system requests such as facility repair and replacement and IT items. **Figure IV.1** provides a summary of the behavioral health items requested for the 2018-2019 biennium.

Figure IV.1 HHS System Behavioral Health Exceptional Items FY 2018-2019 ($ in millions)

Agency	Item #	Description	Biennium GR	Biennium AF
DFPS	1	Increase Funding to Meet Needs of the Growing Number of Vulnerable Children, Adults, and Their Families	$2.2	$ 2.2
HHSC	7	Funding to Sustain Enhanced Community Coordination Services and Transition Support Teams	$13.0	$13.0
HHSC	5	Maintain Community Services at fiscal year 2017 Levels for community-based mental health and substance abuse programs for youth and adults	$4.7	$4.7
HHSC	8	Maintain Psychiatric Bed Capacity in the State Hospitals and community-based mental health residential options	$121.0	$121.0
HHSC	16	Reduce Community Mental Health Wait List for youth and adults.	$8.2	$8.17
HHSC	18	Repair State Hospital Facility	$ -	$99.2
HHSC	19	Regional Laundry/Facility Upkeep	$1.4	$1.4
HHSC	20	Fleet Operations	$6.5	$6.5
HHSC	22	Expand Psychiatric Bed Capacity	$100.7	$100.7
HHSC	27	Hepatitis C Treatment in acute cases anticipated to be in state hospital care the entire duration of treatment	$19.8	$19.8
HHSC	28	Enhance Community Services for community-based mental health and substance abuse treatments for youth and adults.	$44.5	$44.5
HHSC	45	Avatar electronic medical record support as a result of SSLCs moving to a different electronic medical records system	$6.1	$6.1
HHSC	46	Hospital - Life Record at Rio Grande State Center	$2.0	$2.0
HHSC	47	Hospital - Infrastructure to provide resources to support telemedicine, document imaging, and hospital systems	$2.00	$2.0
HHSC	TBD	Facility Replacement	TBD	TBD
HHS System Behavioral Health Exceptional Items Total			**$332.1**	**$431.1**

Increase HHS Community Services (Waiting/Interest Lists)

The Health and Human Services Commission supports funding additional waiver slots in community-based services programs to provide more timely service and to provide clients greater choice in the type of service they may access. The HHSC 2018-2019 biennium LAR includes exceptional items combining the HHS legacy agencies of DARS, DADS, and DSHS items requesting funds to continue increasing capacity in community services efforts. These exceptional items would serve 20,598 individuals by the end of fiscal year 2019 and cost $364.9 million in General Revenue (GR) for the 2018-2019 biennium. Most programs would receive federal matching funds (see **Appendix D** for details by program).

HHSC Exceptional Item #15 -Reduce Community Program Interest List ($346.3 million GR/ $803.4 million AF and includes 147 FTEs.)

This request reduces the waiting/interest lists for community-based services that include more than 100,000 unduplicated individuals across all waiver programs. This exceptional item provides services for an additional 19,010 individuals served in 1915(c) Medicaid waiver programs, as well as non-Medicaid programs with an interest list. Funding would provide additional slots for the following:

- Community Living Assistance and Support Services (4,204)
- Medically Dependent Children's Program (1,029 waiver and 180 Medical Assistance Only slots)
- Deaf-Blind with Multiple Disabilities (13)
- Home and Community-Based Services (8,882)
- Texas Home Living (1,403).

This item would also increase the number of individuals served in Non-Medicaid Services by 3,299.

HHSC Exceptional Item #16- Reduce Community Mental Health Wait List ($8.2 million GR/ $8.2 million AF)

This item request reduces the waiting list for youth and adult community mental health services provided by local mental health authorities (LMHAs). Funding this item proposes to eliminate the community mental health wait list with an estimated 838 individuals as of April 2016.

HHSC Exceptional Item #17-Comprehensive Rehabilitation Services (CRS) and Independent Living Services (ILS) Waitlist ($10.4 million GR/ $10.4 million AF)

This request would fund the CRS intensive rehabilitation services to help consumers who have experienced a traumatic brain injury or traumatic spinal cord injury live independently in their home and community. Funding would include providing services to 156 additional individuals.

House Bill 2463, 84th Legislature, 2015, directed the integration of the DARS legacy agency Independent Living program for individuals who are blind or have visual impairments, and the ILS program for individuals with significant disabilities into a single ILS program by September 1, 2016. The bill also directed the agency to ensure all services are directly provided by centers for independent living (CILs) or other nonprofit organizations. This request includes providing services to 594 additional individuals.

Information Technology Systems Needs

The Health and Human Services Commission Information Technology organization provides leadership and direction across the HHS system related to automated systems to achieve an efficient and effective health and human services system for Texans. To continue to fulfill this purpose, fifteen exceptional items are included in the HHSC LAR **(**see **Figure IV.2)**. These items cross multiple agencies and represent the most critical information technology needs to enable Health and Human Services programs to provide client services in the most efficient manner possible.

Figure IV.2

HHSC Information Technology Exceptional Items FY 2018-2019 ($ in millions)			
Item #	**Description**	**Biennial GR**	**Biennial AF**
41	Critical Incident Reporting	$ 1.3	$ 2.5
42	Quality Reporting System (QRS)	$ 0.6	$ 1.2
43	LTC Online Portal Specialized Services System Quality Improvements	$ 4.1	$ 16.5
44	Rehab Works Replacement Solution	$ 3.3	$ 3.3
45	Avatar Support (Electronic Medical Records System in State Hospitals)	$ 6.1	$ 6.1
46	Maintain State Hospital Technology for Patient Care-Hospital Record at RGSC	$ 2.0	$ 2.0
47	Hospital Infrastructure	$ 2.0	$ 2.0
48	TIERS Transition	$ 4.2	$ 12.1
49	Social Security Number Removal	$ 0.7	$ 7.1
50	HHS Electronic Discovery Solution	$ 6.1	$ 8.3
51	HHS Cybersecurity Project	$ 3.5	$ 4.8
52	DIR Data Center Services	$ 38.2	$ 59.7
53	Legacy System Modernization – Non-DCS IT Infrastructure	$ 33.7	$ 43.6
54	Seat Management (leases of personal computers)	$ 7.1	$ 7.4
55	Enterprise Identity and Access Management	$ 2.0	$ 2.7
	HHSC IT Exceptional Item Total	**$ 114.8**	**$ 179.4**

Each HHSC item is described separately below. In addition to these HHSC exceptional items, HHS agencies included in their agency-specific LARs information technology projects that do not impact multiple agencies. Those items are also described below.

HHSC Exceptional Item #41-Critical Incident Reporting ($1.3 million GR/ $2.5 million AF)

This item provides funding to develop a consistent incident management system across the 1915(c) waiver and intermediate care facilities for individuals with an intellectual disability or

related condition (ICFs/IID). ICFs/IID are required, under current rules, to track reportable incidents on an individual basis within eight different categories. However, DADS only requires monthly aggregate reporting of a minimal set of incident data for the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) programs and does not require the same reporting for Community Living Assistance and Support Services (CLASS) and the Deaf-Blind with Multiple Disabilities (DBMD) Program. In order to receive federal funding for 1915(c) and ICF/IID programs, the Centers for Medicare and Medicaid Services (CMS) also requires states to have an incident management system that effectively tracks those incidents through resolution and prevents further similar incidents to the extent possible.

HHSC Exceptional Item #42- Quality Reporting System (QRS) ($0.6 million GR/ $1.2 million AF)

This item provides funding to develop an improved Long-Term Care Quality Reporting System (QRS) to implement management actions from the Sunset Advisory Commission. The Commission called for DADS to make more consistent information available for all provider types, give every provider an overall rating using a five-star system, publicize current and historical enforcement data on individual providers, and include staffing information such as turnover and staff-to-resident ratios for each provider.

HHSC Exceptional Item #43- LTC Online Portal Specialized Services System Quality Improvements ($4.1 million GR/ $16.5 million AF)

This item funds improvements to the Long-Term Care (LTC) online portal Preadmission Screening and Resident Review (PASRR) forms and functionality. The LTC online portal, part of Texas' Medicaid Management Information System implemented in 2006, is a system with a web portal for service providers to submit claims, service authorization forms, corrections and inquiries. Additional functionality is needed pertaining to individuals receiving specialized services as required by federal law in the PASRR process to ensure nursing facility providers comply with program requirements for timely and accurate completion.

HHSC Exceptional Item #44- ReHabWorks Replacement Solution ($3.3 million GR/ $3.3 million AF)

ReHabWorks was a case-review system used by DARS for Vocational Rehabilitation, Blindness Education, Screening, and Treatment (BEST), Comprehensive Rehabilitation Services (CRS), and Blind Children's Vocational Discovery and Development Program (BCVDDP). On September 1, 2016, the Texas Workforce Commission assumed responsibility for ReHabWorks, supporting both TWC and HHSC programs. With this exceptional item, HHSC will seek an "off-the-shelf" software solution requiring minimal customization, interface development, and data conversion, including end-user utilities for configuration, to replace ReHabWorks for BEST, CRS and BCVDDP, as TWC will no longer support the legacy DARS programs at HHSC.

HHSC Exceptional Item #45-Avatar Support ($6.1 million GR/ $6.1 million AF)

Avatar is the electronic medical record system utilized by the state hospitals. Maintaining full functionality of Avatar (including funding for licensing, maintenance, upgrades, and staff support) is critical to daily operations. The Health and Human Services Commission has historically managed operational and technical support for the Avatar Electronic Health Record (EHR), using funds provided from the Department of Aging and Disability Services and the Department of State Health Services. The state supported living centers are transitioning to a different system, creating a funding gap for Avatar for the state hospitals. Because Avatar is vital to state hospital functions, state hospitals will have to provide the entirety of funding for licensing, maintenance, upgrades, and support staff.

HHSC Exceptional Item #46-Maintain State Hospital Technology for Patient Care – Hospital Record at RGSC ($2 million GR/ $2 million AF)

This item provides for the installation and maintenance services of the Life Record system at the Rio Grande State Center (RGSC), in order to align it with the rest of the state supported living center (SSLC) system. As a large ten-facility hospital system, the state mental health hospitals have significant technology needs that must be maintained and that can enhance patient care with and among the facilities. RGSC is a dual facility with both an SSLC and a state mental health hospital. The SSLC portion of RGSC was not included in the transition to the new SSLC Life Record. RGSC clinicians need to have access the records of current SSLC patients to enhance treatment and ensure continuity of care is maximized.

HHSC Exceptional Item #47-Hospital Infrastructure ($2 million GR/ $2 million AF)

This item provides funding to replace the current video conferencing system in the ten-facility state hospital system. The state mental health hospitals have significant technology needs that must be maintained and that can enhance patient care with and among the facilities. Video conferencing technology allows use of telepsychiatry in the state hospitals, and can reduce the cost of full staffing for these hospitals. However, the current video conferencing system is outdated and has reached its end of life, hampering the ability of hospitals to communicate to other video conferencing systems throughout the state. Replacement of the system will allow the state hospital system to expand the reach of precious psychiatrist resources through expanded use of telepsychiatry.

HHSC Exceptional Item #48- TIERS Transition ($4.2 million GR/ $12.1 million AF)

The current contract for Texas Integrated Eligibility Redesign System (TIERS) Software Development and Technical Support Services ends June 28, 2018. TIERS determines client benefit eligibility for various HHS system programs (such as Medicaid, CHIP, TANF, SNAP, etc.). The TIERS contract supports four user-facing applications, including the main TIERS

module, the YourTexasBenefits.com site, the Your Texas Benefits mobile application, and the Long-Term Services and Support (LTSS) application. A system as complex and critical as TIERS requires a carefully-planned transition from the incumbent vendor to a possible new vendor. This item supports a six-month transition plan for TIERS Software Development and Technical Support Services.

HHSC Exceptional Item #49- Social Security Number (SSN) Removal ($0.7 million GR/ $7.1 million AF)

CMS is leading the initiative to remove the Social Security numbers from Medicare cards and systems. The Health Insurance Claim Number (HICN) is the card's identifier, which consists of the primary claimant's Social Security numbers along with a supplemental code that establishes the beneficiary's relationship to a primary wage earner. The HICN is used to justify entitlement to Medicare benefits and is displayed on beneficiaries' Medicare cards. CMS intends to replace the HICN with a new, randomly generated, Medicare Billing Identifier. For Texas to be fully compliant, policies and systems must be examined and the appropriate changes identified, tested and implemented prior to CMS distributing new Medicare cards. This initiative will encompass all HHS systems that currently use or contain the HICN.

HHSC Exceptional Item #50- HHS Electronic Discovery Solution ($6.1 million GR/ $8.3 million AF)

This item would establish the Legal Case Management Solution and refresh eDiscovery technologies currently in use. Technical advances in the legal technology marketspace are maturing. Solutions are available that can enable legal teams to better manage and respond to litigation matters, investigations and public information requests that require evidence and information to be identified, culled, vetted, reviewed, analyzed and produced.

HHSC Exceptional Item #51- HHS Cybersecurity Project ($3.5 million GR/ $4.8 million AF)

Security threats continue to be the number one concern for industry and organizations in both the public and private sectors. HHSC serves millions of Texans who rely on our ability to provide them with basic services and protect their confidential information. Building and maintaining strong security allows us to reduce the number of security breaches and respond more quickly to security threats while minimizing agency impact. State and federal regulations and policies require HHS to monitor its computer networks, ensure client privacy, and protect confidential information. This item funds the HHS Cybersecurity Project that includes the following improvements to help protect information from unauthorized access, use, disclosure, disruption, modification, or destruction:

- Data and Log Analysis Correlation Tools
- Secure Remote Access Improvement.

HHSC Exceptional Item #52- DIR Data Center Services ($38.2 million GR/ $59.7 million AF)

This item funds ongoing operations, disaster recovery, technology refreshes and application remediation for Data Center Services (DCS). Various HHS programs have expanded over time to meet legislative mandates, state security standards and statewide human resource initiatives. Newly established DIR policy regarding the usage of up-to-date software also drives DCS billings or charges to HHSC.

HHSC Exceptional Item #53- Legacy System Modernization - Non DCS IT Infrastructure ($33.7 million GR/ $43.6 million AF)

HHSC is requesting exceptional item funding to refresh legacy hardware and software products to current manufacturer supported versions. The affected infrastructure supports critical business applications within HHSC, DSHS and DFPS, and includes servers, storage, software, network switches and routers and infrastructure which supports software-based telephone systems. Refreshing the hardware and software will improve functionality, reduce system outages, ensure security compliance, reduce staff support requirements and maintain vendor standard support.

HHSC Exceptional Item #54- Seat Management ($7.1 million GR/ $7.4 million AF)

This exceptional item will cover maintenance and lease payments above base funding for the existing leased computer equipment, and allow for replacement of PCs that have reached the end of their 4-year life cycle and no longer adequately support the business needs of the agency.

HHSC Exceptional Item #55- Enterprise Identity and Access Management (IAM) ($2 million GR/ $2.7 million AF)

HHS staff are highly dependent on computer applications to provide services to their clients. The public also depends on external facing applications, like the DFPS e-report system, to access various HHS services. To access these systems, requestors must complete numerous paper or online forms, which must then be approved by supervisors and application owners. The Enterprise Portal was implemented to streamline the provisioning and de-provisioning of applications within the HHS system and to address significant audit deficiencies. The HHS Enterprise Portal allows Identity and Access Management to automate the request, approval, and creation of accounts that reside in applications managed by HHS, as well as the ability to review and certify accounts, automate removal of access due to user termination or role change, and provide a central repository for audit and compliance response.

There are a total of 433 applications and 47 forms that could be integrated into the portal. With existing resources and over the last 18 months, the portal was designed, developed and implemented with approximately 70 (or 16 percent) of the applications integrated.

DFPS IT Exceptional Item (See Figure IV.3)

Figure IV.3

DFPS Information Technology Exceptional Items FY 2018 - 2019 ($ in millions)			
Item #	Description	Biennial GR	Biennial AF
4b	Address Provider Placement Capacity Portal and IMPACT System Interoperability	$10.3	$11.9

DFPS Exceptional Item #4b- Address Provider Placement Capacity Portal and IMPACT System Interoperability ($10.3 million GR/ $11.9 million AF)

Improving collaboration and data sharing with child-care providers and reducing timeframes to locate appropriate placements for children is critical to ensure adequate, high quality capacity in the foster care system. A portal system is needed to track placement provider capacity in real time, allow for automated data sharing with providers, and serve as a case management system for placement staff to ensure children and youth are receiving quality and timely services in a manner that best supports the achievement of safety and permanency for children and youth in care. This item funds the development of a real time flexible two-way data exchange between IMPACT and provider systems to manage payments of purchased client services and of a portal to allow contracted providers of foster care services to view and update current capacity within their network.

DSHS IT Exceptional Items (See Figure IV.4)

Figure IV.4

DSHS Information Technology Exceptional Items FY 2018 - 2019 ($ in millions)			
Item #	Description	Biennial GR	Biennial AF
4	Tuberculosis Prevention and Control (Video Directly Observed Therapy)	$ .9	$ .9
5	State Laboratory Needs (Division for Disease Control and Prevention Services Laboratory Server Environment and Software)	$1.5	$1.5
7	Public Health Information Technology	$11.8	$11.8
	DSHS IT Exceptional Item Total	**$14.2**	**$14.2**

DSHS Exceptional Item #4- Tuberculosis Prevention and Control (Video Directly Observed Therapy) ($0.9 million GR/ $0.9 million AF)

The funds will be used to procure a system that will allow the remote monitoring of individuals with Tuberculosis (TB) infection and TB disease to ensure completion of the required course of medications. When patients do not complete the entire required course of medication, the opportunities for disease spread and emergence of drug-resistant TB increase.

DSHS Exceptional Item #5- State Laboratory Needs (DCPS Laboratory Server Environment and Software) ($1.5 million GR/ $1.5 million AF)

The Division for Disease Control and Prevention Services (DCPS) needs to continue and expand the existing lease of the server environment and add a disaster recovery functionality. This item will procure software to support genome sequencing for tuberculosis testing. This funding would provide the Laboratory the ability to perform analysis in support of identification of antibiotic resistant bacteria and bacteria that are part of an outbreak investigation. A delay in recovering the new born screening system would result in an average of 1,600 babies per day having late results or remaining untested.

DSHS Exceptional Item #7- Public Health Information Technology ($11.8 million GR/ $11.8 million AF)

This item supports two initiatives: a system for the blood lead surveillance program and a pharmacy warehouse inventory system.

The blood lead surveillance program's need is an efficient method to collect, cleanse, process, and report data. Currently staff are unable to collect, cleanse and report information in a timely manner. Improvement in business rules and architectural design is essential. Without the needed additional functionality, the blood lead surveillance program will continue to use inefficient workarounds, experience data processing delays, and untimely reporting of results. The program will continue to have difficulty meeting the program's objectives and data quality.
The Disease Control and Prevention Section (DCPS) Pharmacy Branch needs to acquire and implement a combined warehouse and inventory system that integrates access to other entities and shipping distribution functionality. The current Inventory Tracking Electronic Asset Management System (ITEAMS) application has become Food and Drug Administration (FDA) non-compliant and no longer meets the Branch's business needs.

Retention and Recruitment of Critical Service Staff

The 2018-2019 biennium appropriation request to provide salary increases to improve the retention and recruitment of critical HHS agency staff is included in HHSC Exceptional Item #9 and in DSHS Exceptional Items #3 and #4. These requests focus on many staff who provide direct care to clients with high turnover.

HHSC Exceptional Item #9-Maintain Critical Direct Delivery Staffing in State Supported Living Centers and State Hospitals ($69.2 million GR/ $96.4 million AF)

HHS agency facilities are facing high turnover and vacancy in many critical staffing areas. Annualized turnover at SSLCs has remained above 35 percent since fiscal year 2012, and was 37 percent in fiscal year 2016. For state hospitals in fiscal year 2015, the annualized turnover rates for critical shortage positions at state hospitals were as high as 34 percent.

This request would increase salaries for SSLC licensed vocational nurses (LVNs), registered nurses (RNs), and direct support professionals. It would also increase the salaries of psychiatric nurse assistants (PNAs), LVNs, RNs, psychiatrists, and physicians at State Hospitals. Furthermore, Exceptional Item 9 would provide maximum security pay or high risk patient pay for PNAs at State Hospitals who are not currently receiving this pay but are interacting with these clients. In this request the highest paid staff positions would receive a 4 percent salary increase ascending to a 10 percent increase at the lower paid staff positions. As shown in **Figure IV.5** this items totals $69.2 million in General Revenue and $96.4 million All Funds over the biennium.

Figure IV.5 Requested FY 2018-2019 Funding for HHS Facilities Staff Retention and Recruitment ($ in millions)

Facility	Staff Recommended	Requested Percent Salary Increase	Number of Positions	Turnover Rate Through 08-23-2016	Biennium GR	Biennium All Funds
SSLC	Licensed Vocational Nurses	4%-10%	721	34.6%	$2.97	$6.78
SSLC	Registered Nurses	4%-10%	812	24.1%	$3.99	$9.13
SSLC	Direct Support Professionals	10%	6,700	47.1%	$14.20	$32.45
SSLC Subtotal			**8,233**		**$21.16**	**$48.36**
State Hospitals	Psychiatric Nursing Assistants	4%-10%	3,175	33.1%	$13.08	$13.08
State Hospitals	Licensed Vocational Nurses and Registered Nurses	4%-10%	1,430	25.7%	$12.78	$12.78
State Hospitals	Psychiatrists	12%	137	18.7%	$7.14	$7.14
State Hospitals	Advanced Practice Registered Nursed and Physician Assistants	4%	48	28.9%	$.90	$.90
State Hospitals	Physicians	42%	42	9.8%	$4.44	$4.44
State Hospitals	Designated Specialized Behavioral Management	6.8%	2,403	36.37%	$9.74	$9.74
State Hospitals Subtotal			**7,235**		**$48.07**	**$48.07**
Total Facilities Retention and Recruitment Request			**15,468**		**$69.23**	**$96.43**

DSHS Exceptional Item #3- Support Regional and Local Public Health Services and DSHS Exceptional Item #4- Strengthen the State Public Health Laboratory ($3.7 million GR/ $3.7 million AF)

The DSHS LAR includes exceptional items to improve retention and recruitment of staff in the areas of Public Health Services and the Public Health Laboratory. These positions are public health professionals who are in the field daily. Many of the positions are highly technical and on-the-job training can take up to two years. All positions are an integral part of DSHS's ability to respond to on-going public health needs and emergencies. DSHS Exceptional Item #3 includes salary increases for Regional and Local Health Nurses. DSHS Exceptional Item #4 includes salary increases for various laboratory staff in the amount of $2.7 million. **Figure IV.6** displays the DSHS staff retention and recruitment requests for the 2018-2019 biennium.

Figure IV.6 Request 2018-2019 Biennial Funding for DSHS Staff Retention and Recruitment ($ in millions)

Category	Staff Recommended	Requested Percent Salary Increase	Number of Positions	Biennium GR	Biennium All Funds
Public Health	Public Health Nurses	10%	57	$1.0	$1.0
Public Health	Licensed Vocational Nurses	7.5%	10	$0.1	$0.1
Laboratory	Technical Staff	10.0% - 15.0%	310	$2.7	$2.7
DSHS Public Health and Laboratory Total			**377**	**$3.7**	**$3.7**

State-Operated Facilities

HHSC has identified four areas of need most critical to ensure the health, safety, welfare and environment of care infrastructure items affecting patients, residents and staff in state-operated facilities. These areas include: facility repair and renovations, new construction, fleet operations, and laundry services. HHSC has included the exceptional items for the system.

Facility Repairs and Renovation

HHSC Exceptional Item #18-Facilities Repair and Renovation ($188.6 million AF)

This item provides critical infrastructure repairs and renovations of state-operated facilities, state mental health hospital system and State Supported Living Centers (SSLCs), to address issues related to residents' health, safety, welfare and environment of care including fire alarm systems, emergency generators, roofing, HVAC systems, water and waste water lines, electrical, and plumbing.

There are 12 SSLC campuses composed of 836 buildings averaging 49 years old, ranging from one to 116 years. As a result of the age of the buildings, ongoing capital investments are required to ensure that the buildings are functional, safe and in compliance with all pertinent standards.

The state hospital system has 12 hospital campuses composed of 573 buildings which are in need of continued repair and maintenance because of age and life safety and fire code requirements. The Rio Grande State Center is operated by DSHS with which the legacy agency DADS contracts to provide services. The average age of the hospital buildings is 52 years, ranging between 2 and 157 years. There are a number of buildings on the campuses that are unused and need to be demolished because they are unsafe and are not cost effective candidates for renovation. State hospitals must maintain Joint Commission accreditation to receive federal funding. The state must provide a safe and therapeutic environment conducive to patient recovery. These repairs would limit high cost emergency repairs in the future.

Figure IV.7 below shows the amount of All Funds requested for facility repairs and renovation. HHSC requested general obligation bond proceeds to fund these facility needs.

Figure IV.7. Summary of 2018-2019 Biennium Repair and Renovation Needs and Requests (AF $ in millions)

Agency	Identified Needs	Request
State Supported Living Centers	$238.9	$93.1
State Mental Health Hospitals (includes Rio Grande State Center)	$222.0	$95.5
Total	**$460.9**	**$188.6**

Regional Laundry and Facility Upkeep

HHSC Exceptional Item #19- Regional Laundry and Facility Upkeep ($5.4 million GR/ $5.4 million AF)

In fiscal year 2005, SSLCs and state mental health hospitals consolidated 13 individual laundry facilities into five regional facilities. Although a significant amount of equipment was replaced as part of the Energy Savings Performance Initiative through the State Energy Conservation Office (SECO). Beginning with the 2014-2015 biennium, a 10-year replacement plan was established to ensure the replacement of equipment on a regular industry standard schedule. Additionally, trailers are required to transport soiled linens and clothing and replace them with fresh, clean laundry.

To address facility upkeep needs, this item would also fund perimeter fencing, new freezer vault, demolition for unused, unsafe patient and other state hospital buildings, and capital authority for

two new construction projects at SSLCs. The exceptional item details are shown in **Figure IV.8** below.

Figure IV.8. FY2018-19 Regional Laundry and Facility Upkeep Request (AF $ in millions)

Facility	Description	Request
SSLCs	New construction projects - Entrance for guard bldg.; Covered walkway (for resident/staff traffic)	$0.5
State Hospitals	Demolition of unused, unsafe bldgs. Install Perimeter Fence Construct New Freezer Vault	$4.2
SSLCs/ State Hospitals	Regional Laundry Equipment	$0.6
Total		**$5.3**

Fleet Operations

HHSC Exceptional Item #20 -Fleet Operations ($15.8 million GR/ $15.8 million AF)

The HHSC request for vehicles is consistent with replacement priorities identified in the HHS Enterprise Vehicle Replacement Plan. The HHSC vehicle replacement plan addresses issues of excessive time and money spent on repairs and maintenance of older, problematic vehicles, increased risk of injury to residents, patients and staff, possible issues with certification, and elimination or reduction in programs due to lack of vehicles to support them. The request includes passenger cars, SUVs, light duty trucks, medium trucks, and vans that are primarily used for supporting client services at state facilities. The request includes vehicles for SSLCs - 219, state hospitals - 200, and DSHS and HHSC - 28 (includes 20 for Public Health, and 7 for HHSC regional offices) (**See Figure IV.9**).

Figure IV.9. HHS System Vehicle Needs (AF $ in millions)

Agency	Number of Vehicles	Request
SSLCs	219	$8.4
State Hospitals	200	$6.5
HHSC/DSHS	28	$0.8
Total	**447**	**$15.8**

New Construction: State Hospitals and State Supported Living Centers

HHSC Exceptional Item #20- New Construction: State Hospitals and State Supported Living Centers

This item serves as a placeholder, acknowledging the need to critically review state-operated facilities, as it relates to quality service delivery and aging infrastructure. These state-operated facilities (state hospital and SSLC systems) serve differing, but equally vulnerable populations with intense needs. Both the SSLCs and state hospitals have considered the need for smaller structures to address inadequate spaces for providing current standards of care and client and staff safety. While the residents of these facilities have high medical and behavioral health needs, the rapid population growth of Texas adds additional pressure to arrive at a solution to meet these populations' needs.

Texas must address the challenges of deteriorating infrastructure and inadequate space, especially in light of Texas' rapid population growth and the impact that will have on the increasing need for mental health, behavioral health, and long-term care. Considerations include how to currently operate, where to locate facilities, and what the overall model for the delivery of care is. These systems are in need of substantial infrastructure improvements and new strategically located construction of facilities to meet the changing needs of Texas. However, HHSC cannot adequately address these needs without direction from the legislature.

Women's Health Services

During the 2016-2017 biennium, the women's health programs previously at HHSC and DSHS were moved and restructured at HHSC. The Healthy Texas Women program, launched July 2016, leverages existing resources and technology to increase provider partnerships and access. The three women's health programs at HHSC in the 2018-2019 biennium, the Healthy Texas Women program, Family Planning Program, and the Breast and Cervical Cancer Screening program, provide an array of services to clients.

Healthy Texas Women: The HHSC Healthy Texas Women program (HTW) provides services for women ages 15 to 44 years of age (a minor must have parental consent) who are at or below 200 percent of the Federal Poverty Level. HTW services include family planning services, contraceptive services, pregnancy testing and counseling, health screenings, and sexually transmitted infection services. HTW provides screening, diagnosis and treatment for issues that affect maternal health and future pregnancies, including hypertension, diabetes, and cholesterol.

Family Planning: The HHSC Family Planning Program provides statewide family planning services to low-income women and men 64 and younger, who are at or below 250 percent of the Federal Poverty Level. The services available to clients include family planning services, contraceptive services, pregnancy testing and counseling, health screenings, sexually transmitted infection services, and limited prenatal services. Exceptional Item 23 in the HHSC LAR requests

$20 million to provide additional funding for the Family Planning Program, serving an estimated 35,000 additional women per year for a total of 150,500 served.

Breast and Cervical Cancer Screening: The HHSC Breast and Cervical Cancer Screening (BCCS) program provides breast cancer screenings for women ages 50-64 and cervical cancer screenings for women ages 21-64 who are at or below 200% of the Federal Poverty Level. The services available to clients include screening services, diagnostic services, and cervical dysplasia management and treatment.

Figure IV.10 Historical Women's Health Services FY 2010-2015

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Family Planning	212,477	195,709	82,953	48,902	55,869	66,118
Breast and Cervical Cancer Screening	33,483	35,911	37,748	36,718	33,599	34,376
Expanded Primary Health Care for Women					147,083	158,209
Women's Health Program/Texas Women's Health Program	107,567	127,536	126,473	115,440	114,441	105,205
Total	***353,527***	***359,156***	***247,174***	***201,060***	***350,992***	***363,908***

V. SELECT MEDICAID INITIATIVES

Cost Containment Initiatives

Rider 50 Medicaid Cost Containment Status - Fiscal Years 2016-2017

The General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Health and Human Services Commission, Rider 50, Medicaid Cost Containment) includes 17 cost-containment initiatives with a goal of saving $373 million in general revenue ($870 million all funds) in the 2016-2017 biennium. These initiatives are primarily focused on paying appropriate rates, reduction of fraud, waste and abuse, and program efficiencies, such as improvements in third party recoupments.

Based on current implementation plans and savings estimates, $137 million in general revenue is expected to be achieved this biennium. This follows on legislative cost containment requirements over the past decade. Most recently, the 2014-2015 biennium General Appropriations Act included a cost containment rider (Article II, HHSC Rider 51) that set a savings target of $400 million in general revenue, an estimated $438 million in general revenue was achieved.

These efforts have resulted in a transformation of the state's Medicaid payment and service delivery structure into a managed care model. Since many of the large savings initiatives have been implemented, HHSC is working now on items with smaller increments of savings to continually refine our Medicaid program as evidenced by the set of cost containment efforts described in this report.

The table below recaps items included in the Rider 50 along with current savings estimates. Following the table is a description of the major savings initiatives underway **(see Figure V.1).**

In addition to these items, HHSC continues its effort to identify further savings across the HHS system in all programs and administrative functions. These additional initiatives are anticipated to result in more savings in the current biennium and will be reported to the Legislature at the beginning of session.

Figure V.1 Cost Containment Initiatives Fiscal Years 2016-2017

Item	Item Description	HB1 GR Target	Estimated Savings-GR	Estimated Savings-AF
1	Continue strengthening and expanding prior authorization and utilization reviews	$ 15.0	TBD	TBD
2	Incentivize appropriate neonatal intensive care unit utilization and coding	$ -	$ -	$ -
3	Fully implement dually eligible Medicare/Medicaid integrated care model and long-term services and supports quality payment initiative	$ -	$ -	$ -
4	Maximize co-payments in Medicaid programs (item not being pursued)	$ -	$ -	$ -
5	Increase fraud, waste, and abuse prevention and detection	$ 25.0	$ 25.8	$ 57.8
5a	*Hospital Reviews*	*$ -*	*$ 7.7*	*$ 18.0*
5b	*Acute Care Reviews*	*$ -*	*$ 5.6*	*$ 14.0*
5c	*Inspections*	*$ -*	*$ 5.5*	*$ 8.3*
5d	*Integrity Initiative*	*$ -*	*$ 7.0*	*$ 17.5*
6	Explore changes to premium structure for managed care organizations and contracting tools to reduce costs and increase efficiency	$ -	$ 6.8	$ 18.7
6a	*Limit rate for below average cost plans in a community compared to the actual plan cost experience*	*$ -*	*$ 5.3*	*$ 14.9*
6b	*Reduce maximum net reinsurance from $0.75 to $0.50*	*$ -*	*$ 1.5*	*$ 3.8*
7	Renegotiate more efficient contracts, including reducing the administrative contract profit margin and establish rebate provisions where possible	$ -	$ 3.9	$ 9.7
8	Develop a dynamic premium development process for managed care organizations that has an ongoing methodology for reducing inappropriate utilization, improving outcomes, reducing unnecessary spending, and increasing efficiency. (Item not being pursued)	$ -	$ -	$ -
9	Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services	$ -	$ 10.2	$ 17.6
9a	*Diagnostic Radiology*	*$ -*	*$ 5.7*	*$ 7.3*
9b	*Screening, Brief Intervention and Referral to Treatment*	*$ -*	*$ 3.0*	*$ 6.7*
9c	*Medical Transportation Program- Reduced capitation rates to incentivize better contracting with transportation providers at lower rates.*	*$ -*	*$ 1.2*	*$ 2.9*
9d	*Medical Transportation Program- Reduced capitation rates to be consistent with the State of Texas travel reimbursement schedule for mileage.*	*$ -*	*$ 0.3*	*$ 0.7*
10	Improve birth outcomes, including improving access to information and payment reform	$ -	$ -	$ -
11	Increase efficiencies in the vendor drug program	$ 15.0	$ 15.6	$ 36.1
11a	*Enhancements to Physician Administered Drug Rebates*	$ -	*$ 11.3*	*$ 26.2*
11b	*Implement MCO 340B Pricing Programs*	$ -	*$ 2.5*	*$ 5.9*
11c	*340B Pharmacy Overpayment Refund*	$ -	*$ 0.9*	*$ 2.0*
11d	*Fee-for-service NADAC pricing methodology*	$ -	*$ 0.9*	*$ 2.0*
12/13	Increase third party recoupments and Create a pilot program on motor vehicle subrogation	$ 10.0	$ 10.5	$ 24.0
12/13a	*MCO Encounter Recovery*	*$ -*	*$ 5.1*	*$ 11.7*
12/13b	*Motor Vehicle Pilot*	*$ -*	*$ -*	*$ -*
12/13c	*Commercial Insurance 3rd Party Payment Recovery*	*$ -*	*$ 5.4*	*$ 12.3*
12/13d	*Behavioral Health cost-avoidance*	*$ -*	*$ -*	*$ -*
14	Assess options to reduce costs for retroactive Medicaid claims (Item under consideration)	$ -	$ -	$ -
15	Review the cost effectiveness of including children with disabilities in dental managed care	$ -	$ -	$ -
16	Review and determine the benefits of providing the managed care-organizations with the ability to create a pharmacy lock-in program	$ -	$ -	$ -
17	Implement additional initiatives identified by HHSC	$ 158.0	$ 6.0	$ 16.0
17a	*Suspend dental pay for quality program*	*$ -*	*$ 6.0*	*$ 16.0*
Acute care therapy services		$ 150.0	$ 58.4	$ 150.6
	Therapies-Reimbursement Methodology	*$ 100.0*	*$ 54.6*	*$ 141.8*
	Therapies-Policy Initiatives	*$ 50.0*	*$ 3.8*	*$ 8.8*
	Total Cost Containment Rider 50	**$ 373.0**	**$ 137.2**	**$ 330.5**

Continue strengthening and expanding prior authorization and utilization reviews

Utilization Reviews of the Home and Community Based Services (HCBS) in STAR+PLUS were conducted and fiscal year 2015 data indicates the MCOs face challenges with upgrading the process for determining whether members require HCBS STAR+PLUS waiver services to meet their needs or if other STAR+PLUS services are sufficient. The fiscal year 2015 findings revealed a widespread lack of documentation on a majority of the HCBS STAR+PLUS waiver required forms and assessments. This lack of documentation resulted in individual services plans that do not accurately address or reflect the needs of the member.

Education for STAR+PLUS MCOs, regarding placement of clients into appropriate risk groups, is ongoing. Technical on-site assistance to each of the STAR+PLUS MCOs has been provided. Additionally, HHSC has provided a series of webinars, targeted to MCO service coordinators, to provide training on HCBS STAR+PLUS waiver responsibilities encompassing assessments, service planning, documentation requirements, and ongoing monitoring of member needs and related topics. Recoupments when appropriate are being assessed to providers. This effort will ensure clients are placed in the appropriate risk groups and corresponding savings are realized.

Increase fraud, waste, and abuse prevention and detection

The Office of Inspector General (OIG) is pursuing four initiatives aimed at containing Medicaid costs, including hospital reviews, acute care reviews, increased inspections and a new overarching Integrity Initiative with managed care organizations.

- **Hospital reviews:** When the Utilization Review Unit identifies instances of overbilling or under billing during its hospital reviews, it refers its results to the HHSC Medicaid claims administrator, who is responsible for recouping overpayments and adjusting underpayments. Through the end of fiscal year 2016, the HHSC Office of Inspector General reviewed 61,518 hospital claims, about 71 percent of the 87,000 hospital claims reviews planned for the fiscal year. The estimated net change from the previous year in overpayment recoveries through hospital and nursing facility reviews in fiscal year 2016 increased by about $4.9 million in GR.
- **Acute care reviews**: Nurses perform retrospective reviews of acute care claims and related services provided to Medicaid recipients to assess the following:
    - Medical necessity for acute care and out-patient services.
    - Appropriateness of the diagnosis and treatment.
    - Quality of acute care by providers of medical services.
    - Appropriate use of Current Procedural Terminology (CPT) coding guidelines.

The transfer of eight registered nurses to the newly incorporated Office of Medical Services Division was initiated. Continued training will therefore increase record review outcomes while continuing quality assurance activities through fiscal year 2017. The program completed the review required by HHSC Rider 45, Medication Therapy Management, which

encompassed 15 months and 714 cases. The program will focus on increased utilization review during fiscal year 2017.

- **Increased Inspections**: The mission of the newly established Inspections Division is to conduct inspections and reviews of HHS system programs focused on systemic issues and providing practical recommendations to improve the effectiveness and efficiency of HHS programs to prevent fraud, waste, and abuse and to ensure the greatest benefit to the people of Texas. The Inspections Division proposes to conduct four inspections during fiscal years 2016 and 2017 including an inspection of how effectively HHSC and IG are executing the Treasury Offset Program (TOP) to identify and recoup erroneous payments in Social Services Programs.

The TOP inspection will be conducted in the first quarter of fiscal year 2017 to allow for maximum recoveries in fiscal year 2017 as well as an improved process providing for increased recoveries into future fiscal years.

- **Integrity Initiative**: The Inspector General announced the IG Integrity Initiative (IGII) on April 21, 2016, before the Senate Health and Human Services Committee. It represents a new collaborative vision for cooperative statewide Medicaid oversight engaging the IG and Medicaid providers, MCOs, and any person or entity who receives Medicaid funding that meets the participation requirements below.
    - Incorporate integrity into their Mission or Values Statement.
    - Report all fraud, waste, and abuse to the IG whenever and wherever they find it.
    - Train all applicable staff on Medicaid integrity practices.
    - Include a link from the provider's website to the IG's website.
    - Prominently display the IG's Integrity Line posters in high traffic areas.

The IG is working with MCOs to track and record recoveries due to this initiative. It is assumed that recoveries will be measurable by MCOs and that recoveries will be captured in the MCOs' experience which is used to build the capitation rates. A new division at the IG will focus on comprehensive inspections in key areas selected by the Executive Commissioner

<u>Explore changes to premium structure for managed care organizations and contracting tools to reduce costs and increase efficiency</u>

Fiscal year 2017 MCO rates were adjusted to decrease costs in two areas:

Limit rate for below average cost plans in a community compared to the actual plan cost experience: The STAR and CHIP premiums are calculated using a community rating methodology that sets an average premium for all health plans participating in a service area. As a result of this average, there are health plans whose actual costs are above the average and those

that are below the average. For those plans well below this community average the premium is capped.

- **Reduce Maximum net reinsurance:** The rate development includes an allowance for the expected net cost of reinsurance incurred by the health plan. The estimated cost of reinsurance is the difference between the reinsurance premiums paid by the health plans and the recoveries received by these health plans from the reinsurer. This rating allowance was reduced from a maximum amount of $0.75 per member per month to $0.50 per member per month in 2017.

Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services

- **Reduce diagnostic radiology rates**: As a result of the scheduled biennial review of acute care Medicaid fees for diagnostic radiology services, HHSC determined that certain acute care diagnostic radiology fees could be reduced based on the relation to Medicare fees for the same services and will implement the rate change effective February 1, 2017. General hospital diagnostic radiology services fees are tied to acute care Medicaid fees and so will be reduced as well. Rural hospital diagnostic radiology services fees will be exempt from the reductions.
- **Screening, Brief Intervention and Referral to Treatment (SBIRT):** SBIRT is a comprehensive, public health approach to the delivery of early intervention and treatment services for clients 10 and older with alcohol and/or substance use disorders, as well as those who are at risk of developing these disorders. SBIRT is currently available to children 10 to 20 years old who present at an emergency department for trauma or injury related to substance use. The expanded SBIRT benefit will include the following services which produce savings because of reduced health care costs related to substance abuse
    - Expand SBIRT to outpatient settings and for adults 21 and older.
    - Include a four hour training requirement for all providers performing SBIRT.
    - Introduce two new procedure codes.
    - Add limitations of two screening only sessions per year and four combined screening and brief intervention sessions per year.
- **Medical Transportation**: Effective January 1, 2016 reimbursement for Individual Transportation Participant service reduced from $0.56 a mile to $0.54 a mile (consistent with the State of Texas travel reimbursement schedule for mileage). The base period claim cost for the fiscal year 2017 rate development cycle has been adjusted to reflect this change.
- **Medical Transportation**: Effective September 1, 2014, a full risk capitated arrangement was expanded to the remaining Texas regions through the Managed Transportation Organization (MTO) contracts. Effective with this change, some MTOs reimbursed demand response providers significantly higher than under FFS. For the fiscal year 2017 rate development cycle, the base period claims cost per trip for demand response service was capped.

Increase efficiencies in the vendor drug program

The Vendor Drug Program (VDP) implemented four policies to contain costs beginning in fiscal year 2016, as follows:

- **Clinician Administered Drugs**: HHSC began invoicing drug manufacturers for Clinician Administered Drugs (CADs) in November 2015 with increased rebate revenue amounts attained by tightening the requirements for submission and editing of claims for clinician-administered drugs for clients in MCOs and FFS. This will result in collection of more federal drug rebates (i.e. increased revenue). Future invoices will also be at the higher rates.
- **MCO 340B Pricing Programs**: The Health Resources and Services Administration (HRSA) 340B program requires drug manufacturers to provide outpatient drugs to eligible health care organizations (i.e., covered entities) at significantly reduced prices, enabling covered entities to purchase drugs at a discounted price. Insurers, including Medicaid programs, may also share in the savings generated by the 340B Program. MCO contracts were modified to require plans to implement a 340B program to reimburse eligible providers at the lower 340B purchase price. The total savings will be reflected in MCO rates for fiscal year 2016 and 2017.
- **340B Pharmacy Overpayment Recovery**: Prior to 2015, 340B pharmacies were required to bill Medicaid their actual purchase price (the discounted 340B price). A large 340B pharmacy self-reported a pharmacy claim billing system error. They had improperly billed the program and were overpaid. The provider is making repayment.
- **Fee For Service Pricing Methodology:** VDP currently pays FFS contracted pharmacies using an estimated acquisition ingredient cost methodology based on pricing information received from drug manufacturers and published drug pricing benchmarks. HHSC is adopting a new ingredient cost methodology which is based on pharmacies' actual acquisition cost (AAC), using the National Average Drug Acquisition Cost (NADAC) published by CMS. This change will also allow Texas to be compliant with newly finalized CMS rules for covered outpatient drugs, before the April 2017 deadline. CMS also requires states that adopt AAC methodology to pay a dispensing fee based on a recent study of the cost of dispensing. Accordingly, HHSC is increasing the fixed component of the variable dispensing fee formula to $7.93 per claim. Together, the new methodology will be less costly. Reimbursement in managed care is not impacted by these changes.

Increase third party recoupments (TPR) and create a pilot program on motor vehicle subrogation

HHSC is implementing the following initiatives to increase third party recoupments:

- **MCO Encounter Recovery**: HHSC has partnered with Texas Medicaid and Healthcare Partnership (TMHP) to modify the state's recovery activity on MCO Encounter Recovery billings. Per the MCO Contract, after 120 days from the date of adjudication of a claim

that is subject to TPR, HHSC has the right to attempt recovery, independent of any MCO action. HHSC will retain, in full, all funds received as a result of any state-initiated third-party recoupments or subrogation action. To increase efficiencies, business rules were redesigned for the program to improve processes resulting in higher recovery beginning May 2016.

- **Motor Vehicle pilot program**: Create a pilot program to data match with the motor vehicle claims data. The state of Rhode Island has designed the Medical Assistance Intercept System (MAIS) which electronically matches Medicaid recipients with liability insurance claims. HHSC is currently working to sign an interstate compact agreement with the state of Rhode Island.
- **Commercial Insurance 3rd Party Payment Recovery:** TMHP advised of outstanding payment from a commercial insurance plan. HHSC is working with the insurer to resolve the issue so that TMHP can rebill these denied claims. To date, $2.1 million has been recovered from this effort.
- **Behavioral Health Cost Avoidance**: Currently, HHSC pays approximately $3 million per year in behavioral health claims in instances where other insurance should have paid the claims. HHSC is working with TMHP to add an edit to the system which will allow the agency to cost-avoid these claims. This project is expected to be implemented in May 2017. Behavioral health claims will include an edit that allows for third-party payments.

Acute Care Therapy Services

Reimbursement methodology: HHSC intends to implement therapy fee changes directed by the 2016-2017 General Appropriations Act as soon as legally possible. Litigation delayed implementation, however, a recent decision by the Texas Supreme Court favorable to the state should allow HHSC to move forward. Implementation details are still pending at the date of publication for this document. The current savings estimate reflects adjustments to the Medicaid and CHIP Managed Care capitation rates in both fiscal years 2016 and 2017 to account for savings from MCOs' flexibility to negotiate contracts and fees with therapy providers. A State Plan Amendment (SPA) to implement the reductions is also pending review by CMS.

Policy Initiatives: Policy changes to comply with the rider include changes to the adult and child therapy policies. Due to the temporary injunction we are not able to implement two policy changes that require a rate hearing and could result in significant savings. HHSC anticipates the policy changes will have minimal impact in managed care as the majority of plans have already implemented utilization controls. The largest population affected will be children who remain in FFS until the STAR Kids implementation in November 2016.

Healthcare Transformation and Quality Improvement Waiver

On December 12, 2011, Texas received approval from the federal Centers for Medicare and Medicaid Services (CMS) for the Texas Healthcare Transformation and Quality Improvement Program Waiver, a five-year 1115 Demonstration Waiver that expired September 30, 2016. The waiver was negotiated with CMS to meet legislative mandates to expand Medicaid managed care statewide, preserve hospital safety-net supplemental payments (previous Upper Payment Limit funding), achieve savings, and improve quality of care. The approved 1115 waiver includes the following goals:

- Expand risk-based managed care statewide.
- Support the development and maintenance of a coordinated care delivery system through the creation of Regional Healthcare Partnerships (RHPs) and RHP five-year care and quality improvement transformation plans.
- Improve outcomes while containing cost growth.
- Transition to quality-based payment system across managed care and hospitals.
- Provide a mechanism for investments in delivery system reform including improved coordination in the current indigent care system.

The waiver allows the state to expand Medicaid managed care while preserving hospital funding, provides incentive payments for health care improvements, and directs more funding to hospitals and other providers that serve large numbers of Medicaid and uninsured patients. Hospital payments stayed largely the same for the first year of the waiver, with hospital transition payments through September 30, 2012. This approach provided transition time and system stability during development and implementation of waiver payment systems. Effective October 1, 2012, waiver payments are made through two sub-pools: the Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP) pools.

- **Uncompensated Care Pool Payments** are designed to help offset the costs of uncompensated care provided by hospitals or other providers to Medicaid clients or individuals who have no sources of third party coverage.
- **DSRIP Pool Payments** are incentive payments to hospitals and other providers that develop programs or strategies to improve access to health care, quality of care, cost-effectiveness of care, and the health of the patients and families served.

On September 30, 2015, Texas submitted a waiver renewal application requesting a 5-year extension that would allow the state to continue all three components of the waiver (statewide managed care, UC pool, and DSRIP pool). On May 1, 2016, the Centers for Medicare and Medicaid Services (CMS) granted Texas a 15-month extension from October 1, 2016 through December 31, 2017. This extension maintains current funding levels for both UC and DSRIP. HHSC is working with CMS on a longer term extension.

Figure V.2 shows the total amounts that the state is authorized to allocate for the UC and DSRIP Pools in each demonstration year (DY) including a 15-month extension period. These amounts include both state and federal shares.

Figure V.2 Pool Allocations According to Demonstration Year (All Funds in Billions)

Type of Pool & Percent Allocation	DY 1 (2011-2012)	DY 2 (2012-2013)	DY 3 (2013-2014)	DY 4 (2014-2015)	DY 5 (2015-2016)	Extension DY6 (20016-2017)	Extension Partial DY7 (Oct-Dec 2017)
UC	$ 3.7	$3.9	$3.5	$3.3	$3.1	$3.1	$0.8
DSRIP	$0.5	$2.3	$2.7	$2.9	$3.1	$3.1	$0.8
Total/DY	**$4.2**	**$6.2**	**$6.2**	**$6.2**	**$6.2**	**$6.2**	**$1.6**
% UC	88%	63%	57%	54%	50%	50%	50%
% DSRIP	12%	37%	43%	46%	50%	50%	50%

The waiver allowed the state to increase available funding to hospitals and other providers by $36.8 billion All Funds over all years of the waiver with the 15-month extension period by including the use of trends for historic UPL funds and availability of additional funds from managed care savings. In fiscal year 2011, UPL hospital payments were $2.8 billion compared to $4.2 billion available in uncompensated care and DSRIP payments in the first year of the waiver.

Under the transformation waiver, eligibility for UC or DSRIP payments requires participation in a Regional Healthcare Partnership (RHP). Within each RHP, participants include governmental entities providing public funds known as intergovernmental transfers, Medicaid providers and other stakeholders. Participants developed a regional plan identifying partners, community needs, proposed DSRIP projects, and funding distribution. Each RHP is required to have one anchoring entity, which acts as a primary point of contact for HHSC in the region and is responsible for seeking regional stakeholder engagement and coordinating development of a regional plan. As of September 2016, there are 1,451 approved and active DSRIP projects being implemented by 297 Medicaid providers, including hospitals (public and private), community mental health centers, physician practices (most of which are affiliated with academic health science centers), and local health departments. DSRIP funds are earned based on achievement of project-specific metrics. As of July 2016, DSRIP providers earned more than $7.9 billion while serving more than 5.2 million more individuals (based on the reporting through April 2016, can include duplicated counts) compared to the service levels before the projects' implementation.

UC payments for the first five years of the waiver have been finalized and disbursed except for small percentages of funds held back for Demonstration Years 3-5 as a contingency pending resolution of litigation between children's hospitals and CMS.

Before negotiating the long-term waiver extension, CMS required Texas to submit an independent study related to how the two pools in the waiver interact with the Medicaid shortfall and what uncompensated care would be if Texas opted to expand Medicaid. The state submitted the final report to CMS on August 31, 2016.

The 15-month extension granted by CMS allows the state to continue negotiations on a longer term extension. In the extension approval letter from May 1, 2016, CMS communicated that absent another agreement by December 31, 2017, DSRIP will be phased down 25 percent each year thereafter, and UC will not be renewed except at a reduced level consistent with CMS' principles for uncompensated care.

VI. FEDERAL FUNDS: CURRENT ISSUES

This chapter outlines issues affecting federal funding to the Texas Health and Human Services (HHS) agencies. The federal appropriations process, the Budget Control Act of 2011 (sequester), rising caseloads for Medicaid and other entitlement programs, and the economy can affect the state's ability to receive federal funds to maintain existing services to recipients.

In addition, HHS system agencies are implementing state legislative actions, particularly those related to agency consolidation, and assessing potential implications to federal funding streams to ensure continuity of services, seamless transitions for clients, accountability for reporting requirements, and, compliance with state and federal rules and regulations. In addition, agencies are examining the cost allocation methods associated with the federal share of administrative costs for federally funded health and human services programs to ensure the state is maximizing the use of federal funds.

For the 2018-2019 biennium, the HHS agencies' legislative appropriations base request and exceptional items include $45 billion in Federal Funds or 51.5 percent of the total requested appropriations.

HHS System Legislative Appropriations Request for State Fiscal Years 2018-2019

Figure VI.1 ($ in millions)

Agency	Federal Funds	All Funds	Percent Federal Funds of All Funds
HHSC	$42,760.1	$81,657.3	52.4%
DSHS	$584.9	$1,656.2	35.3%
DFPS	$1,609.8	$4,058.6	39.7%
Total	**$44,954.8**	**$87,372.1**	**51.5%**

Excludes employee benefits, certain payments made as a result of local funding sources (Intergovernmental Transfers), and the value of Supplemental Nutrition Assistance Program benefits.

Source: Legislative Appropriations Requests for the 2018-2019 Biennium

The HHS system agencies utilized almost 200 different sources of federal funds. Of those sources, the top 30 major federal funding streams accounted for approximately 99 percent of all federal funds to the HHS agencies. Medicaid is the largest federal funding source at approximately 80 percent. The next largest is Children's Health Insurance Program (CHIP) at approximately 7 percent. A table of the top 30 federal funding sources used by the Texas health and human services system is attached as **Appendix E**.

Federal Budget Outlook

1. Federal Appropriations Bills

In December 2015, Congress passed a short-term continuing resolution to keep the federal government open while finalizing the omnibus appropriations bill, the Consolidated Appropriations Act 2016, which funded the remainder of federal fiscal year 2016. This measure allocated level funding to most major health and human services programs for 2016. As in FY 2015, appropriations were passed in short term continuing resolutions followed by a comprehensive bill that funded the remaining federal fiscal year. In September 2016, a short-term continuing resolution passed to keep the federal government open until December 9, 2016. The measure imposes a 0.496 percent across-the-board funding reduction to comply with spending caps and includes $1.1 billion in fiscal year 2016 to address the Zika virus.

2. Future Sequestration Impact

The Budget Control Act of 2011 requires funding reductions to achieve savings and to limit the size of the federal budget. This is commonly referred to as sequestration. Reductions under the act were extended an additional two years by the Bipartisan Budget Act of 2013 requiring cuts over federal fiscal years 2013-2023. If Congress enacts appropriations that exceed the caps set in legislation, a sequestration is automatically triggered to reduce appropriations to within the required limits.

Both discretionary and mandatory federal programs are subject to sequester; however, some programs are exempt, including Medicaid, CHIP, and Temporary Assistance for Needy Families (TANF). Factors, such as level of growth in mandatory programs, and rule exceptions for certain programs, such as a limit on reductions to Medicare, may impact the calculations for the reductions. Additionally, Congress could enact legislation at any time that repeals the law or modifies the exemptions or rules associated with sequestration.

If future decreases in federal funding occur to discretionary and mandatory programs covered under sequestration, it might result in reductions in numbers of clients served and levels of services provided by the Texas HHS system. Estimates of future year reductions are not possible as the exact reduction depends on the factors applied and the base determined as subject to sequestration after applying defined exemptions and special rules.

The HHS system agencies continue to monitor and analyze available information and assess the potential impact of a future federal sequestration to clients and services. Federal agencies have not provided specific guidance about future sequestration reductions.

Pending Federal Reauthorizations

Many of the health and human services system federal grant programs are pending program reauthorizations, some for many years. Historically, federal grant programs are extended through the federal appropriations bills passed by Congress for each federal fiscal year.

The following summarizes the status of key programs:

Federal allotments for the CHIP program were authorized through federal fiscal year 2017 (September 30, 2017). CHIP contingency funds have also been extended through federal fiscal year 2017. States are allowed to expend allotments during a two year period.

The Affordable Care Act provided an increase in the Enhanced Federal Medical Assistance Percentage (EFMAP) for CHIP by 23 percentage points (certain expenditures were excluded) beginning in federal fiscal year 2016 and continuing through fiscal year 2019. The Medicare Access and CHIP Reauthorization Act of 2015 maintained this increase for EFMAP and reduced the allotments available in federal fiscal year 2018 by one-third. The formula for state allotments may be adjusted to account for the higher federal matching rate.

The Child Nutrition Reauthorization legislation drafted every five years sets policy for the Women Infant and Children program and other child nutrition programs. The previous Child Nutrition Reauthorization bill, called the Healthy, Hunger Free Kids Act, expired in federal fiscal year 2015, and was extended as part of the Consolidated Appropriations Act 2016.

The TANF program was created in 1996 (P.L. 104-193) and replaced the Aid to Families with Dependent Children (AFDC). TANF is administered by the U.S. Department of Health and Human Services and is an entitlement to the states.

TANF has four program goals:

- To provide assistance to needy families so that children can be cared for in their own homes or in the homes of relatives.
- End the dependence of needy parents on government benefits by promoting job preparation, work and marriage.
- Prevent and reduce the incidence of out of wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies.
- Encourage the formation and maintenance of two-parent families.

Since program authorization expired in 2010, Congress has extended TANF with short-term extensions rather than a full reauthorization. The most recent extension was part of the Consolidated Appropriations Act 2016 and extended TANF through federal fiscal year 2016.

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87) authorized the program which is the largest federal program specifically dedicated to providing HIV care and treatment. The legislation was first enacted in 1990. The program has been extended through the federal appropriations process since expiring in 2013. Despite no reauthorization from Congress, appropriations can continue because the act is not a self-repealing appropriation. The program has been adjusted with each reauthorization to accommodate new and emerging needs, such as increased emphasis on core medical services and changes in funding formulas. DSHS continues to monitor appropriations and assess the implementation of the Affordable Care Act to determine potential fiscal impact to the state.

Agency Specific Federal Issues

This section includes information on federal funding issues affecting specific Texas HHS agencies.

1. Title IV Part E Foster Care Assistance (DFPS)

Texas continues to experience a decline in federal financial participation for the federal Title IV-E Foster Care program which helps to provide safe and stable out-of-home care for children. The methodology for claiming funds uses a population ratio which is the percentage of each state's foster care caseload that qualifies for federal financial participation. The percentage allocated to Title IV-E Foster Care Assistance Administration is computed by dividing the total number of children determined eligible for Title IV-E Foster Care Assistance and residing in a Title IV-E eligible (licensed) foster care placement/living arrangement by the total number of children who are placed away from their parents or guardians and reside in 24-hour substitute care in placements in a foster care setting.

The ratio is used to determine the amount of federal Title IV-E Foster Care administrative claiming available for child protective services direct delivery staff. The average annual rate for fiscal year 2015 was 34.6 percent as compared with fiscal year 2014 at 36.9 percent.

There are two major factors contributing to this decline:

- Income eligibility for Title IV-E is linked to standards from the 1996 Aid to Families with Dependent Children (AFDC). These standards can only be adjusted through a federal law change. To qualify for IV-E funds today, a child has to come from a poorer household than he or she would have had to in 1996.
- Relative or kinship placements are not Title IV-E eligible placements since they have not been verified as a foster home. As the percentage of children in conservatorship who are in relative or kinship placements increases, the population ratio decreases.

2. Disability Determination Services Program

The Disability Determination Services (DDS) program is 100 percent federally funded by the Social Security Administration (SSA) and is exempt from the sequestration legislation.

The DDS program has operated under a federal hiring freeze the last few years. Staffing levels have been down since 2011, currently DDS has 183 vacant positions. While the program continues to perform better than the national average, DDS continues to work with the SSA to discuss alternatives for workload capacity and staffing strategies.

3. Public Health Preparedness (DSHS)

The 2013 reauthorization of the 2006 Pandemic All-Hazards Preparedness Act provided states and independently funded jurisdictions with funding for public health and medical preparedness programs, such as the Hospital Preparedness Program (HPP) and the Public Health Emergency

Preparedness (PHEP) Cooperative Agreement grants. Additionally, the act provided increased flexibility in allowing states to temporarily deploy federally funded state personnel, funded in programs other than preparedness, to meet critical community needs in a disaster. Texas uses dollars from these federally funded programs to fund public health and medical preparedness activities at the local, regional and state level.

In fiscal year 2015, Texas received level funding to sustain public health and healthcare systems preparedness activities. Texas also received one-time supplemental Ebola preparedness funding. These funds supported hospital preparedness activities including establishing regional treatment centers, assessment hospitals, and health care coalitions to ensure overall health care system preparedness for Texas; development of a national network for Ebola patient care, including establishing University of Texas Medical Branch as one of approximately ten federally designated regional Ebola and other special pathogen treatment centers; and, purchase of regional stockpiles of personal protective equipment.

Public health and healthcare system preparedness funds remained fairly level in fiscal year 2016, with the exception of Ebola related funding, which was reduced approximately $3.6 million. Texas was able to use state funds to continue the Ebola activities associated with the reduced funding. In addition, Texas also received one-time supplemental funding from the Center for Disease Control and Prevention for Zika Public Health Preparedness and Response (PHPR). These funds were awarded based on the risk of local transmission and could be used to rapidly identify and investigate possible outbreaks of Zika virus, coordinate a comprehensive response to Zika prevention and outbreaks, identify and connect families affected by Zika to community services, and to purchase preparedness resources like repellant, screens, and supplies for Zika prevention kits. Texas received approximately $1.5 million in Zika PHPR funds that are available through June 2017.

DSHS continues to monitor activities at the federal level in order to assess potential future impacts to public health preparedness funding to Texas. If future federal allocations to Texas are reduced it might diminish state, regional and local public health and healthcare partners' capacity in an all-hazards response. Such capacity may include, but is not limited to, epidemiologic surveillance, investigation and response to disease outbreaks and environmental health concerns; provision of medical surge of essential healthcare providers and services; and, planning efforts for mitigating the health impact of natural and man-made disasters.

4. Title V Maternal and Child Health Services Block Grant (DSHS/HHSC)

The federal Maternal and Child Health Block Grant is authorized under Title V of the Social Security Act and is the longest-standing public health legislation in American history. The original authorization occurred in 1935. There continue to be maternal and child health needs that are not addressed solely through recent changes to public and private health insurance. The Title V block grant funds those essential services while maintaining state flexibility in determining priority needs to improve the health and well-being of women and children.

The federal Health Resources and Services Administration (HRSA) determines the allocation

formula for the Title V Maternal and Child Health Services Block Grant using the American Community Survey poverty estimates. The formula is based on the number of children living in poverty (in an individual state) as compared to the total number of children living in poverty in the United States. Title V programs are required to spend at least thirty percent of funds on children and adolescents, at least thirty percent of funds on children with special health care needs, and no more than ten percent on administrative costs.

In 2015, HRSA released new guidance for the block grant which restructured the application and annual reporting of performance and budget information to document compliance. The new process reduced reporting burden and duplication across sections of the application and annual report and integrated a five-year needs assessment summary. These revisions, as well as completion of the five-year needs assessment in fiscal year 2016, serve as drivers to address the state's unique needs through state-identified priorities, and newly selected national and state performance measures.

5. Affordable Care Act Funding to the HHS System (HHSC/DSHS/DADS)

In 2010, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Affordability Reconciliation Act of 2010, collectively known as the Affordable Care Act (ACA), were signed into federal law.

The ACA established the Prevention and Public Health Fund (PPHF) to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. Beginning in 2010, the PPHF began funding public health efforts such as building public health infrastructure for immunizations, tobacco prevention, and public health workforce and training. Since 2010, funding for certain core public health activities has shifted from CDC appropriated funds to funds made available through the ACA PPHF. Texas has received funding for several core public health activities through the PPHF including breast and cervical cancer screenings, suicide prevention, the Preventive Health and Health Services Block Grant, abstinence education programs, and several chronic disease prevention activities.

Beginning in calendar year 2014, ACA required covered entities under Section 9010 to pay the ACA health insurance provider (HIP) fee. The fee is an excise tax, and therefore is non-deductible for federal tax purposes. The 2014 payment was paid on September 30, 2014 and was based on premiums paid to the affected Managed Care Organizations (MCOs) and Dental Maintenance Organizations (DMOs), or "insurers," in calendar year 2013. The total state fiscal year 2015 ACA HIP fee payment to all MCOs/DMOs (including HHSC and DSHS programs) was approximately $210 million, of which $86.1 million was state general revenue.

The payments to the affected MCOs/DMOs included three parts:

- The amount of the health insurance provider fee attributable to Texas Medicaid and CHIP premiums
- The federal income tax liability, if any, that the insurer incurs as a result of receiving HHSC's payment for the amount of the ACA HIP Fee
- Texas state premium tax attributable to the capitation adjustment

Certain insurers are exempt from the ACA HIP Fee. Notably, insurers that are non-profit, owned by public entities, or have greater than eighty percent of gross revenues from government supported programs that target low-income, elderly, or disabled populations. The federal Consolidated Appropriations Act, 2016, included a one-year moratorium in calendar year 2017 on the ACA health insurance providers' fee. The moratorium pertains to calendar year 2016 premium revenue, which in Texas Medicaid/CHIP would have been paid in state fiscal year 2018 if the current process for reimbursing MCOs continues. The Texas Attorney General is in litigation over the legality of assessing this fee on Medicaid and CHIP programs.

Beginning in June 2015 under ACA, certain public and mental health activities were covered by private health insurance plans. These activities included: infectious disease control, prevention, and treatment; health promotion and chronic disease prevention; laboratory services; primary care and nutrition services; behavioral health services; community capacity; and state-owned and privately-owned hospital services.

The health and human services system agencies continued implementing certain ACA-related programs and initiatives during fiscal year 2016, such as: the Community First Choice, Disproportionate Share Hospital Program, and Presumptive Eligibility. The status of these programs or initiatives is addressed below**.**

Community First Choice - CFC (HHSC/DADS)

The Community First Choice (CFC) federal program allows states to receive a 6 percent increase in federal matching funds to provide home and community-based attendant services and supports as a state plan benefit for individuals with disabilities who are enrolled in Medicaid and require an institutional level of care.

Beginning in fiscal year 2015, Texas provided the following CFC services:

- Personal assistance services
- Habilitation services
- Emergency response services; and
- Support consultation services

The 6 percent increase in federal matching funds would also be received for services that are currently provided to individuals meeting intermediate care facility level of care criteria for individuals with an intellectual disability or related condition through four intellectual and developmental disability waivers administered by DADS. The CFC services are provided as a state plan service rather than as a waiver benefit.

Disproportionate Share Hospital Program-DSH (HHSC)

States make Medicaid Disproportionate Share Hospital (DSH) payments to hospitals serving a disproportionate share of low income patients and experiencing high levels of uncompensated care costs. The Affordable Care Act included reductions to state DSH allotments. Subsequent legislation has delayed implementation dates, most recently the Bipartisan Budget Act and the Medicare Access

and CHIP Reauthorization Act of 2015 shifted the reductions to fiscal years 2018 through 2025. The Affordable Care Act provisions related to expanded coverage through private insurance and Medicaid were intended to reduce the amount of uncompensated care covered by hospitals and providers.

On February 2, 2016 in the Federal Register, the federal government released disproportionate share hospital allocations for federal fiscal year 2015. The allocation for Texas was $1.036 billion, as compared to the federal fiscal year 2014 allocation of $1.020 billion.

Presumptive Eligibility (HHSC)

Presumptive Eligibility was implemented in Texas in February 2015. The ACA mandated that states allow qualified hospitals the option to determine Medicaid presumptive eligibility for pregnant women, children, low-income caretaker relatives, and foster care groups. States are prohibited from requiring qualified hospitals to verify eligibility criteria and only have the option to require the hospital to ask the applicant to attest to the applicants U.S. citizenship/alien status and residency. Qualified hospitals must make the eligibility determination based on information provided by the applicant. A qualified hospital must meet the following requirements to participate in the Texas Presumptive Eligibility program:

- Participates as a provider under the State's Medicaid plan or 1115 waiver.
- Informs HHSC of intention to make presumptive eligibility determinations.
- Agrees to make presumptive eligibility determinations consistent with the State's policies and procedures.
- Assists individuals in completing and submitting the full application for Medicaid assistance and understanding the documents needed to determine Medicaid ongoing.
- Has not been disqualified by the State.

Provider Enrollment Fee (HHSC/DADS)

In fiscal year 2015, HHSC delegated authority to DADS to collect this fee for Long-Term Services and Supports providers. The provider screening and enrollment fees are defined as payments from medical providers and suppliers required by the federal Centers for Medicare and Medicaid Services (CMS) as a condition for enrolling as a provider in the Medicaid and CHIP programs. The state collects and receives the funds as Appropriated Receipts - Match for Medicaid. Collected funds may be expended as authorized by federal law to support provider enrollment. In the event revenues collected are greater than expenditures, any unused fee balances shall be disbursed to the federal government as required by federal law.

6. Healthcare Transformation and Quality Improvement Program 1115 Waiver (HHSC)

Texas received approval for the Section 1115 Transformation Waiver in December 2011. The five-year demonstration waiver allowed Texas to expand its use of Medicaid managed care to achieve program savings while preserving locally funded supplemental payments to safety net hospitals. **(See Healthcare Transformation and Quality Improvement Waiver, Chapter V)**

7. Social Services Block Grant (HHSC/DFPS/DSHS/TWC)

Title XX Social Services Block Grant (SSBG) funds are appropriated by the Texas Legislature to state agencies to help meet specified social service needs for defined low income and at-risk populations.

Title XX was made a block grant by the Omnibus Budget Reconciliation Act of 1981, PL 97-35. Under this block grant, the state may provide social services directed at the goals of Title XX and may make expenditures for administration and training. The goals for the individuals served include:

- Achieving or maintaining self-sufficiency - economic, physical, and otherwise – to include preventing, eliminating, or reducing dependency.
- Preventing or remedying neglect, abuse, and exploitation of children and adults; and preserving, rehabilitating, or reuniting families.
- Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.
- Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

Achievement of these goals is sought through several programs administered by HHSC, DSHS, DFPS, and the Texas Workforce Commission (TWC).

8. Money Follows the Person (HHSC/DADS)

In 2007, HHSC and DADS successfully competed for a Deficit Reduction Act of 2005 Money Follows the Person (MFP) Demonstration grant award to build upon and enhance its existing Promoting Independence/Money Follows the Person initiatives. The MFP Demonstration provides financial incentives to move individuals from institutions to community settings and includes an enhanced FMAP for client services costs. The MFP Demonstration helps people who are residing in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID). It provides individuals long-term services in the community setting of their choice without having to be placed on an interest list. The MFP Demonstration also supports direct services, such as behavioral health and relocation assistance, as well as projects designed to enhance the infrastructure of community based services. Examples of projects include customized employment services and enhanced services and service coordination for individuals with intellectual and developmental disability with complex medical/behavioral health needs.

Congressional authorization for the MFP Demonstration ended September 30, 2016. The Centers for Medicare and Medicaid Services (CMS) awarded a supplemental grant for states to implement sustainability strategies. Supplemental funds allocated by Congress were less than expected. As a result, the state will close-out activities one year earlier than expected. Transitions from institutional services to home and community-based services will continue as before the state received the MFP Demonstration grant. The state will no longer collect the enhanced match

for individuals who transition after August 31, 2017. The MFP Demonstration funded projects will conclude no later than the end of state fiscal year 2019.

Federal Funds Enhancement Initiatives

The Texas HHS agencies were successful in efforts to enhance revenue and maximize the use of federal funds to provide services during the last fiscal year. By working with various federal agencies, the state identified expenditures where additional federal funds could be accessed and qualified for new opportunities to bring additional dollars to Texas. Agencies continue to seek available funding and identify innovative ways for increasing access to federal funds to support the state's mission and interests related to health and human services.

1. **Minimum Payments Amounts Program (HHSC)**

   Effective March 1, 2015, upon carve-in of nursing facilities to managed care, HHSC created a new minimum payment to eligible NFs to be made through the managed care organizations. This program, referred to as the Minimum Payment Amounts Program (MPAP), was developed in an effort to continue a certain level of funding to nursing facilities that had previously participated in the nursing facility upper payment limits (UPL) program, a program which is prohibited by federal regulations in a managed care environment. MPAP currently provides increased funding to 287 nursing facilities to improve the quality of the care they provide to Medicaid nursing facilities residents. The non-federal share for this program is provided by intergovernmental transfers from the non-state governmental entities that own the nursing facilities. MPAP is expected to provide more than $378.5 million in additional federal funds to participating nursing facilities for state fiscal year 2016. CMS has discontinued the program effective August 31, 2016.

2. **Network Access Improvement Program (HHSC)**

   Effective March 1, 2015 several health plans implemented programs aimed at improving network access for Medicaid members. The Network Access Improvement Program (NAIP) is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing various institutions to provide high quality, well-coordinated, and continuous care. NAIP is expected to provide over $306.1 million in additional federal funds in state fiscal year 2016.

3. **TANF Contingency Fund (HHSC)**

   The Temporary Assistance for Needy Families (TANF) Contingency fund provides states with additional federal funds to help meet the needs of low income families during periods of economic downturn. States access TANF Contingency funds when they reach high levels of unemployment and/or SNAP caseloads. Contingency funds may be used only in the fiscal year for which they are awarded and may not be carried over for use in

a succeeding fiscal year. These funds can be used for any purpose for which regular TANF funds are used.

To draw upon contingency funds, a state must both (1) meet a test of "economic need" and (2) spend from its own funds more than what the state spent in fiscal year 1994 on cash, emergency assistance, and job training in TANF's predecessor programs. A state meets the "economic need" test if its seasonally adjusted unemployment rate averaged over the most recent three-month period is at least 6.5 percent *and* at least ten percent higher than its rate in the corresponding three-month period in either of the previous two years; ***or*** its SNAP/ food stamps caseload over the most recent three-month period is at least ten percent higher than the adjusted caseload in the corresponding three-month period in fiscal year 1994 or fiscal year 1995.

In 2016 Texas applied for and received approximately $47.7 million in additional funds requested through the TANF Contingency Funds grant. These funds are separate and apart from the TANF Emergency Contingency Funds. A 2017 application has recently been submitted.

Unlike the regular TANF block grant which provides a fixed funding amount to states regardless of economic conditions, the TANF Contingency Fund provides additional TANF funds to states when states reach high levels of unemployment and/or food stamp caseloads. Texas met the threshold, based on SNAP caseload. If the state remains eligible and if Congress continues appropriations, HHSC will continue to apply for TANF Contingency Funds.

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VII. PROVIDER RATE CONSIDERATIONS AND METHODOLOGY

Overview of Provider Rate Considerations and Methodology

Direct services received by health and human services clients are predominantly provided through the private sector and local public entities. While state employees determine client eligibility and provide protective and regulatory services, medical, residential and social services are generally received by clients in community settings from private and local public sector individuals or entities[1]. These providers may also serve individuals who do not receive state-funded services. The provider community expects, at a minimum, to be reimbursed for the cost of rendering service and most providers operate as a business, desiring the opportunity to earn a profit when providing efficient care which meets regulatory standards. The Texas Health and Human Services system should provide adequate reimbursement to permit client access to necessary and efficiently delivered services of acceptable quality for clients enrolled in state funded programs.

Figure VII.1 illustrates the cost of providing a 1 percent rate change in provider reimbursement. The 1 percent rate increment can be used to estimate the fiscal impact to the state for each 1 percent rate increase or decrease. **Appendix F1.** shows overall percent rate changes required to recognize increases/decreases in costs incurred by providers based on various methodologies. Rate increases might be needed in order to appropriately reimburse providers for changes in their costs in delivering care to HHS clients. Without additional funding for rate increases, continued rising costs incurred by providers could erode the quality of services delivered and could result in access to care problems for clients because of fewer providers willing to deliver services for the level of Medicaid reimbursement, unless providers can adjust their business practices to reduce costs.

HHSC develops approximately 46,344 different rates, primarily for the Medicaid program. Of this amount 360 rates are for health maintenance organizations; 1,000 are for long-term services programs; 1,000 are for nursing facilities; 25 for child foster care services; 43 for school health and related services; 171 for inpatient hospital standard dollar amounts and 745 for inpatient hospitals diagnostic related groups; 40,000 for physicians and other professionals; 2,300 for durable medical equipment; and 700 for therapy providers.

In addition to the rate tables, information is provided on several specific rate issues, including long-term services and supports and compensation for attendant workers.

[1]State employees also provide mental health and residential services at state hospitals, state supported living centers and state centers.

See **Figure VII.1** and **Appendix F1.** for the cost of providing a one percent rate change for each program. In addition, **Appendix F1.** provides estimates for the cost of fully funding the various rates using current methodologies; and **Appendix F2.** provides estimates for a $1 per hour increase for long term services and supports attendant wages.

Relationship between Fee-for-Service Rates and Managed Care Capitation Rates

For services provided through both a fee-for-service (FFS) and a managed care delivery system, FFS rate changes are incorporated into the calculation of managed care capitation rates.

Costs presented in **Figure VII.1**, **Appendix F1.** and **Appendix F2.** include costs for services delivered through both systems and include managed care premium tax costs (1.75 percent of managed care premium impact) and risk margin costs (currently 2 percent of managed care premium impact).

Most contracts between managed care organizations (MCO) and providers incorporate payment rates based on a percentage of the FFS rate for the same service. As well, Texas Government Code, Section 533.00251(c)(1) indicates HHSC is responsible for setting the minimum reimbursement rate paid to a nursing facility under the managed care program. HHSC also produces "proxy" rates for former FFS services that have been totally carved in to managed care such as Community Based Alternatives and STAR+Plus Community First Choice to facilitate MCO capitation development.

HHSC also administers the Nursing Facility Direct Care Rate Enhancement program for the MCOs and is working with the MCOs to increase HHSC oversight of the Community Care Attendant Compensation Rate Enhancement program.

Impact of HHS Transformation on HHSC Rate Setting Functions

As part of the HHS Transformation, all HHS system rate setting functions are to be consolidated under HHSC. Currently, HHSC performs all appropriate rate setting functions for the Department of Family and Protective Services (DFPS), the Department of Aging and Disability Services (DADS) and the former Department of Assistive and Rehabilitative Services (DARS). Rate setting functions for the Department of State Health Services (DSHS) should be consolidated under HHSC by the end of fiscal year 2017.

Cost of One Percent Rate Change

Figure VII.1

Estimated Cost of One Percent Rate Change

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
Long Term Care Programs (Legacy DADS)								
Community Attendant Services	9/1/2015	Increase in attendant wage rate to $8.00 per hour	NA	NA	7,096,897	3,105,602	7,403,662	3,239,102
Community Living Assistance and Support Services	8/1/2009	$0.80 per hour minimum wage rate increase	NA	NA	2,700,360	1,072,043	2,700,360	1,071,773
Day Activity and Health Services - Title XIX Note 1	9/1/2015	Increase in attendant wage rate to $8.00 per hour	NA	NA	89,411	39,126	40,437	17,691
Deaf-Blind Multiple Disabilities	6/15/2010	18% Intervenors	NA	NA	131,760	55,510	131,760	55,497
Home and Community-based Services	9/1/2015	0.47% to 3.79% for SL/RSS and DH	NA	NA	0		0	
Home Delivered Meals - Title XX	9/1/2007	1.43%	NA	NA	175,558	175,558	175,558	175,558
Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions	9/1/2015	2.02%	NA	NA	2,911,557	1,274,097	2,907,078	1,271,847
Non-Medicaid Services - Title XX	9/1/2015	Increase in attendant wage rate to $8.00 per hour	NA	NA	751,121	751,121	751,121	751,121
Nursing Facilities (FFS)								
Nursing Facility Care Note 1	9/1/2014	4.00% (6.00% total for 2014-15 biennium)	NA	NA	3,755,625	1,643,462	3,745,364	1,638,597
NF Hospice Note 2	9/1/2014	4.00% (6.00% total for 2014-15 biennium)	NA	NA	2,907,517	1,272,329	2,957,516	1,293,913
NF Therapies	NA	NA	NA	NA	681	298	681	298
NF Ventilator	9/1/2014	4.00% (6.00% total for 2014-15 biennium)	NA	NA	8,771	3,838	8,771	3,837
Total: Nursing Facilities					**6,672,594**	**2,919,927**	**6,712,332**	**2,936,645**
PASSR Assessment Note 3	NA	NA	NA	NA	7,000	1,750	7,000	1,750
PASSR Specialized Services Notes 3 & 4	NA	NA	NA	NA	9,194	4,023	13,791	6,034
Primary Home Care Note 1	9/1/2015	Increase in base wage rate to $8.00 per hour	NA	NA	161,512	70,678	170,986	74,806
Program of All-inclusive Care for the Elderly (PACE) Note 5	NA	NA	9/1/2015	Budgetary Reduction (7.2%)	822,955	360,125	822,955	360,043
Service Coordination (ID)	6/1/2010	5.00%	NA	NA	759,964	332,560	762,980	333,804
Texas Home Living Waiver	10/1/2009	39.49%	9/1/2013	Match HCS	987,034	394,024	987,034	393,925
Total Long Term Care Programs (Legacy DADS) (with totals only included)					**23,276,917**	**10,556,144**	**23,587,054**	**10,689,596**

Note 1: The cost of the rate increase only includes the impact on services that will remain as fee-for-service under DADS. The corresponding impact on services delivered through managed care is included in the applicable STAR+PLUS programs.

Note 2: Nursing Facility Hospice rates are tied by federal law to 95% of NF rates - any changes to NF rates will impact Hospice Payments.

Note 3: PASRR Assessments and Specialized Services were effective 2/1/2013 therefore there have been no rate increases or redutions

Note 4: PASRR rates are tied to Medicaid therapy rates

Note 5: Only considers eliminating the budgetary reduction. No other growth, or provider rate increases included

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
DARS Legacy Programs								
Comprehensive Rehabilitative Services (CRS) Note 1 & 2	9/1/2016	0.00%	NA	NA	242,735	242,735	237,413	237,413
ECI - Case Management	3/15/2010	24.00%	NA	NA	185,588	81,176	185,592	81,215
ECI - Specialized Skills Training	3/15/2010	5.71%	NA	NA	343,534	150,262	343,542	150,334
Total DARS Legacy programs					**771,857**	**474,173**	**766,547**	**468,962**
Note 1: CRS moved from a provider specific contracted rate to a standard program wide rate methodology on September 1, 2016.								
Note 2: All figures assume that 4% reduction has been restored.								
DFPS								
24-Hr. Residential Child Care (Foster Care) - Foster Family	9/1/2013	4.30%	NA	NA	171,206	74,715	171,206	32,687
24-Hr. Residential Child Care (Foster Care) CPA								
Foster Family Pass Through	9/1/2013	4.30%	NA	NA	1,149,536	802,741	1,149,536	821,831
Retainage	9/1/2015	Basic - 9.29% Moderate - 1.14% Specialized - 0.42% Intense - 0.01%	NA	NA	1,076,518	674,875	1,076,518	719,800
Subtotal: 24-Hr. Residential Child Care CPA Pass Through/Retainage					2,226,054	1,477,616	2,226,054	1,541,631
24-Hr. Residential Child Care (Foster Care) - Residential Treatment Facility	9/1/2015	Specialized - 9.58% Intense - 0.30%	NA	NA	1,209,583	959,270	1,209,583	966,899
24-Hr. Residential Child Care (Foster Care) - Emergency Shelter	9/1/2015	6.00%	NA	NA	365,880	274,739	365,880	274,781
Total All 24-Hr. Residential Child Care (Foster Care) Note 7					3,972,723	Note 1 2,786,340	3,972,723	Note 2 2,815,998
Psychiatric Transition (Intensive Psychiatric Step Down)	NA	NA	NA	NA	42,485	Note 3 39,670	42,485	Note 4 38,523
Supervised Independent Living	NA	NA	NA	NA	20,866	Note 5 15,053	20,866	Note 6 15,053
Adoption Subsidies	9/1/2003	Basic PT	NA	NA	594,143	259,522	571,814	250,169
Permanency Care Assistance (PCA)	10/1/2010	Basic PT	NA	NA	50,247	9,897	44,334	9,786
Total DFPS (with totals only included)					**4,680,464**	**3,109,482**	**4,652,222**	**3,129,529**

Note 1: If TANF funding is available, up to $1,355,292 of this amount is eligible for TANF funding the remaining $1,458,618 must be GR

Note 2: If TANF funding is available, up to $1,438,214 of this amount is eligible for TANF funding the remaining $1,470,795 must be GR

Note 3: If TANF funding is available, up to $22,719 of this amount is eligible for TANF funding the remaining $16,339 must be GR

Note 4: If TANF funding is available, up to $22,791 of this amount is eligible for TANF funding the remaining $15,999 must be GR

Note 5: If TANF funding is available, up to $6,422 of this amount is eligible for TANF funding the remaining $8,627 must be GR

Note 6: If TANF funding is available, up to $6,419 of this amount is eligible for TANF funding the remaining $8,629 must be GR

Note 7 Includes Foster Care redesign costs

Adoption & PCA: In FY 2003, Adoption Tier 1 was 66% of monthly basic foster care passthrough rate and Tier 2 was 90%. PCA became effective October 1, 2010. The adopted rates mirror the adoption assistance rates.

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
DSHS Legacy Programs								
Children with Special Health Care Needs (CSHCN) - Ambulance Services Notes 1 & 2	9/1/2009	2.50%	2/1/2011	2.00%	4,187	4,187	4,187	4,187
CSHCN - Drugs/Biologicals Notes 1 & 2	10/1/2008	2.50%	2/1/2011	2.00%	109,571	109,571	109,571	109,571
CSHCN - Durable Medical Equipment, Prosthetics, Orthotics, Supplies Notes 1 & 2	Various 2008	2.50%	2/1/2011	2.00%	10,771	10,771	10,771	10,771
CSHCN - Nursing Notes 1 & 2	11/1/2002	2.50%	2/1/2011	2.00%	211	211	211	211
CSHCN - Physician & Professional Services - Total Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	35,843	35,843	35,843	35,843
CSHCN - Outpatient Hospital Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	41,316	41,316	41,316	41,316
Home and Community Based Services - Adult Mental Health Note 3	6/1/2016	New Service	NA	NA	7,934,218	4,044,071	7,934,218	4,043,277
Maternal and Child Health - Dental Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	28,730	28,730	28,730	28,730
Maternal and Child Health - Physician & Professional Services - Adults Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	3,302	3,302	3,302	3,302
Note 1 & 2 Maternal and Child Health - Physician & Professional Services - Children	9/1/2007	2.50%	2/1/2011	2.00%	12,361	12,361	12,361	12,361
Mental Health (MH) Targeted Case Management - Adult Note 4	9/1/2004	New Service	NA	NA	4,894,882	2,142,000	4,894,882	2,141,511
Mental Health (MH) Targeted Case Management - Children Note 4	9/1/2004	New Service	NA	NA	2,874,772	1,258,000	2,874,772	1,257,713
MH Rehabilitative Services - Adult Note 4	9/1/2004	New Service	NA	NA	15,330,418	6,708,591	15,330,418	6,707,058
MH Rehabilitative Services - Children Note 4	9/1/2004	New Service	NA	NA	9,003,820	3,940,072	9,003,820	3,939,171
Substance Use Disorder (Indigent Services) Notes 1, 2 & 5	9/1/2016	Varied	NA	NA	17,037,082	4,993,569	17,037,082	4,993,569
TEFRA Based Inpatient Hospital (Cost-Based) Notes 1 & 2	NA	NA	NA	NA	24,232	24,232	24,232	24,232
Youth Empowerment Services (YES) Waiver Note 6	3/15/2016	Revised payment rates for Supported Employment and Employment Assistance from hourly rate to 15 minute rate.	NA	NA	8,679,514	3,798,155	8,679,514	3,797,287
Total DSHS Legacy Programs (with totals only included)					**66,025,230**	**27,154,982**	**66,025,230**	**27,150,110**

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
	Date	Percent	Date	Percent	2018		2019	
					AF	GR	AF	GR
Total DSHS Legacy Programs (with totals only included)					**66,025,230**	**27,154,982**	**66,025,230**	**27,150,110**

Note 1: Any increase in rates must be funded with GR to maintain level services since federal block grants will not be increased for rate increases

Note 2: "GR" for these programs is Fund 8003 GR Match for Maternal Child Health Block Grant or 8002 General Revenue for Substance Abuse Block Grant. Any reduction in general revenue may result in loss of federal block grants and elimination of this program. For Substance Abuse Disorder, there is not a required State Match but a required State Maintenance of Effort of State funding to be no less than prior two year average.

Note 3: Home and Community-based Services Adult Mental Health (HCBS-AMH) transferred to HHSC on 9/1/16. HCBS-AMH services beginning in SFY2017. The HCBS services include those for non-Medicaid clients and non-eligible services for Medicaid clients (Indigent) paid by 100% GR. Therefore FMAP is not a state Medicaid match percentage. This is the state portion of both State Match and Indigent services using a blended rate. HCBS is not fully implemented.

Note 4: Mental Health Targeted Case Management and Rehabilitative Services rates adjusted effective 9-1-2011 to reflect the change in reimbursement methodology eliminating cost settlement adjusted rates to reflect a statewide prospective in lieu of provider specific rate with cost settlement.

Note 5: Substance Use Disorder for indigent services transferred to HHSC on 9/1/16. Substance Use Disorder for indigent services has requested an Exceptional Item to maintain treatment capacity in FY18-19. Additionally, a rate increase is requested to bring remaining rates up to February 2015 Rate Study recommendations. This rate increase will need to be funded 100% with State Funds. The rate under FMAP is the projected percentage of SAPT Block Grant MOE (State) funding.

Note 6: YES Waiver Program transferred to HHSC on 9/1/16. YES Waiver program is not fully implemented. Assuming Waiver Modification proposed to add Case Management is approved in FY2017, then the current FY18-19 base appropropriation will not support Rate increase and Waiver Modification.

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
	Date	Percent	Date	Percent	2018		2019	
					AF	GR	AF	GR
HHSC								
Ambulance Services (Air Transportation) Notes 1 & 2	9/1/2009	29.97%	2/1/2011	2.00%	393,545	172,215	410,052	179,398
Ambulance Services (Ground Transportation) Notes 1 & 2	9/1/2009	29.97%	2/1/2011	2.00%	1,282,707	561,313	1,340,114	586,300
Ambulatory Surgical Center/Hospital Ambulatory Surgical Center	9/1/2007	2.50%	9/1/2011	5.00%	1,739,344	761,137	1,767,173	773,138
Anesthesia - Adults	1/1/2010	9.23%	2/1/2011	2.00%	366,979	160,590	385,238	168,542
Anesthesia - Children	9/1/2007	21.58%	2/1/2011	2.00%	424,440	185,735	444,362	194,408
Anesthesia - Certified Registered Nurse Anesthetist - Adults	1/1/2010	9.23%	2/1/2011	2.00%	252,894	110,666	265,349	116,090
Anesthesia - Certified Registered Nurse Anesthetist - Children	9/1/2007	21.58%	2/1/2011	2.00%	219,478	96,044	229,902	100,582
Birthing Centers - Facility Services Note 3	7/1/2012	250.00%	9/1/2011	5.00%	3,226	1,412	3,397	1,486
Birthing Centers - Professional Services Note 3	7/1/2012	250.00%	NA	NA	2,430	1,063	2,563	1,121
Children & Pregnant Women - Case Management -Adults	9/1/2007	55.50%	2/1/2011	2.00%	472	207	479	210
Children & Pregnant Women - Case Management - Children	9/1/2007	55.50%	2/1/2011	2.00%	11,187	4,895	11,366	4,973

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
Children's Health Insurance Program (CHIP) (including perinate, excluding pharmacy costs)	9/1/2016	4.1% (9/1/16)	NA	NA	6,271,638	477,899	6,271,638	477,899
CHIP Dental	9/1/2016	8.4% Overall	NA	NA	1,102,258	83,992	1,102,258	83,992
Clinical Laboratory Fees (non-state owned)	4/1/2008	2.60%	9/1/2011	10.50%	3,660,697	1,601,921	3,719,268	1,627,180
Dental Services - Adults	9/1/2007	52.50%	2/1/2011	2.00%	122,685	53,687	128,786	56,344
Dental Services - Children's	9/1/2007	52.50%	2/1/2011	2.00%	12,990,643	5,684,705	13,686,052	5,987,648
Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS)								
Diabetic Equipment and Supplies	Various 2008	10.00%	9/1/2011	10.00%	67,493	29,535	70,924	31,029
Hearing Services	Various 2008	10.00%	9/1/2011	Reimbursement limited to lesser of provider's acquisition cost or fees determined by HHSC.	56,024	24,516	57,154	25,005
Hospital Beds and Accessories	Various 2008	10.00%	9/1/2011	10.00%	57,558	25,187	59,849	26,184
Incontinence Supplies	Various 2008	10.00%	9/1/2011	10.00%	1,374,131	601,320	1,409,921	616,840
Kidney Machines and Access	Various 2008	10.00%	9/1/2011	10.00%	11,291	4,941	11,701	5,119
Miscellaneous DME Equipment and Supplies	Various 2008	10.00%	9/1/2011	10.00%	894,469	391,420	926,368	405,286
Mobility Aids	Various 2008	10.00%	9/1/2011	10.00%	55,994	24,503	57,839	25,305
Neurostimulators	Various 2008	10.00%	9/1/2011	10.00%	6,368	2,787	6,719	2,940
Nutrition (Enteral and Parenteral)	Various 2008	10.00%	9/1/2011	10.00%	1,479,427	647,397	1,516,287	663,376
Orthotics	Various 2008	10.00%	9/1/2011	10.00%	178,273	78,012	184,081	80,535
Oxygen and Related Respiratory Equipment	Various 2008	10.00%	9/1/2011	10.00%	436,697	191,099	452,128	197,806
Prosthetics	Various 2008	10.00%	9/1/2011	10.00%	56,683	24,804	58,333	25,521
Speech Generating Devices/Augmentive Communication Devices	Various 2008	10.00%	9/1/2011	10.00%	12,015	5,258	12,306	5,384
Wheel Chairs	Various 2008	10.00%	9/1/2011	10.00%	456,467	199,750	473,671	207,231
Wound Therapy	Various 2008	10.00%	9/1/2011	10.00%	27,678	12,112	29,151	12,754
Vision	5/1/2016	6.50%	5/1/2016	10.00%	322,333	141,053	337,133	147,496
Environmental Lead Investigations	7/1/2010	New Benefit	2/1/2011	2.00%	20	9	21	9
Family Planning Clinics - Adults	9/1/2007	4.00%	9/1/2011	5.00%	20,265	8,868	21,284	9,312
Family Planning Clinics - Children	9/1/2007	10.06%	9/1/2011	5.00%	22,206	9,717	23,329	10,206
Federally Qualified Health Centers Notes 4 & 5	1/1/2016	Medicare Economic Index (MEI) (1.1%) or MEI+0.5%	1/1/2011	1.00%	2,251,735	985,359	2,303,720	1,007,878
Freestanding Psychiatric Hospitals (non-state owned)	1/1/2008	18.18%	9/1/2011	8.00%	1,071,404	468,846	1,088,547	476,239
Freestanding Psychiatric Hospitals -(state owned)	NA	NA	NA	NA	108,398	47,435	108,398	47,424

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
HHA- Home Health Aide Services	9/1/2007	2.50%	2/1/2011	2.00%	823	360	866	379
HHA - Other Services (Supplies) - Adults	9/1/2007	2.50%	2/1/2011	2.00%	254,836	111,516	268,636	117,528
HHA - Other Services (Supplies) - Children	9/1/2007	2.50%	2/1/2011	2.00%	227,138	99,396	239,763	104,896
HHA - Skilled Nursing Services - Adults	9/1/2007	2.50%	2/1/2011	2.00%	101,962	44,619	107,517	47,039
HHA - Skilled Nursing Services - Children	9/1/2007	2.50%	2/1/2011	2.00%	23,185	10,146	24,215	10,594
Inpatient Hospital Note 6	9/1/2015	$312,514,064		NA	36,194,436	15,838,685	36,773,547	16,088,427
Laboratory Services - Adults	9/1/2007	12.50%	2/1/2011	2.00%	1,009,719	441,853	1,055,748	461,890
Laboratory Services - Children	9/1/2007	27.50%	2/1/2011	2.00%	554,299	242,561	579,966	253,735
Long-Acting Reversible Contraceptive (LARC), Sterilization, and Associated Services - Adults	9/1/2013	18.00%	NA	NA	214,918	21,492	226,567	22,657
Long-Acting Reversible Contraceptive (LARC), Sterilization, and Associated Services - Children	9/1/2013	19.00%	NA	NA	178,586	17,859	188,218	18,822
Maternity Service Clinic	NA	NA	9/1/2011	7.00%	2,021	884	2,118	927
Medicare Advantage	NA	NA	1/1/2012	Decrease in payment rate from $25 to $10.	109,316	47,837	109,316	47,826
Orthodontics - Adults	9/1/2007	52.50%	2/1/2011	2.00%	1,232	539	1,295	567
Orthodontics - Children	9/1/2007	52.50%	2/1/2011	2.00%	71,199	31,157	75,139	32,873
Outpatient Hospital Note 7	9/1/2015	$29,573,966		NA	13,026,986	5,700,609	13,087,220	5,725,659
Outpatient Imaging Note 8	9/1/2015	$3,000,000		NA	1,986,683	869,372	2,018,470	883,081
Physician- Administered Drugs/Biological Fees (Nononcology) - Adults	10/1/2008	3.59%	2/1/2011	24.00%	167,360	73,237	176,240	77,105
Physician- Administered Drugs/Biological Fees (Nononcology) - Children	10/1/2008	3.59%	2/1/2011	24.00%	111,135	48,633	116,768	51,086
Physician And Other Practitioners Adults	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	7,424,164	3,248,814	7,793,713	3,409,749
Physician And Other Practitioners Children	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	12,673,069	5,545,735	13,291,821	5,815,172
Physician-Administered Oncology Drugs - Adults	10/1/2008	3.59%	2/1/2011	2.00%	636,307	278,448	661,419	289,371
Physician-Administered Oncology Drugs - Children	10/1/2008	3.59%	2/1/2011	2.00%	168,061	73,543	177,046	77,458
Physicians Vaccine Administration - Adults	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	41,160	18,012	43,429	19,000

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
Physicians Vaccine Administration - Children	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	543,432	237,806	572,165	250,322
Audiologist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	1,379	603	1,455	637
Audiologist - Children	9/1/2007	27.50%	2/1/2011	2.00%	6,626	2,900	6,937	3,035
Certified Nurse Midwife - Adults	9/1/2007	27.50%	2/1/2011	2.00%	6,880	3,011	7,255	3,174
Certified Nurse Midwife - Children	9/1/2007	27.50%	2/1/2011	2.00%	1,273	557	1,339	586
Chiropractors - Adults	9/1/2007	12.50%	2/1/2011	2.00%	2,261	989	2,379	1,041
Chiropractors - Children	9/1/2007	27.50%	2/1/2011	2.00%	2,004	877	2,107	922
Geneticist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	11,084	4,850	11,698	5,118
Geneticist - Children	9/1/2007	27.50%	2/1/2011	2.00%	8,911	3,899	9,302	4,070
Licensed Clinical Social Worker/CCP Social Worker - Adults	9/1/2007	12.50%	2/1/2011	2.00%	13,509	5,912	14,219	6,221
Licensed Clinical Social Worker/CCP Social Worker - Children	9/1/2007	27.50%	2/1/2011	2.00%	67,515	29,545	70,878	31,009
Licensed Marriage and Family Therapist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	822	360	863	378
Licensed Marriage and Family Therapist - Children	9/1/2007	27.50%	2/1/2011	2.00%	8,269	3,619	8,676	3,796
Licensed Professional Counselors - Adults	9/1/2007	12.50%	2/1/2011	2.00%	163,739	71,652	171,654	75,099
Licensed Professional Counselors - Children	9/1/2007	27.50%	2/1/2011	2.00%	622,734	272,508	653,715	286,000
Nephrology - Adults	9/1/2007	12.50%	2/1/2011	2.00%	421,116	184,280	444,012	194,255
Nephrology - Children	9/1/2007	27.50%	2/1/2011	2.00%	1,430	626	1,478	647
Optometrist/Optician - Adults	9/1/2007	12.50%	2/1/2011	2.00%	139,815	61,183	145,859	63,813
Optometrist/Optician - Children	9/1/2007	27.50%	2/1/2011	2.00%	580,423	253,993	609,096	266,480
Physician Assistants and Nurse Practitioners - Adults	9/1/2007	12.50%	2/1/2011	2.00%	37,039	16,208	38,932	17,033
Physician Assistants and Nurse Practitioners - Children	9/1/2007	27.50%	2/1/2011	2.00%	218,476	95,605	229,887	100,576
Podiatrist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	36,160	15,824	38,042	16,643
Podiatrist - Children	9/1/2007	27.50%	2/1/2011	2.00%	38,252	16,739	40,228	17,600
Psychologists - Adults	9/1/2007	12.50%	2/1/2011	2.00%	17,333	7,585	18,227	7,974
Psychologists - Children	9/1/2007	27.50%	2/1/2011	2.00%	151,371	66,240	159,020	69,571
Licensed Psychological Associate - Adults	NA	NA	NA	NA	151	66	159	70
Licensed Psychological Associate - Children	NA	NA	NA	NA	7,610	3,330	8,011	3,505
Portable X-ray Supplier - Adults	9/1/2007	12.50%	2/1/2011	2.00%	102,991	45,069	107,978	47,240
Portable X-ray Supplier - Children	9/1/2007	27.50%	2/1/2011	2.00%	72,740	31,831	76,294	33,379
Provisionally Licensed Psychologist - Adults	NA	NA	NA	NA	92	40	96	42
Provisionally Licensed Psychologist - Children	NA	NA	NA	NA	964	422	1,011	442
Radiation Therapy Centers - Adults	NA	NA	2/1/2011	2.00%	4,344	1,901	4,509	1,973
Radiation Therapy Centers - Children	NA	NA	2/1/2011	2.00%	6,548	2,865	6,830	2,988
Renal Dialysis Facilities	9/1/2007	2.50%	9/1/2011	5.00%	296,938	129,940	301,689	131,989
Rural Health Clinics Note 9	1/1/2016	Medicare Economic Index (MEI) (1.1%)	NA	NA	1,179,325	516,073	1,310,466	573,329

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
STAR KIDS Long Term Care - Medically Dependent Children Program Note 10	NA	NA	NA	NA	995,991	435,846	995,991	435,746
STAR+PLUS Long Term Care - Community Based Alternatives Notes 10 & 11	9/1/2015	Increase of 1.28% for Attendant wage increases	NA	NA	11,992,411	4,849,317	11,992,411	4,848,113
STAR+PLUS Long Term Care - Day Activity and Health Services Notes 10 & 11	9/1/2014	Increase in attendant base wage rate to $7.86 per hour	NA	NA	1,570,180	676,402	1,570,180	676,242
STAR+PLUS Long Term Care -- Nursing Facility Notes 10 & 11	9/1/2014	4.00% (also 2.00% eff. 9/1/2013; 6.00% total for 14-15 biennium)	NA	NA	25,003,834	10,941,678	25,003,834	10,939,177
STAR+PLUS Long Term Care - Primary Home Care Notes 10 & 11	9/1/2015	Increase of 1.28% for Attendant wage increases	NA	NA	14,643,411	6,308,084	14,643,411	6,306,590
Substance Use Disorder Services (Chemical Dependency Treatment Facility)	9/1/2013	19.00%	NA	NA	193,866	84,836	203,712	89,124
TEFRA Based Inpatient Hospital (Cost-Based)	NA	NA	NA	NA	1,879,337	822,398	1,669,184	730,268
Texas Women's Health Program (GR ONLY)	9/1/2007	22.50%	2/1/2011	2.00%	221,980	221,980	225,531	225,531
Therapy Services - Comprehensive Outpatient Rehabilitation Facility (CORF) / Outpatient Rehabilitation Facility (ORF) (PT 65, PS25) - Children	1/1/2006	NA	9/1/2013	2.5% NOTE: Significant reductions for the 2016-17 biennium were pending at the time of publication	1,780,734	779,249	1,841,265	805,553
Therapy Services - Home Health Agency - Adults	1/1/2006	NA	9/1/2013	1.5% NOTE: Significant reductions for the 2016-17 biennium were pending at the time of publication	26,056	11,402	27,483	12,024
Therapy Services - Home Health Agency - Children	1/1/2006	NA	9/1/2013	1.5% NOTE: Significant reductions for the 2016-17 biennium were pending from implementation at the time of publication	4,608,199	2,016,548	4,765,199	2,084,775

Estimated Cost of One Percent Rate Change (continued)

Program by Budget Agency	Last Legislative or Federal Rate Increase		Legislative or Federal Rate Reduction Since Last Rate Increase		Incremental Cost of 1 Percent Rate Change			
					2018		2019	
	Date	Percent	Date	Percent	AF	GR	AF	GR
Therapy Services - Independent Therapists (PT 34, 35, 50) - Adults	1/1/2006	NA	9/1/2013	4.00% - office setting 1.50% - home setting NOTE: Significant reductions for the 2016-17 biennium were enjoined from implementation at the time of publication	69,785	30,538	73,554	32,180
Therapy Services - Independent Therapists (PT 34, 35, 50) - Children	1/1/2006	NA	9/1/2013	4.00% - office setting 1.50% - home setting NOTE: Significant reductions for the 2016-17 biennium were enjoined from implementation at the time of publication	1,257,217	550,158	1,300,944	569,163
Therapy Services - Independent Therapists (Early Childhood Intervention) - Children	1/1/2006	NA	9/1/2013	1.5% NOTE: Significant reductions for the 2016-17 biennium were enjoined from implementation at the time of publication	327,897	143,488	342,540	149,861
THSteps Medical Checkups	9/1/2007	27.50%	2/1/2011	2.00%	1,293,361	565,975	1,353,391	592,109
THSteps Newborn	9/1/2007	27.50%	2/1/2011	2.00%	1,447,035	633,223	1,510,013	660,631
THSteps Other Services (Managed Care only)	NA	NA	2/1/2011	2.00%	3,078,582	1,347,187	3,249,399	1,421,612
THSteps Personal Care Services and Attendant Care	8/1/2009	7.00%	9/1/2010	1.00%	1,259,078	550,973	1,281,840	560,805
THSteps Private Duty Nursing	7/1/2008	15.00%	2/1/2011	2.00%	6,704,847	2,934,041	6,842,363	2,993,534
Tuberculosis Clinics	NA	NA	9/1/2011	5.00%	2,016	882	2,092	915
Total HHSC (with totals only included)					**196,119,520**	**82,639,828**	**199,966,701**	**84,298,941**

Note 1: Basic and Advanced Life Support Costs were allocated between air and ground ambulance based on number of clients served.

Note 2: Effective September 1, 2013, Ambulance Services were fully exempted from Medicare equalization which increased revenues received for dually-eligible consumers.

Note 3: Rural Health Centers are exempt from rate changes because they have federally mandated Medical Economic Inflators provided annually. Estimates are based on 1 percent increase in reimbursement.

Note 4: Federally Qualified Health Center Rate increases are limited to MEI plus .5 percent, they have federally mandated Medical Economic Inflators provided annually. Estimates are based on 1 percent increase in reimbursement.

Note 5: Recently, some Federally Qualifed Health Centers (FQHCs) have acquired physician practices and retained their client base. This activity may cause FQHC costs to increase over the next biennium as FQHC rates are significantly higher than physician reimbursement. HHSC does not have a way of predicting how many clients will be moved to the FQHC client base, and therefore it is difficult

Note 6: Last rate of increase percentage column for Inpatient Hospitals reflects actual dollars appropriated by the 84th legislature Trauma designated and Safety Net Hospitals.

Note 7: Last rate of increase percentage column for Outpatient Hospitals reflects actual dollars appropriated by the 84th legislature for rural hospital outpatient reimbursement increases.

Note 8: Last rate of increase percentage column for Outpatient Hospital Imagings reflects actual dollars appropriated by the 84th legislature for rural hospital outpatient reimbursement increases.

Note 9: Rural Health Centers are exempt from rate changes because they have federally mandated Medical Economic Inflators provided annually

Note 10: Reflects the impact of potential DADS fee-for-service rate increases on corresponding services delivered through managed care.

Note 11: Costs for the Duals Demonstration program are included in the STAR+Plus costs.

Total HHS	**290,873,988**	**123,934,609**	**294,997,754**	**125,737,138**

Long Term Services and Supports

Enhancing Community IDD Services for Persons with Complex Medical and/or Behavioral Needs

While Texas has invested a great deal in community-based care for individuals with intellectual or developmental disabilities (IDD), the state still has challenges in its treatment of individuals with IDD who also have complex medical and/or mental health issues. This fact has been noted by numerous stakeholders as well as Texas Sunset Commission staff. To address this issue, effective January 1, 2015, HHSC created an add-on payment rate for non-state operated facility services for individuals with high medical needs who lived in a state supported living center (SSLC) for at least six months before referral to a non-state operated facility. Individuals must meet the following criteria in order to qualify for the high medical needs add-on rate:

- Lived in an SSLC at least six months immediately before referral to a non-state operated facility.
- Have a level of need (LON) which includes a medical LON increase but not a LON of pervasive plus.
- Have a Resource Utilization Group (RUG-III) classification in the major RUG-III classification groups of Extensive Services, Rehabilitation, Special Care, or Clinically Complex.

In addition, effective January 2017, HHSC will implement the following new services under the Home and Community-Based Services (HCS) program to provide additional support for eligible persons who have medical needs that exceed the service specification for existing HCS services and who need additional support in order to remain in a community setting: High Medical Needs (HMN) Support, HMN Registered Nursing (RN) and Licensed Vocational Nursing (LVN) services. HCS providers who care for high-needs individuals will receive separate payment rates for these new services.

Apportioning Rate Changes Pro Rata

In the event that appropriations are not adequate to fully fund payment rate increases included in this 2018-2019 Consolidated Budget Request for a specific program and no direction is given by the Legislature as to legislative intent on the distribution of appropriated funds across services and cost areas (e.g., direct care versus indirect care) within that long term services and supports program, HHSC will distribute appropriated funds for the program proportionally based on each of the program's service types and cost area ratio of rates as determined in accordance with published reimbursement methodology to existing payment rates. Any rate reductions will be applied in a similar manner.

For example, if the current Consolidated Budget Request includes a rate increase of ten percent for Program A and Program A's rates were comprised of two cost centers: one a direct care cost center and one an indirect cost center. The 10 percent requested rate increase is a total rate increase for the program, comprised of a 20 percent increase for direct care costs and a 5 percent increase for indirect costs (based on a calculation of the rates at the time the request was determined). If funds were appropriated to cover 50 percent of the requested rate increase (i.e., a 5 percent rate increase overall), the direct care cost center would increase ten percent (50 percent of the 20 percent increase) and the indirect cost center would increase 2.5 percent (50 percent of the 5 percent increase).

Comparison of Nursing Facility Medicaid Rates to Private Pay Rates

Data from nursing facility providers' fiscal year 2014 cost reports showed the average daily payment for a Medicaid recipient was $138.44, whereas the average daily payment for a private pay resident was $159.80 and the average daily payment for a Medicare resident was $441.28. It should be noted that Medicare residents are significantly more expensive to care for than Medicaid residents because of their higher acuity levels and need for rehabilitative therapies. A comparison of Nursing Facility Medicaid rates to estimated private pay amounts is detailed below **(See Figure VII.2)**.

It is important to note that the figures quoted below do not include any nursing facility supplemental payments made under the former nursing facility upper payment limits (UPL) program or under the Minimum Payment Amounts Program (MPAP). Both of these programs allowed qualified non-state government-owned nursing facilities to receive supplemental payments that covered the difference between the Medicaid base rate and what Medicare would have paid for the care of the resident had Medicare been the primary payor.

Figure VII.2 Comparison of Nursing Facility Rates Fiscal Year 2014

Procedure Description	Average Medicaid Fee	Average Private Pay	Percent Medicaid to Average Private Pay
Nursing Facility	$138.44	$159.80	86.63%

Attendant Compensation

Direct support workers, typically referred to as attendants, provide the majority of services to consumers in a number of community-based programs. Texas faces serious challenges in meeting current and future needs for a stable and adequate attendant workforce. The demand for new attendants in Texas is expected to increase substantially over the next decade because of numerous factors including the aging of the baby boom generation, the aging of family caregivers, and the increasing prevalence of various disabilities. Meanwhile, retention of attendants has long been a challenge. High rates of job turnover exist throughout the state. Low

compensation is a significant issue with attendant wages in Texas ranking among the lowest in the nation.

A Home and Community-Based Services Workforce Advisory Council was established by HHSC in 2009 to identify and study attendant workforce issues, including wages and benefits, turnover, recruitment, training and skill development, and retention. The Council made three priority recommendations. All three recommendations are concerned with improving compensation levels, as research shows that wages and benefits are the most important factors affecting attendant recruitment and retention.

Appendix F2. – Attendant Wages per Hour and Cost of Increasing Attendant Wages by $1.00 per Hour, presents the minimum attendant wages per hour assumed in fiscal year 2017 base payment rates for the various programs as well as the maximum attendant wages per hour assumed in the fiscal year 2017 rates assuming full participation in one of HHSC's wage enhancement programs. This table also presents the estimated cost of increasing attendant wages assumed in program rates by $1.00 per hour plus associated payroll taxes and benefits. Costs are presented separately for each individual program employing attendants. Figures presented in this table can be used in calculating the fiscal impact of various wage options for attendants.

General Rate Enhancement Overview

The Direct Care Staff Rate Enhancement and the Attendant Compensation Rate Enhancement programs were implemented September 1, 2000, in former Department of Human Services non-IID nursing facility and community-based programs respectively (Article II, Department of Human Services, Riders 37 and 38, H.B. 1, 76th Legislature, Regular Session, 1999) with the goal of incentivizing increased staffing and compensation levels in nursing facilities and increased compensation for community care attendants. IID community-based programs were added to the Attendant Compensation Rate Enhancement September 1, 2010.

Participation in the enhancement programs is optional with providers indicating their desire to enroll and preferred enrollment level during an annual open enrollment conducted each summer. Funding for enhancement levels is limited to available appropriations. Providers indicate their desire to participate by submitting a signed Enrollment Contract Amendment choosing to enroll and indicating the level of enhanced add-on rate they desire to receive. Requested add-on rate levels are granted beginning with the lowest level and granting successive levels until requested enhancements are granted within available funds. When funds are limited and not all requested levels can be granted, pre-existing levels for each provider are granted priority over newly requested levels.

Providers participating in the Attendant Compensation Rate Enhancement program agree to spend approximately 90 percent of their total attendant revenues, including their enhanced add-on rate revenues, on attendant compensation. For the Direct Care Staff Enhancement program

for nursing facility there are both staffing and spending requirements. Participating nursing facility providers are required to spend approximately 85 percent of their total revenues, including their enhanced add-on revenues, on staffing and staff compensation.
The determination of each provider's compliance with the rate enhancement spending requirements is made on an annual basis from cost and/or accountability reports submitted to HHSC. Participants failing to meet spending and/ or staffing requirements for the reporting period are subject to recoupment of their enhanced add-on revenues associated with the unmet spending and/or staffing requirements.

Nursing Facility Supplemental Payments

In 2012, HHSC created a nursing facility upper payment limit (UPL) supplemental payment program for non-state government-owned nursing facilities. Eligible nursing facilities could apply to participate in this program and, if approved, the nursing facilities could receive supplemental payments based on the difference between the amount paid through fee-for-service Medicaid and the amount Medicare would have paid for those same services. As with other supplemental payment programs operated by HHSC, the non-federal share of the supplemental Medicaid payment was funded through intergovernmental transfers (IGTs) provided by the non-state governmental entities that own the participating nursing facilities. Payments were made under the nursing facility UPL program for services provided between October 2013 and February 28, 2015. When the nursing facility UPL program was implemented, there were fewer than 30 non-state government-owned nursing facilities in Texas; due to the incentives under the nursing facility UPL program, an additional 90 nursing facilities transitioned from private to public ownership by the time the program ended.

On March 1, 2015, nursing facility services were "carved-in" to managed care. In other words, the capitated payment HHSC makes to Medicaid managed care organizations (MCOs) includes funds for nursing facility services provided by nursing facilities contracted with the MCOs. As a result of the carve-in, HHSC was prohibited by federal regulations from continuing the nursing facility UPL program.

In an effort to continue a certain level of funding to the nursing facility UPL participants, HHSC created the minimum payment amount program or MPAP. In order to eligible to receive payments in the program a nursing facility was required to meet multiple criteria:

- The nursing facility must be owned by a non-state governmental entity.
- The nursing facility must make certain representations and certifications on a form to be prescribed by HHSC.
- The nursing facility must enter into an IGT responsibility agreement with the State prior to the applicable payment period. For fiscal year 2016, 279 publicly owned nursing facilities received roughly $664 million AF under MPAP.

In April, 2016, the Centers for Medicare and Medicaid Services (CMS) notified HHSC that it had determined that the MPAP IGT responsibility agreement indicated that minimum payments would only be made to nursing facilities that had entered into such an agreement, thereby making MPAP payments contingent upon IGT transfers. CMS went on to state that it would not approve any future contract and rate actions containing this arrangement or any other stipulations on provider payments such as that found in the MPAP. As a result, the MPAP ended August 31, 2016.

HHSC is currently working with stakeholders to develop a new program that is compatible with CMS requirements. This program, the Quality Incentive Payment Program is currently scheduled to roll out September 1, 2017. The non-federal share will be provided through IGTs, payment will be based upon achievement of quality metrics and the program will be open to both public and private nursing facilities.

Foster Care Redesign

The 2012-2013 GAA (Article II, Department of Family and Protective Services (DFPS), H.B. 1, 82nd Legislature, Regular Session, 2011) and S.B. 218, 82nd Legislature, Regular Session, 2011, directed the DFPS to implement a redesign of the foster care system in accordance with recommendations contained in DFPS's December 2010 Foster Care Redesign report submitted to the Legislature. House Bill 1 and Senate Bill 218 permitted HHSC to use payment rates for foster care under the redesigned system that are different from those used for non-redesign 24-hour residential child care so long as the implementation of the redesigned system did not lead to additional costs to the state. HHSC developed the first set of payment rates for Single Source Continuum Contractors (SSCC) under Foster Care Redesign in August 2012 for Regions 2, and 9. Effective September 2015, a new payment rate for SSCC contractors went into effect for Region 3b. DFPS hopes to expand Foster Care Redesign to additional regions during the 2018-2019 biennium.

Department of Labor Fair Labor Standards Act Rules Impact

On January 1, 2015, the U.S. Department of Labor (DOL) issued a final rule which extended the application of Fair Labor Standards Act (FLSA) protections to most home care workers, effective November 1, 2015. This rule ensures that most workers are eligible to receive overtime and travel pay. HHSC added questions to annual cost reports for 2015 for programs that provide attendant services to collect data for use in quantifying the fiscal impact of the rule. Additionally, a survey was sent to Financial Management Services Agencies in order to collect wage data for Consumer Directed Services attendants.

On May 23, 2016, the DOL published a second update to the FLSA in the U.S. Federal Register which updated the salary level required for an employee to be exempt from FLSA requirements regarding overtime protections under the "white collar" exemption. The rule raised the salary

threshold under which most white collar workers are entitled to overtime compensation from $455 a week ($23,660 for a full-year worker) to $913 a week ($47,476 for a full-year worker) effective December 1, 2016. The DOL has since announced that it will not enforce the updated salary threshold for providers of Medicaid-funded services for individuals with intellectual or developmental disabilities in residential homes and facilities with 15 or fewer beds until March 17, 2019. HHSC created an online survey for Long-Term Services and Supports providers that was designed to capture the additional allowable costs associated with employees whose salary falls between $455 and $915 per week and who were previously exempt from overtime pay. Details of the results of the collected cost report and survey data for the above-referenced DOL rule were not available at the time this Consolidated Budget Request was developed but will be available in separate reports before the 85th legislative session.

Attendant Recruitment and Retention

In response to HHSC Rider 89 which directed HHSC to develop recruitment and retention strategies for community attendants to address the projected shortage of attendants, HHSC is collecting data from Long-Term Services and Supports providers who provide attendant services through cost reports and a provider survey. The Cost Reports for 2015 will collect data on attendant hourly wages, benefits and turnover. The survey, which was conducted online, will collect detailed data on:

- Initial wages paid to attendants.
- Basis of wage increases (e.g., additional training completed; length of employment; merit-based increases).
- Additional opportunities for wage enhancements (e.g., for bilingual and ASL proficient attendants; attendants working in high wage areas of the state; attendants working in remote areas of the state; attendants working with high needs consumers, etc.).
- Estimated time required to fill an attendant vacancy.
- Average length of employment for direct care workers.

Details of the results of the collected cost report and survey data for attendant recruitment and retention were not available at the time this Consolidated Budget Request was developed but will be available in a separate report prior to the 85th legislative session.

Increased Wage Enhancement Funding for ICF/IID and HCS Programs

Effective September 1, 2010, the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) and Home and Community-Based Services (HCS) programs transitioned from the fiscal accountability system to the Attendant Compensation Rate Enhancement program. The fiscal accountability system had required all ICF/IID and HCS

providers to meet certain spending requirements for a broad range of staff, however due to provider and HHSC concerns it was determined that the fiscal accountability system was not sustainable long term.

The ICF/IID and HCS programs were incorporated into the Attendant Compensation Rate Enhancement program rules at 1 Texas Administrative Code §355.112 which administered the program for other community care attendant services since the inception of the program in state fiscal year 2001. Currently, the maximum level of participation level available to ICF/IID and HCS providers is 25, however for other community care programs the maximum level of participation available is 35, subject to the availability of funds. In an effort to equalize the Attendant Compensation Rate Enhancement program between ICF/IID, HCS and other community care programs, HHSC included an exceptional item in its 2018-2019 LAR to fund increasing ICF/IID and HCS participation levels from 25 to 35.

Hospitals

Changes to the Final Standard Dollar Amount Payment for Inpatient Services

The 2016-2017 General Appropriations Act (Article II, House Bill 1, 84th Legislature, Regular Session 2015), included increases for hospital inpatient rates under Special Provisions Relating to all Health and Human Services Agencies, Sections 32 and 59. These increases were implemented September 1, 2015, when the amount of the standard dollar amount (SDA) add-on for trauma-designated hospitals was increased, a new add-on was created for certain safety-net hospitals and a hospital quality incentive program was created.

Certain urban hospitals are eligible for an increase to their Base SDA through a trauma add-on. To be eligible for the trauma add-on, a hospital must be designated as a trauma hospital by the Texas Department of State Health Services. For inpatient claims with dates of discharge beginning September 1, 2015, the trauma add-on percentages were increased to the following:

- 28.3 percent for hospitals with a Level 1 trauma designation
- 18.1 percent for hospitals with a Level 2 trauma designation
- 3.1 percent for hospitals with a Level 3 trauma designation
- 2 percent for hospitals with a Level 4 trauma designation

The safety-net add-on increases the final SDA to reflect the higher costs of providing inpatient care in a hospital that provides a significant percentage of its services to Medicaid or uninsured patients. To be eligible for the safety-net add-on, a hospital must be an urban or children's hospital that meets the eligibility and qualification requirements described in 1 Tex. Admin. Code §355.8065 (relating to Disproportionate Share Hospital Reimbursement Methodology) for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

Together, these two changes resulted in an average 8.8 percent increase in inpatient hospital rates.

Changes to Hospital Outpatient Reimbursement

The 2016-2017 General Appropriations Act (Article II, Health and Human Services Commission, House Bill 1, 84th Legislature, Regular Session, 2015, Special Provisions Relating to all Health and Human Services Agencies, Section 58) directed HHSC to expend certain funds to provide increases in, or add-ons to, Medicaid outpatient provider rates for rural hospitals to ensure access to critical services. To accomplish these legislative objectives, HHSC made the following amendments to the reimbursement methodology for rural hospital outpatient services provided beginning September 1, 2015:

- Increase general outpatient reimbursements so final payments do not exceed 100 percent of cost.
- Increase reimbursement for outpatient emergency department services that do not qualify as emergency visits such that final payments do not exceed 65 percent of cost.
- Create rural hospital add-ons to the outpatient hospital imaging services fee schedule.

Combined these changes resulted in an average 1.8 percent increase in outpatient hospital rates.

Medicaid Shortfall

Medicaid hospital base payment rates do not cover the full cost to the hospital of providing the service. In 2014:

- Inpatient rates covered approximately 57 percent of costs on average for urban Medicaid hospitals and 66.8 percent of costs on average for all Medicaid hospitals; and
- Outpatient rules limit payments to 72 percent of cost for high volume hospitals and 68.4 percent of cost for all others.

The Medicaid shortfall, which is the difference between hospital costs and Medicaid payments, is partially covered by supplemental payments made under the disproportionate share hospital (DSH) and uncompensated care (UC) programs.

Supplemental Payment Programs

Supplemental payment programs provide vital funding for Texas' hospital safety-net. These programs include the UC program and Delivery System Incentive Payment Program (DSRIP) under the 1115 waiver, the DSH program and the Network Adequacy Incentive Payment (NAIP) program. The non-federal share of all of these programs is funded with intergovernmental transfers (IGT) primarily from public hospital districts.

Fiscal year 2016 estimated Texas Medicaid hospital payments and supplemental payments totaled $13.862 billion. Only 38.35 percent of these funds came from base Medicaid payment rates; 26.38 percent came from supplemental payment IGTs and 35.27 percent came from federal matching of supplemental payment IGTs.

While HHSC has administered various supplemental payment programs for at least a decade, these programs exist in a perpetually changing regulatory environment which exposes them to risks that do not apply to base Medicaid payments. Risks are predominantly due to the funding of the non-federal share of these programs through IGT rather than state general revenue. Known risks include:

- CMS interpretations of federal regulations pertaining to the use of certain types of public-private arrangements such as Low-Income and Needy Care Collaboration Agreements, Collaborative Endeavor Agreements and Public-Private Partnerships.
- New federally managed care regulations limiting the use of IGT Responsibility Agreements.
- Statutory reductions in future DSH allocations under the Affordable Care Act (ACA).
    - Reductions are currently scheduled to begin in federal fiscal year 2018 at $2 billion a year nationwide; by the final year of reductions, federal fiscal year 2015, the reductions will total $8 billion a year nationwide.
    - Specific reductions that will be assigned to Texas are unknown at this time.
- CMS UC pool principles. CMS has indicated it will apply the following principles when determining the size of Texas' UC pool after December 31, 2017:
    - Coverage is the best way to assure beneficiary access to healthcare for low income individuals and UC pool funding should not pay for costs that would otherwise be covered in a Medicaid expansion.
    - Medicaid should support the provision of services to Medicaid and low income uninsured individuals.
    - Provider payment rates must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care (e.g., UC should not cover costs associated with Medicaid shortfall).
- CMS' position regarding "pay-to-play" arrangements as detailed in the discussion of the nursing facility MPAP above.

Trauma Funds

Legislative appropriations from the state's trauma fund (GR dedicated Designated Trauma Facility and Emergency Medical Services account 5111) support Medicaid trauma-related payments to 290 hospitals.

- $150 million annual general revenue matched with $192 million in federal funds totals $343 million in higher hospital payments which reduce the size of the Medicaid shortfall.
- An additional $24 million is appropriated for other purposes.
- This appropriation level includes prior year fund balances as well as current biennium revenues.
    - The Comptroller of Public Accounts Certification Revenue Estimate for the 2016-2017 biennium includes $117.9 million annual revenue for Account 5111.
- Use of the fund balance achieves two goals:
    - Use of dedicated account for statutorily authorized purposes.
    - Wind down reliance on GR-D funds for GR certification purposes.
- As a result, the annual appropriation level is not sustainable beyond the 2016-2017 biennium (subject to Revenue Estimate).
- Further revenue may be affected by legislative action as the Driver Responsibility Program and other revenue sources for account 5111 are reviewed.

Acute Care Services

Biennial Review of Medicaid Acute Care Fees

Most Medicaid acute care fees are based on the Medicare Relative Value Unit (RVU) system, which is an evidence-based, national standard used to compare the relative value of professional health care services. Based upon actual empirical measurement, RVUs quantify the relative work, practice expense and malpractice cost associated with each rated service. A total RVU amount, based on the sum of these three components, is then assigned to each Current Procedural Terminology (CPT) code. Rates are typically set at some percentage of the Medicare rate for a similar service. Rates for services that do not have an equivalent Medicare RVU are based on the fees for comparable services, an examination of fees from other states, market rates, or other fee analyzer tools.

For the majority of Medicaid acute care programs, agency rules, the Medicaid State Plan, or agency policy require fee reviews at periodic intervals. In 2008, HHSC set a goal to review all acute care reimbursement rates at least once every two years and implemented a fee review plan to reach that goal. The intent of the review process was to utilize a consistent and objective approach to updating rates. Prior to this initiative, most of the acute care fees had not had a systematic review and had not been updated in six to ten years, or in some cases longer. The fee review plan included improving internal processes and assigning a portion of the first level review of acute care fees to the Medicaid claims processing contractor. HHSC added an amendment to the Medicaid claims administrator contract in August 2008 that made the

contractor responsible for reviewing and recommending to HHSC changes to approximately one eighth of approximately 66,000 fees every quarter. HHSC reviews and approves the contractor's work schedule and recommendations, including fee determination and fiscal impact analysis. The first calendar fee review was implemented effective April 1, 2009. The eighth and final calendar fee review in the first two-year cycle was completed and implemented effective January 1, 2011. HHSC's Rate Analysis Department continues to update rates based on this established two year review calendar cycle. One of the results of these fee reviews was the identification and implementation of needed systems changes to allow HHSC to pay separate rates for age groups (children vs. adults) and by place of service (facility or non-facility). It also improved the online fee schedules to allow them to display the most recent fee review dates so that providers will know when the fees were reviewed and revised.

With these reviews, the Texas Medicaid conversion factor that is multiplied by the RVU to determine the payment fee is not changed. Conversion factors are revised when appropriations warrant an update for fee increases or decreases. Tangible items such as durable medical equipment or physician-administered drugs are reviewed based on available market research and pricing and recommended to be updated as appropriate.

Physicians/Professional Services

Medicaid reimburses all physicians and professionals according to the same fee schedule. Medicaid pays Advanced Practice Nurses and Physician Assistants at 92 percent of the fee paid to physicians for the same service and 100 percent of the fee paid to physicians for laboratory, X-ray and injections. Medicaid also pays Licensed Clinical Social Workers, Licensed Professional Counselors, Licensed Marriage and Family Therapists and Licensed Psychological Associates
70 percent of the fee paid to psychiatrists and psychologists for the same service.

Medicaid currently pays approximately 78 percent of Medicare for physician and professional services to children and 73 percent of Medicare for physician and professional services to adults. This Medicare methodology is based on the primary Medicaid conversion factor of $28.07 for services provided to children and the primary Medicaid conversion factor of $26.73 for services provided to adults. An additional conversion factor of $30.00 was added as an option to increase a rate beyond the normal threshold for children and adults as deemed necessary by medical staff. By way of comparison, the Medicare conversion factor effective August 5, 2016, is $35.80.

Figure VII.3 Comparison of Medicare to Texas Medicaid Conversion Factors For Physicians and Other Professionals

Medicare 2016 Conversion Factor	$35.80
Texas Medicaid 2016 Conversion Factor for Adults	$26.73
Percent of Medicare for Adults	**74.7%**
Texas Medicaid 2016 Conversion Factor for Children	$28.07
Percent of Medicare for Children	**78.3%**

The above **Figure VII.3** does not adequately reflect the percentages reimbursed for the most utilized physician procedure codes which include Evaluation and Management (E&M) services. The E&M services consists of approximately 450 procedure codes which have had minimal, if any, adjustment since 2007. The E&M procedure code grouping includes but is not limited to: basic physician office visits, preventative counseling, and established patient periodic visits. Due to the high utilization for these procedure codes, an increase of only $1.00 to one procedure code would represent a cost to the commission of one million plus dollars all funds. Many of these procedure codes remain reimbursed at 40 to 70 percent of the Medicare reimbursement which is far below the average of approximately 75 to 78 percent of Medicare reimbursement for other Medicaid physician services.

Significant Medicaid Fee-for-Service Rate Actions 2012-2017

Long Term Services and Supports (Biennial)

- Nursing Facilities
  - Fiscal years 2010-2011 – 2.7 percent increase; one percent reduction; additional 2 percent reduction
  - Fiscal years 2012-2013 – no changes
  - Fiscal years 2014-2015 – two percent in fiscal year 2014 and four percent in fiscal year 2015 for a total 6 percent increase
  - Fiscal years 2016-2017 – no changes
- Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IID)
  - Fiscal years 2012-2013 – 2 percent reduction
  - Fiscal years 2014-2015 – no change
  - Fiscal years 2016-2017 - 2.02 percent increase for two years
- Community Care other than Home and Community-based Services/Texas Home Living (HCS/TxHmL)

- Fiscal years 2012-2013 – Community Based Alternatives (CBA) Personal Attendant Services (PAS) 3.95 percent reduction
- Fiscal years 2014-2015 – increases to support $7.50 per hour minimum wage for attendants in fiscal year 2013 and $7.86 per hour in fiscal year 2014; $20 million GR increase for rate enhancements
- Fiscal years 2016-2017 - increases to support $8.00 per hour minimum wage for attendants in fiscal years 2016 and 2017; $7.5 million GR increase for rate enhancements

- HCS/TxHmL
  - Fiscal years 2012-2013 – decreases ranging from 1 to 42 percent depending on service
  - Fiscal years 2014-2015 – no change
  - Fiscal years 2016-2017 - 2.02 percent increase for two years only for
  - Supervised Living/Residential Support Services (SL/RSS), and Day Habilitation (DH)

Hospitals (Biennial)

- Inpatient
  - Fiscal years 2010-2011 – two separate 1 percent reductions
  - Fiscal years 2012-2013 – moved to statewide standard dollar amount (SDA); 8 percent reduction with one-year $20 million hold-harmless
  - Fiscal years 2014-2015 – 10 percent reduction to outlier payments (children's hospitals exempt); pay adult rates for labor and delivery services provided at children's hospitals; transition children's and rural hospitals from cost-based reimbursement to All Patient Refined Diagnosis Related Group (APR-DRG) reimbursement.
  - Fiscal years 2016-2017 - 8.8 percent increase in inpatient payments through increased trauma add-on payments, creation of safety-net add-on and hospital quality incentive payments.
- Outpatient
  - Fiscal years 2010-2011 – two separate one percent reductions
  - Fiscal years 2012-2013 – eight percent reduction; implemented imaging fee schedule; 40 percent reduction for non-emergent Emergency Room services
  - Fiscal years 2014-2015 – 5.3 percent reduction and subsequent freeze (children's, rural and state-owned exempt); imaging fees greater than 125 percent of acute care fee reduced to 125 percent of acute care fee; flat fee for non-emergent Emergency Room visits at 125 percent of acute care office visit fee (rural hospitals exempt)
  - Fiscal years 2016-2017 - 1.8 percent increase in statewide average outpatient rates (limited to rural hospitals).

Acute Care (Biennial)

In general, most Acute Care Medicaid services last had a rate increase September 1, 2007. Many Acute Care provider rates were reduced by 1 percent September 1, 2010, 1 percent February 1, 2011, and by varying percentages September 1, 2011. Significant provider rate actions include:

- Ambulance
  - Fiscal years 2010-2011 – 29.7 percent increase; two separate one percent reductions
  - Fiscal years 2012-2013 – Medicare equalization (emergency and Part B deductibles exempt)
  - Fiscal years 2014-2015 – Fully exempt from Medicare equalization; 5 percent reduction
- Therapies
  - Fiscal years 2010-2011
    - CORF/ORF and Independent Therapist in office setting – three reductions totaling 7 percent
    - Home Health Agencies and Independent Therapist in home setting- two reductions totaling 2 percent
  - Fiscal years 2012-2013
    - CORF/ORF- 10 percent reduction for evaluations; 19 percent reduction for re-evaluations; 2.5 percent reduction for all other services
    - Independent Therapist- 2.76 percent reduction to Speech evaluations conducted in the home; 10 percent reduction for Speech, Physical and Occupational re-evaluations; seven percent reduction for all other Speech services
    - Home Health Agencies- 2.76 percent reduction for Speech evaluations; 10 percent reduction for Speech, Physical and Occupational re-evaluations
  - Fiscal years 2014-2015
    - CORF/ORF- 2.5 percent reduction
    - Independent Therapist in office setting- 4 percent reduction
    - Home Health Agencies and Independent Therapist in a home setting- 1.5 percent reduction
  - Fiscal years 2016-2017
    The 2016-2017 General Appropriations Act, 84th Legislature, Regular Session, Article II, Rider 50 at pages II-96 through II-98 (Health and Human Services Section, Health and Human Services Commission) directed HHSC to achieve at least $50 million in GR savings through rate reductions for acute

care therapy services (an average 20 percent rate reduction). These reductions were blocked by a temporary injunction. On September 23, 2016, the Texas Supreme Court declined to hear a lawsuit over the reductions' legality which had the effect of lifting the temporary injunction and allowing the reductions to proceed. Final disposition of the reductions was not available at the time this Consolidated Budget Request was developed but should be available prior to the 85th legislative session.

- Physicians
    - Fiscal years 2010-2011 – two separate 1 percent reductions
    - January 1, 2013 through December 31, 2014 – Affordable Care Act (ACA) increases for primary care evaluation and management
- Dental Services – fiscal years 2010-2011 – two separate 1 percent reductions
- Vendor Drug Dispensing
    - Fiscal years 2010-2011 – two separate 1 percent reductions
    - Fiscal years 2012-2013 - $0.85 reduction

VIII. APPENDICES

A. **Long Term Care Plan**

Section 533.062 of the Texas Health and Safety Code requires the Long-Term Care Plan for Individuals with Intellectual Disabilities and Related Conditions to be developed prior to each legislative session and adjusted following legislative action on appropriations for long-term care services specific to this population.

The Health and Human Services Commission publishes the plan solely to reflect the legislative appropriations for the 1) state supported living centers (SSLCs) and licensed/certified community-based intermediate care facilities serving individuals with an intellectual disability or related conditions (ICF/IID), and 2) the various waiver programs serving individuals with intellectual disabilities and related conditions. Data in this plan represent the average monthly number of persons expected to participate in each service. They do not necessarily represent the number of institutional beds or waiver slots available.

HHSC's legislative appropriations request contains seven exceptional items relating to LTSS. The items focus on providing community-based services for individuals with an intellectual disability or a related condition as well as improving the quality measurement system for community-based services.

- **Exceptional Item #14 Provide Transition to Community Services (formerly Promoting Independence slots).** HHSC is requesting funds to provide the following slots:
    - 500 Home and Community-based Services (HCS) slots for residents of SSLCs and large ICFs/IID distributed as 400 slots for residents of SSLCs and 100 slots for large and medium ICF/IIDs;
    - 236 HCS slots for Department of Family and Protective Services (DFPS) children aging out of foster care;
    - 400 HCS crisis slots for persons at imminent risk of institutionalization;
    - 120 HCS slots for the movement of individuals with IDD from state hospitals;
    - 40 HCS slots for DFPS children transitioning from general residence operations facilities;
    - 700 slots for individuals with IDD moving from nursing facilities (NFs);
    - 600 HCS slots for individuals with IDD diverted from nursing facility placement; and,
    - 550 Medically Dependent Children Program (MDCP) slots for children diverted from nursing facility placement.

- **Exceptional Item #4 Maintain Medicaid Waiver Program at Fiscal Year 2017 Levels.** This item provides waiver funding based on the end of the year population level. The budget instruction requirement of agencies to request an average of the two previous years as the base for the following biennium does not consider "ramping up" of individuals throughout the biennium. The end of year population count will ensure waiver programs have necessary funds towards the end of the biennium.

- **Exceptional Item #15 Reducing Community Programs Interest List (formerly Community Expansion).** HHSC is requesting an increase in funding for an additional 19,010 slots for community services formerly administered by DADS legacy agency, including HCS, Medically Dependent Children Program (MDCP), Texas Home Living (TxHmL), Community Living Assistance and Supports Services (CLASS), Deaf- Blind with Multiple Disabilities (DBMD) and Title XX individuals above the SSI level.

- **Exceptional Item #40 Community Day Habilitation Programs - HCBS Requirements.** HHSC requests funds to assist community-based providers and their subcontracted day habilitation providers to make changes to day habilitation services to meet CMS HCBS settings rule requirements related to community integration, setting choice, right to privacy, dignity and respect and individual autonomy.

- **Exceptional Item #42 Quality Reporting System Updates.** HHSC is seeking funds to replace the current Quality Reporting System. The 15 year old system has multiple data input sources, and the current data storage process makes it challenging to upload quality information on the HHSC website for public use.

- **Exceptional Items #41 Community Critical Incident Reporting System** HHSC is requesting funds to purchase a system to collect consistent critical incident information across multiple 1915(c) community-based programs required to meet CMS assurances related to health and welfare.

- **Exceptional Item #43 PASRR LTC Online Portal Quality Improvements.** HHSC requests funds to add functionality to the LTC Portal related to individuals who receive specialized services in nursing facilities as required by federal law in the Pre-admission Screening and Review (PASRR) program. Currently, compliance information is tracked manually. This item would eliminate the need for manual tracking of nursing facility compliance and would ensure quality services are delivered.

Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)

The ICF/IID program is a Medicaid-funded program that provides 24-hour residential services

and supports for individuals with an intellectual disability or related conditions in settings of four or more persons. ICF/IID services are provided in two settings: state supported living centers (SSLCs) and community-based facilities.

The primary purpose of the Medicaid ICF/IID program is the provision of health and habilitation services. Provision of active treatment is the core requirement for certification as an ICF/IID. Each facility must comply with federal and state standards, applicable laws, and regulations.

Legislative Appropriations Request

	FY 2018	FY 2019
SSLCs	2,965	2,965
ICFs/IID	5,004	5,010

*Data represents the average monthly number of persons expected to participate in each service.

Waiver Programs

Section 1915(c) of the Social Security Act provides that upon federal approval states may "waive" various federal Medicaid requirements to provide an array of support services in the community as an alternative to institutional care. Medicaid expenses for individuals in waiver programs cannot exceed, in the aggregate, Medicaid expenses for institutional services for individuals with similar needs. States can limit the number of persons served through waiver programs.

Home and Community-based Services (HCS) Program

The HCS program serves individuals with a primary diagnosis of an intellectual disability or a related condition who qualify for a Level of Care I. The HCS program provides individualized services and supports for persons living in their family home, their own home, in a foster/companion care setting, or in a residence with no more than four individuals who receive similar services.

HCS Exceptional Items

Initiative	2018	2019
Maintain August 2017	594	594
Promoting Independence	704	2,002
Interest List Reduction	2,221	6,662

*Data represents the average monthly number of persons expected to participate in each service.

Texas Home Living (TxHmL) Program

The TxHmL program provides individualized community-based services and supports for individuals with a primary diagnosis of an intellectual disability or a related condition who qualify for a Level of Care I. Selected essential services and supports are provided for individuals so they can continue to live with their families or in their own homes. The sharp

increase in the number of individuals served by TxHmL beginning in 2012 reflects legislative direction to refinance services formerly provided by local authorities using only General Revenue (GR) funds. Individuals who received GR funded services in the past are now enrolled in the TxHmL waiver, which allows federal matching funds to support the cost of these services.

TxHmL Exceptional Items

Initiative	2018	2019
Maintain August 2017	103	103
Interest List Reduction	351	1,053

*Data represents the average monthly number of persons expected to participate in each service.

Community Living Assistance and Support Services (CLASS) Program

The CLASS program provides home and community-based services for adults and children with related conditions so they can live with their families or in their own homes as an alternative to ICF/IID services. Individuals with related conditions have a diagnosis listed on the DADS Approved Diagnostic Codes for Persons with Related Conditions. The disability must originate before age 22 and limit the individual's ability to perform activities of daily living.

CLASS Exceptional Items

Initiative	2018	2019
Maintain August 2017	122	122
Interest List Reduction	1,051	3,153

*Data represents the average monthly number of persons expected to participate in each service.

Deaf-Blind with Multiple Disabilities (DBMD) Program

The DBMD program provides home and community-based services for individuals who have deaf blindness with one or more other disabilities. Individuals live with their families, in their own homes, or in residences with no more than six individuals. The program focuses on increasing opportunities for individuals to communicate and interact with their environment.

DBMD Exceptional Items

Initiative	2018	2019
Maintain August 2017	6	6
Interest List Reduction	3	9

*Data represents the average monthly number of persons expected to participate in each service.

B. **10% Biennial Base Reduction Schedule**

HHS agencies submitted items totaling $302.2 million in General Revenue as part of a supplemental schedule in each agency's LAR. This schedule represents reductions, and in some cases elimination of various HHS programs. Reductions and the impact on FTEs are listed below. Details of the ten percent reductions are shown in the following tables. Some, but not all, of these general revenue reductions would have corresponding federal fund reductions.

Supplemental 10% Schedule General Revenue/General Revenue Dedicated ($ in millions)				
Agency	**FY 2018**	**FY 2019**	**Biennial**	**FY 2019 FTEs**
HHSC	$ 213.0	$ 218.4	$ 431.5	71.5
DFPS	$ 17.2	$ 17.2	$ 34.5	-
DSHS	$ 30.0	$ 30.0	$ 60.1	231.0
Total	**$ 260.2**	**$ 265.6**	**$ 526.1**	**302.5**

B. **10% Biennial Base Reduction Schedule, continued**

Agency Code: 529, HHSC 10 Percent Biennial Base GR Reduction Options Schedule ($ in millions)										
		GR Reduction Amount			Revenue Loss			FTE Reduction		
Rank	Reduction Item	FY 2018	FY 2019	Biennial Total	FY 2018	FY 2019	Biennial Total	FY 2018	FY 2019
1	Adjust Target for Credit for One-Time Expenses	$.2	$.2	$.4	$.0	$.0	$.0	-	-
2	Method of Finance Swap	$26.2	$26.2	$52.4	$.0	$.0	$.0	-	-
3	Rate Reductions	$142.8	$148.5	$291.2	$176.0	$183.7	$359.7	3.0	-
4	2-Salary Savings - Hold FTEs Vacant	$1.6	$1.6	$3.2	$3.2	$3.2	$6.3	-	-
5	5-Operating Reductions	$7.1	$6.5	$13.6	$18.4	$21.3	$39.7	-	-
6	1-Contractor Reduction	$10.3	$10.7	$21.0	$19.2	$20.5	$39.7	-	-
7	2-Salary Savings - Hold FTEs Vacant-Elig	$5.6	$5.6	$11.2	$6.5	$6.5	$13.1	-	-
8	1-Contractor Reduction-Elig	$5.5	$5.5	$11.0	$8.6	$8.6	$17.3	-	-
9	4-FTE Reduction - Currently Vacant	$.5	$.2	$.7	$1.1	$.9	$1.9	-	-
10	7-Grant, Loan or Pass-through Reductions	$.4	$.4	$.8	$.0	$.0	$.0	-	-
11	8-Delayed Program Implementation	$.0	$.0	$.0	$.1	$.1		-	-
12	Program and Service Reductions	$10.3	$10.3	$20.5	$3.6	$3.6	$7.2	8.0	7.0
13	Reduciton for Child Care Regulation	$2.1	$2.2	$4.3	$.2	$.2	$.4	42.7	43.5
14	Reduction for Adult Protective Services	$.5	$.6	$1.1	$.4	$.5	$.8	17.8	20.7
	Total	**$213.0**	**$218.4**	**$431.5**	**$237.2**	**$249.0**	**$486.0**	**71.5**	**71.2**

B. **10% Biennial Base Reduction Schedule, continued**

Agency Code: 530, DFPS 10 Percent Biennial Base GR Reduction Options Schedule ($ in millions)										
		GR Reduction Amount			Revenue Loss			FTE Reduction		
Rank	Reduction Item	FY 2018	FY 2019	Biennial Total	FY 2018	FY 2019	Biennial Total	FY 2018	FY 2019
1	Reduce Lapsing One-Time Capital Used in Base to Maintain Staff	$15.4	$15.4	$30.8	$1.4	$1.4	$2.8	-	-
2	Reduce CPS One-Time Performance Bonus Used in Base to Maintain Staff	$1.9	$1.9	$3.7	$.2	$.2	$.4	-	-
Total		**$17.2**	**$17.2**	**$34.5**	**$1.6**	**$1.6**	**$3.2**	**-**	**-**

B. **10% Biennial Base Reduction Schedule, continued**

Agency Code: 537, DSHS 10 Percent Biennial Base GR Reduction Options Schedule ($ in millions)

Rank	Reduction Item	GR Reduction Amount			Revenue Loss			FTE Reduction	
		FY 2018	FY 2019	Biennial Total	FY 2018	FY 2019	Biennial Total	FY 2018	FY 2019
1	Abusable Volatile Chemical	$.4	$.4	$.9	$.7	$.7	$1.4	6.0	6.0
2	Laser Hair	$.2	$.2	$.4	$.2	$.2	$.5	2.0	2.0
3	Code Enforcement	$.1	$.1	$.1	$.1	$.1	$.2	1.0	1.0
4	Massage Therapy	$.6	$.6	$1.2	$2.2	$2.2	$4.5	12.5	12.5
5	Primary Care Office	$1.3	$1.3	$2.7	$.0	$.0	$.0	10.0	10.0
6	Texas Health Care Information Collection THCIC	$.1	$.1	$.2	$.0	$.0	$.0	-	-
7	Diabetes and Obesity	$3.0	$3.0	$6.0	$.0	$.0	$.0	6.0	6.0
8	Tobacco	$1.5	$1.5	$3.0	$.0	$.0	$.0	-	-
9	State Health Coordination Council SHHCC Travel	$.0	$.0	$.0	$.0	$.0	$.0	-	-
10	Health Registries	$.8	$.8	$1.6	$.0	$.0	$.0	17.0	17.0
11	Population Based Services/Regional Program Support	$1.3	$1.3	$2.7	$.0	$.0	$.0	5.0	5.0
12	HIV Prevention & Surveillance	$1.0	$1.0	$2.0	$.0	$.0	$.0	-	-
13	Medical Services/Case Management/Support Srvcs	$.6	$.6	$1.3	$.0	$.0	$.0	6.0	6.0
14	Adult Immunizations Safety Net Program	$2.9	$2.9	$5.8	$.0	$.0	$.0	-	-
15	TB IGRA Testing	$3.1	$3.1	$6.3	$.0	$.0	$.0	-	-
16	EMS and Trauma Care Systems	$3.4	$3.4	$6.8	$.0	$.0	$.0	0.5	0.5
17	Food (Meat) and Drug Safety - Meat Safety Assurance Program	$4.8	$4.8	$9.6	$.0	$.0	$.0	141.0	141.0
18	Local Health Department Public Health Services	$1.0	$1.3	$2.3	$.0	$.0	$.0	-	-
19	Infectious Disease Prevention	$2.1	$2.1	$4.3	$.0	$.0	$.0		
20	Laboratory Services	$1.7	$1.4	$3.1	$.0	$.0	$.0	24.0	24.0
	Total	**$30.0**	**$30.0**	**$60.1**	**$3.3**	**$3.3**	**$6.5**	**231.0**	**231.0**

C. DFPS LAR FY 2018-19 Exceptional Items with Sub-item Details

Appendix C. DFPS LAR FY 2018-2019 Exceptional Items ($ in millions)							
		FY 2018		FY 2019		BIENNIAL TOTAL	
	Agency Exceptional Items	GR/GRD	All Funds	GR/GRD	All Funds	GR/GRD	All Funds
1	**Increase Funding to Meet the Needs of the Growing Number of Vulnerable Children, Adults, and Their Families**	**$36.6**	**$37.3**	**$38.4**	**$39.2**	**$75.0**	**$76.6**
	a. Day Care Increased Costs	$15.6	$16.0	$17.4	$18.0	$33.0	$34.0
	b. Increased CPS Purchased Services (Adoption, Post Adoption, Substance Abuse, Other)	$9.4	$9.4	$9.6	$9.6	$18.9	$18.9
	c. Increased APS Emergency Purchased Services	$.5	$.5	$.5	$.5	$1.0	$1.0
	d. Provide 24 Months of Funding for PEI Programs (CYD and HOPES)	$6.6	$6.6	$6.6	$6.6	$13.3	$13.3
	e. Adequately Support Foster Care Redesign (all costs) for Existing Regions 3B and 2C	$4.5	$4.8	$4.3	$4.6	$8.8	$9.4
2	**Increase Staff Resources to Achieve Better Outcomes for Vulnerable Children, Adults, and Their Families**	**$126.3**	**$139.9**	**$122.4**	**$135.6**	**$248.7**	**$275.5**
	a. Increase CPS Workforce to Allow Caseworkers to See Children Timely	$88.2	$98.2	$81.9	$91.2	$170.1	$189.4
	b. Increase Workforce (APS In-Home and Statewide Intake)	$5.4	$5.6	$7.0	$7.3	$12.4	$12.9
	1. Increase APS In-Home Caseworkers to See Adults Timely	$1.7	$1.8	$3.3	$3.5	$5.0	$5.3
	2. Increase SWI Caseworkers to Ensure Timely Response to Intakes	$3.7	$3.8	$3.7	$3.8	$7.4	$7.6
	c. Support CPS Direct Delivery Costs and Critical Operational Supports	$32.7	$36.2	$33.4	$37.1	$66.1	$73.3
3	**Enhance CPS Investigation Capacity to Improve Caseworker Decision Making**	**$4.5**	**$4.8**	**$4.0**	**$4.3**	**$8.6**	**$9.2**
	a. Establish Specialized Unit for Information Analysis	$2.4	$2.4	$2.1	$2.1	$4.4	$4.6
	b. Increase CPS Special Investigators to Strengthen Child Safety and Help Protect Children	$.8	$.9	$.8	$.8	$1.6	$1.8
	c. Increase CPS Investigation Screeners to Better Inform Caseworker Decision Making	$1.3	$1.5	$1.2	$1.3	$2.5	$2.8
4	**Strengthen and Expand High-Quality Capacity and Systems in the Foster Care System**	**$35.6**	**$36.6**	**$75.2**	**$77.9**	**$110.8**	**$114.5**
	a. Expand Foster Care Redesign to 8 New Catchment Areas with Improved Supports	$30.2	$30.5	$69.0	$70.8	$99.2	$101.3
	b. Enhance Provider Placement Capacity by Developing Real-Time Tracking Portal and Improve Data Sharing Capability	$4.7	$5.4	$5.6	$6.4	$10.3	$11.9
	1. Enhance Provider Placement Capacity	$2.7	$3.1	$3.0	$3.5	$5.7	$6.6
	2. Improve Data Sharing Capability	$2.0	$2.3	$2.5	$2.9	$4.6	$5.3
	c. Purchase Reserved Bed Capacity from Residential Treatment Centers	$.7	$.7	$.7	$.7	$1.4	$1.4

C. DFPS LAR FY 2018-19 Exceptional Items Sub-item Details, continued

Appendix C. DFPS LAR FY 2018-2019 Exceptional Items ($ in millions)							
		FY 2018		FY 2019		BIENNIAL TOTAL	
	Agency Exceptional Items	GR/GRD	All Funds	GR/GRD	All Funds	GR/GRD	All Funds
5	**Increase Safety, Permanency, and Well-Being for Children and Youth Through Sustaining CPS Transformation and Engaging Community Partners**	**$14.4**	**$15.9**	**$14.1**	**$15.6**	**$28.5**	**$31.5**
	a. Provide 24 Months of Funding for Safe Signal Initiative	$.3	$.3	$.3	$.3	$.6	$.6
	b. Expand Training to Ensure Adequate Professional Development, Training, and Certification for Agency Staff	$3.6	$4.0	$4.4	$4.8	$8.0	$8.8
	1. Center for Learning & Organizational Excellence Training	$1.5	$1.7	$1.4	$1.6	$2.9	$3.3
	2. CPS Leadership Training	$1.1	$1.2	$2.0	$2.2	$3.1	$3.4
	3. Model for Signs of Safety Training	$1.0	$1.1	$.9	$1.0	$1.9	$2.2
	c. Fund Additional Structure to Allow Split of Region 03 (Dallas) into Two Regions	$.6	$.6	$.5	$.6	$1.1	$1.2
	d. Ensure Effective Use of Data for Improved Caseworker Decision Making	$1.2	$1.3	$1.1	$1.2	$2.2	$2.4
	e. Expand Child Safety Specialists for Review of High Risk Investigations	$2.5	$2.7	$2.3	$2.5	$4.7	$5.3
	f. Expand Caseworker Support Staff for Directly Contacing Parental Child Safety Placements Caregivers	$4.8	$5.3	$4.2	$4.6	$9.0	$9.9
	g. Ensure Compliance with the Federal Interstate Compact on the Placement of Children	$.2	$.2	$.2	$.2	$.4	$.4
	h. Increase Placement Staff Statewide	$.5	$.5	$.4	$.5	$.9	$1.0
	i. Enhance Volunteer Faith and Community Engagement to Link Community Resources	$.8	$.9	$.8	$.9	$1.6	$1.8
6	**Expand and Strengthen Community-Based Prevention and Early Intervention Programs**	**$13.5**	**$13.6**	**$13.1**	**$13.2**	**$26.7**	**$26.7**
	a. Enhance PEI Research, Evaluation, Quality Monitoring/Reporting, Contract Management, and Ability to Proactively Address Child Maltreatment	$.8	$.8	$.7	$.7	$1.4	$1.5
	b. Grow Public Awareness Campaings and Outreach	$1.8	$1.8	$1.2	$1.2	$2.9	$2.9
	c. Expand PEI Services	$11.0	$11.0	$11.3	$11.3	$22.3	$22.3
7	**Further Improve High Quality Care for Children in Foster and Kinship Care**	**TBD**	**TBD**	**TBD**	**TBD**	**TBD**	**TBD**
8	**Increase Funding to Retain High Performing Workforce**	**TBD**	**TBD**	**TBD**	**TBD**	**TBD**	**TBD**
	DFPS Exceptional Item Total	**$230.9**	**$248.2**	**$267.2**	**$285.8**	**$498.1**	**$534.0**

D. Increase Capacity of HHS Community Services (Waiting/Interest Lists)

FY 2018-2019 LAR
Waiting/Interest List Request
($ in millions)

HHSC	Current Wait/ Interest Lists April 2016	Percent Eligible	Number Served August 2017 HB 1	FY 2018 Avg. Monthly Caseload	FY 2018 GR	FY 2018 AF	FY 2019 Avg. Monthly Caseload	FY 2019 GR	FY 2019 AF	18-19 Biennium Caseload as of Aug. 2017 *	18-19 Biennium GR	18-19 Biennium AF
Medically Dep. Children's Program (MDCP)	9,896	10.4%	2,628	258	$2.0	$4.6	773	$6.0	$13.7	1,029	**$8.0**	**$18.3**
Medically Dep. Children's Program (MDCP) (MAO)	8,671	10.4%	N/A	45	$2.0	$4.7	135	$6.3	$14.4	180	**$8.3**	**$19.0**
Comm. Living Asst. & Supp. Svcs. (CLASS)	56,200	37.4%	5,726	1,051	$24.2	$59.7	3,153	$73.5	$181.6	4,204	**$97.6**	**$241.3**
Home and Community-Based Svcs. (HCS)	78,034	65.9%	28,091	2,221	$51.0	$117.6	6,662	$154.0	$354.7	8,882	**$205.0**	**$472.2**
Texas Home Living Waiver	56,123	25.0%	4,362	351	$4.2	$10.2	1,053	$12.8	$31.2	1,403	**$17.0**	**$41.5**
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	57	22.0%	305	3	$.1	$.1	9	$.2	$.4	13	**$.2**	**$.6**
Non-Medicaid Services	37,321	31.7%	32,985	825	$2.5	$2.6	2,475	$7.6	$7.8	3,299	**$10.1**	**$10.4**
Mental Health Services - LMHAs	838	100.0%	3,450	419	$4.1	$4.1	419	$4.1	$4.1	838	**$8.2**	**$8.2**
Comprehensive Rehabilitation Services	156	100.0%	909	151	$6.9	$6.9	5	$.2	$.2	156	**$7.2**	**$7.2**
Independent Living Services	594	100.0%	3,394	486	$2.7	$2.7	108	$.6	$.6	594	**$3.3**	**$3.3**
TOTAL	**247,890**		**81,850**	**5,810**	**$99.7**	**$213.1**	**14,792**	**$265.3**	**$608.8**	**20,598**	**$364.9**	**$822.0**

NOTE: *As of April 2016, the number would serve 100% of interest list estimated to be eligible for DBMD, MCDP, and MH Services - LMHAs. For CLASS, HCS, MDCP: MAO, and TX Home Living, 20% of the interest list estimated to be eligible would be served. For Non-Medicaid Services, 10% increase in number of individuals served.

E. Federal Funds

FY 2016 Top 30 HHS Enterprise Federal Funding Sources ($ in millions)									
Rank	Federal Agency	CFDA	Federal Grant Title	Total HHS System	HHSC	DFPS	DSHS	DADS	DARS
1	HHS-CMS	93.778	Title XIX-Medicaid/Medical Assistance Program (multiple grants)	$17,785.7	$15,291.6	$12.1	$110.4	$2,337.5	$34.1
2	HHS-CMS	93.767	State Children's Health Insurance Program/CHIP	$1,473.7	$1,471.7	-	$2.0	-	-
3	USDA	10.557	Special Supplemental Nutrition Program for Women, Infants, and Children/WIC (2 grants)	$577.7	-	-	$577.7	-	-
4	HHS-ACF	93.558	Title IV - Temporary Assistance for Needy Families/TANF & TANF to Title XX	$390.4	$39.4	$319.2	$21.9	-	$10.0
5	USDA	10.561	State Administration for Supplemental Nutrition Assistance Program/SNAP	$226.8	$226.8	-	-	-	-
6	DOE	84.126	Vocational Rehabilitation Grants to States	$226.6	-	-	-	-	$226.6
7	HHS-ACF	93.658	Title IV-E Foster Care (multiple grants)	$185.6	-	$185.6	-	-	-
8	HHS-SAMHSA	93.959	Substance Abuse Prevention and Treatment Block Grant	$175.0	-	-	$175.0	-	-
9	HHS-ACF	93.659	Title IV-E Adoption Assistance (multiple grants)	$124.6	-	$124.6	-	-	-
10	HHS-ACF	93.667	Title XX Social Services Block Grant	$123.5	$2.6	$32.2	$5.2	$83.4	-
11	SSA	96.001	Disability Determinations	$121.2	-	-	-	-	$121.2
12	HHS-HRSA	93.917	HIV Care Formula Grants	$97.6	-	-	$97.6	-	-
13	HHS-CDC	93.074	Public Health Preparedness (multiple grants)	$68.0	-	-	$68.0	-	-
14	HHS-ACF	93.566	Refugee and Entrant Assistance (multiple grants)	$65.6	$44.8	$6.2	$14.6	-	-
15	DOE	84.181	Special Education Grants	$46.2	-	-	-	-	$46.2
16	HHS-CMS	93.791	Money Follows Person Rebalancing Demonstration	$43.9	$13.8	-	$2.2	$27.8	-
17	HHS-HRSA	93.994	Title V - Maternal and Child Health Services Block Grant	$38.8	-	-	$38.8	-	-
18	HHS-SAMHSA	93.958	Community Mental Health Services Block Grant	$37.1	-	-	$37.1	-	-
19	HHS-ACL	93.045	Title III Part C-Special Programs for the Aging-Nutrition Services	$35.9	-	-	-	$35.9	-
20	HHS-CMS	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare	$33.0	-	-	$4.8	$28.2	-
21	HHS-ACF	93.575	Child Care and Development Block Grant	$31.9	-	$31.9	-	-	-
22	HHS-ACF	93.556	Title IV Part B-Promoting Safe and Stable Families (multiple grants)	$31.3	-	$31.3	-	-	-
23	HHS-CMS	93.796	State Survey Certification of Health Care Providers and Suppliers (Title XIX) Medicaid	$26.0	$.5	-	-	$25.5	-
24	HHS-ACF	93.645	Child Welfare Services Program	$24.0	-	$24.0	-	-	-
25	HHS-ACL	93.044	Title III Part B-Special Programs for the Aging-Supportive Services and Senior Centers	$23.4	-	-	-	$23.4	-
26	SSA	96.000	SSA-VR Reimbursement	$19.8	-	-	-	-	$19.8
27	HHS-CDC	93.268	Immunization Grants	$18.6	-	-	$18.6	-	-
28	HHS-CDC	93.940	HIV Prevention Programs (multiple grants)	$17.1	-	-	$17.1	-	-
29		97.088.000	Cash Management Pilot	$15.7	$15.7	-	-	-	-
30	HHS-ACL	93.053	Nutrition Services Incentive Program	$12.4	-	-	-	$12.4	-
			Subtotal - Top 30 Federal Funding Sources:	**$22,097.2**	**$17,107.0**	**$767.1**	**$1,191.1**	**$2,574.1**	**$457.9**
			All Other Federal Funds:	$192.3	$33.0	$44.7	$85.2	$19.4	$9.9
			TOTAL All Federal Funds FY2015:	**$22,289.4**	**$17,140.0**	**$811.8**	**$1,276.3**	**$2,593.6**	**$467.7**
			Percent Top 30 of All Federal Funds	*99.14%*	*99.81%*	*94.49%*	*93.32%*	*99.25%*	*97.89%*

Source: Legislative Appropriation Requests for the 2018-2019 Biennium 09.28.16 (excludes employee benefits, certain payments made as a result of local funding sources (Intergovernmental Transfers), and the value of SNAP benefits.)

F1. Rate Schedule -- Rate Change Based on Current Review of Costs

F1. Rate Schedule - Rate Change Based on Current Review of Costs and Cost of One Percent Rate Change

KEY - A - Access based
B - Based on rates from other Medicaid progr
BR - Blue Ribbon file of claims data
CD - Percent of claims data
CR - Cost Reports used for prospective rate - trend to FY 2018-19
T - Trending from current rate to FY 2018-19
M - Based on Medicare rates
PA - Pro forma analysis

Program by Budget Agency	Last Legislative or Federal Rate Increase		Rate Reduction Since Last Rate Increase		Method of Determining Rate Change	Estimated 2016-2017 Biennial Cost		Percentage Rate Change to Fully Fund Methodology		Estimated 2018-19 Biennial Cost of Rate Change		Estimated 2018-19 Biennial Cost of One Percent Rate Change	
	Date	Percent	Date	Percent		AF	GR	2018	2019	AF	GR	AF	GR
Long Term Care Programs (Legacy DADS)													
Community Attendant Services	9/1/2015	Increase in attendant wage rate to $8.00 per hour	NA	NA	CR	1,347,276,317	583,042,129	9.33%	9.33%	135,318,889	59,208,636	14,500,559	6,344,704
Community Living Assistance and Support Services	8/1/2009	$0.80 per hour minimum wage rate increase	NA	NA	CR	505,402,856	218,798,804	4.92%	4.92%	26,571,542	10,547,574	5,400,720	2,143,816
Day Activity and Health Services - Title XIX Note 1	9/1/2015	Increase in attendant wage rate to $8.00 per hour	NA	NA	CR	17,317,947	7,493,256	1.73%	1.73%	224,650	98,300	129,848	56,817
Deaf-Blind Multiple Disabilities	6/15/2010	18% intervenors	NA	NA	B	23,596,844	10,219,361	7.89%	7.89%	2,079,172	875,852	263,520	111,007
Home and Community-based Services	9/1/2015	0.47% to 3.79% for SL,RSS and DH	NA	NA	CR	2,283,037,347	988,425,490	-2.34%	-2.34%	(59,336,494)	(25,660,067)	25,357,476	10,965,840
Home Delivered Meals - Title XX	9/1/2007	1.43%	NA	NA	PA	34,962,668	8,537,884	3.80%	3.80%	1,334,242	1,334,242	351,116	351,116
Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions	9/1/2015	2.02%	NA	NA	CR	533,133,556	230,678,068	9.06%	9.09%	52,811,630	23,107,727	5,818,635	2,545,944
Non-Medicaid Services - Title XX	9/1/2015	Increase in attendant wage rate to $8.00 per hour	NA	NA	CR	150,274,446	36,697,000	6.52%	6.52%	9,794,620	9,794,620	1,502,242	1,502,242
Nursing Facilities (FFS)													
Nursing Facility Care Note 1	9/1/2014	4.00% (6.00% total for 2014-15 biennium)	NA	NA	CR	599,326,453	259,321,944	12.27%	12.27%	92,042,317	40,273,122	7,500,989	3,282,059
NF Hospice Note 2	9/1/2014	4.00% (6.00% total for 2014-15 biennium)	NA	NA	CR	516,158,705	223,321,756	12.27%	12.27%	71,968,009	31,489,572	5,865,033	2,566,033
NF Therapies	NA	NA	NA	NA	CR	134,868	58,357	3.80%	3.80%	5,174	2,264	1,362	596
NF Ventilator	9/1/2014	4.00% (6.00% total for 2014-15 biennium)	NA	NA	CR	1,737,807	751,939	18.66%	18.66%	327,310	143,214	17,542	7,675
Total: Nursing Facilities										**164,342,810**	**71,908,172**	**13,384,926**	**5,856,572**

F1. Rate Schedule - Rate Change Based on Current Review of Costs

and Cost of One Percent Rate Change

KEY - A - Access based; CR - Cost Reports used for prospective rate - trend to FY 2018-19; B - Based on rates from other Medicaid progr; T - Trending from current rate to FY 2018-19; BR - Blue Ribbon file of claims data; M - Based on Medicare rates; CD - Percent of claims data; PA - Pro forma analysis

Program by Budget Agency	Last Legislative or Federal Rate Increase		Rate Reduction Since Last Rate Increase		Method of Determining Rate Change	Estimated 2016-2017 Biennial Cost		Percentage Rate Change to Fully Fund Methodology		Estimated 2018-19 Biennial Cost of Rate Change		Estimated 2018-19 Biennial Cost of One Percent Rate Change	
	Date	Percent	Date	Percent		AF	GR	2018	2019	AF	GR	AF	GR
PASSR Assessment Note 3	NA	NA	NA	NA	T	1,400,000	350,000	3.80%	3.80%	53,200	13,300	14,000	3,500
PASSR Specialized Services Notes 3 & 4	NA	NA	NA	NA	T	1,150,937	498,356	3.80%	3.80%	87,345	38,217	22,985	10,057
Primary Home Care Note 1	9/1/2015	Increase in base wage rate to $8.00 per hour	NA	NA	CR	29,339,707	12,700,142	9.28%	9.28%	3,085,244	1,349,944	332,498	145,484
Program of All-inclusive Care for the Elderly (PACE) Note 5	NA	NA	9/1/2015	Budgetary Reduction (7.2%)	PA	82,295,521	35,614,268	7.07%	7.07%	11,636,587	5,091,589	1,645,910	720,168
Service Coordination (ID)	6/1/2010	5.00%	NA	NA	CR	144,855,031	62,681,883	3.80%	3.80%	5,787,187	2,532,183	1,522,944	666,364
Texas Home Living Waiver	10/1/2009	39.49%	9/1/2013	Match HCS	B	236,155,424	102,155,550	5.03%	5.03%	9,929,558	3,963,383	1,974,068	787,949
Total DADS (with totals only included)										**363,720,182**	**164,203,672**	**46,863,971**	**21,245,740**
Comprehensive Rehabilitative Services (CRS) Note 1 & 2	9/1/2016	0.00%	NA	NA	PA	48,547,088	48,547,088	0.00%	0.00%	237,413	237,413	480,148	480,148
ECI - Case Management	3/15/2010	24.00%	NA	NA	CR	35,849,254	15,516,207	1.88%	3.54%	1,004,490	439,495	371,180	162,391
ECI - Specialized Skills Training	3/15/2010	5.71%	NA	NA	CR	66,301,636	28,696,834	1.88%	3.54%	1,859,372	813,532	687,076	300,596
Total DARS Legacy Programs										**3,101,275**	**1,490,440**	**1,538,404**	**943,135**

Note 1: The cost of the rate increase only includes the impact on services that will remain as fee-for-service under DADS. The corresponding impact on services delivered through managed care is included in the applicable STAR+PLUS programs.

Note 2: Nursing Facility Hospice rates are tied by federal law to 95% of NF rates - any changes to NF rates will impact Hospice Payments.

Note 3: PASRR Assessments and Specialized Services were effective 2/1/2013 therefore there have been no rate increases or reductions

Note 4: PASRR rates are tied to Medicaid therapy rates

Note 5: Only considers eliminating the budgetary reduction. No other growth, or provider rate increases included

Note 1: CRS moved from a provider specific contracted rate to a standard program wide rate methodology on September 1, 2016.

Note 2: All figures assume that 4% reduction has been restored.

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DFPS													
24-Hr. Residential Child Care (Foster Care) - Foster Family	9/1/2013	4.30%	NA	NA	CR	17,120,604	11,160,425	-4.51%	-3.40%	(1,354,087)	(447,882)	342,412	107,402
24-Hr. Residential Child Care (Foster Care) CPA													
Foster Family Pass Through	9/1/2013	4.30%	NA	NA	PA	114,953,598	75,392,649	22.75%	24.17%	53,935,860	38,125,679	2,299,072	1,645,037
Retainage	9/1/2015	Basic - 9.29% Moderate - 1.14% Specialized - 0.42% Intense - 0.01%	NA	NA	CR	107,651,789	77,802,072	8.83%	10.09%	20,368,796	13,222,453	2,153,036	1,394,675
Subtotal: 24-Hr. Residential Child Care CPA Pass Through/Retainage						222,605,387	153,194,721	Note 1 14.56%	Note 1 15.87%	74,304,656	51,348,132	4,452,108	3,019,247
24-Hr. Residential Child Care (Foster Care) - Residential Treatment Facility	9/1/2015	Specialized - 9.58% Intense - 0.30%	NA	NA	CR	120,958,341	95,286,168	20.99%	22.63%	52,759,107	42,013,691	2,419,166	1,926,169
24-Hr. Residential Child Care (Foster Care) - Emergency Shelter	9/1/2015	6.00%	NA	NA	CR	36,588,031	26,693,094	39.78%	43.19%	30,354,725	22,795,133	731,760	549,520
Total All 24-Hr. Residential Child Care (Foster Care) Note 7						**397,272,363**	**286,334,408**	**18.84%**	**20.45%**	**156,064,401**	**115,709,074**	**7,945,448**	**5,602,338**
Psychiatric Transition (Intensive Psychiatric Step Down)	NA	NA	NA	NA	PA	4,248,540	3,706,870	4.63%	5.83%	444,310	403,557	84,970	77,193
Supervised Independent Living	NA	NA	NA	NA	PA	2,086,560	1,507,956	Note 10 29.50%	Note 10 29.50%	1,231,119	888,121	41,732	30,106
Adoption Subsidies	9/1/2003	Basic PT	NA	NA	PA	15,717,320	8,004,397	35.97%	37.91%	43,045,887	18,817,616	1,165,957	509,691
Permanency Care Assistance (PCA)	10/1/2010	Basic PT	NA	NA	PA	1,560,201	1,011,749	45.03%	54.30%	4,670,248	977,105	94,581	19,683
Total DFPS (with totals only included)										**205,455,965**	**136,795,473**	**9,332,688**	**6,239,011**

Note 1: If TANF funding is available, up to $1,355,292 of this amount is eligible for TANF funding the remaining $1,458,618 must be GR.
Note 2: If TANF funding is available, up to $1,438,214 of this amount is eligible for TANF funding the remaining $1,470,795 must be GR.
Note 3: If TANF funding is available, up to $22,719 of this amount is eligible for TANF funding the remaining $16,339 must be GR.
Note 4: If TANF funding is available, up to $22,791 of this amount is eligible for TANF funding the remaining $15,999 must be GR.
Note 5: If TANF funding is available, up to $6,422 of this amount is eligible for TANF funding the remaining $8,627 must be GR.
Note 6: If TANF funding is available, up to $6,419 of this amount is eligible for TANF funding the remaining $8,629 must be GR.
Note 7 Includes Foster Care redesign costs
Adoption & PCA: In FY 2003, Adoption Tier 1 was 66% of monthly basic foster care passthrough rate and Tier 2 was 90%. PCA became effective October 1, 2010. The adopted rates mirror the adoption assistance rates.

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DSHS Legacy Programs													
Children with Special Health Care Needs (CSHCN) - Ambulance Services Notes 1 & 2	9/1/2009	2.50%	2/1/2011	2.00%	B	837,390	590,360	1.00%	1.00%	8,374	8,374	8,374	8,374
CSHCN - Drugs Biologicals Notes 1 & 2	10/1/2008	2.50%	2/1/2011	2.00%	B	21,914,122	15,449,456	1.00%	1.00%	219,141	219,142	219,142	219,142
CSHCN - Durable Medical Equipment, Prosthetics, Orthotics, Supplies Notes 1 & 2	Various 2008	2.50%	2/1/2011	2.00%	B	2,154,226	1,518,729	1.00%	1.00%	21,542	21,542	21,542	21,542
CSHCN - Nursing Notes 1 & 2	11/1/2002	2.50%	2/1/2011	2.00%	B	42,135	29,705	1.00%	1.00%	421	422	422	422
CSHCN - Physician & Professional Services - Total Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	B	7,168,680	5,053,919	1.00%	1.00%	71,687	71,686	71,686	71,686
CSHCN - Outpatient Hospital Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	B	8,263,261	5,825,599	1.00%	1.00%	82,633	82,632	82,632	82,632
Home and Community Based Services - Adult Mental Health Note 3	6/1/2016	New Service	NA	NA	B	39,291,105	19,872,419	3.80%	3.80%	60,300,054	30,731,923	15,868,436	8,087,348
Maternal and Child Health - Dental Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	B	5,745,922	520,938	1.00%	1.00%	57,459	57,460	57,460	57,460
Maternal and Child Health - Physician & Professional Services - Adults Notes 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	B	660,376	660,376	1.00%	1.00%	6,604	6,604	6,604	6,604
Maternal and Child Health - Physician & Professional Services - Children Note 1 & 2	9/1/2007	2.50%	2/1/2011	2.00%	B	2,472,256	0	1.00%	1.00%	24,723	24,722	24,722	24,722

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Mental Health (MH) Targeted Case Management - Adult Note 4	9/1/2004	New Service	NA	NA	CR	9,789,764	4,180,700	0.00%	0.00%	0	0	9,789,764	4,283,511
Mental Health (MH) Targeted Case Management - Children Note 4	9/1/2004	New Service	NA	NA	CR	5,749,544	2,455,332	0.00%	0.00%	0	0	5,749,544	2,515,713
MH Rehabilitative Services - Adult Note 4	9/1/2004	New Service	NA	NA	CR	30,660,836	13,083,726	0.00%	0.00%	0	0	30,660,836	13,415,649
MH Rehabilitative Services - Children Note 4	9/1/2004	New Service	NA	NA	CR	18,007,640	7,684,092	0.00%	0.00%	0	0	18,007,640	7,879,243
Substance Use Disorder (Indigent Services) Notes 1, 2 & 5	9/1/2016	Varied	NA	NA	CR	199,335,844	49,287,574	6.27%	6.27%	213,645,004	62,619,350	34,074,164	9,987,138
TEFRA Based Inpatient Hospital (Cost-Based) Notes 1 & 2	NA	NA	NA	NA	CR	4,846,320	3,416,655	1.00%	1.00%	48,463	48,464	48,464	48,464
Youth Empowerment Services (YES) Waiver Note 6	3/15/2016	Revised payment rates for Supported Employment and Employment Assistance from hourly rate to 15 minute rate.	NA	NA	B	34,598,130	14,409,085	3.30%	3.30%	57,284,792	25,064,960	17,359,028	7,595,442
Total DSHS Legacy Programs (with totals only included)										**331,770,897**	**118,957,281**	**132,050,460**	**54,305,092**

Note 1: Any increase in rates must be funded with GR to maintain level services since federal block grants will not be increased for rate increases

Note 2: "GR" for these programs is Fund 8003 GR Match for Maternal Child Health Block Grant or 8002 General Revenue for Substance Abuse Block Grant. Any reduction in general revenue may result in loss of federal block grants and elimination of this program. For Substance Abuse Disorder, there is not a required State Match but a required State Maintenance of Effort of State funding to be no less than prior two year average.

Note 3: Home and Community-based Services Adult Mental Health (HCBS-AMH) transferred to HHSC on 9/1/16. HCBS-AMH services beginning in SFY2017. The HCBS services include those for non-Medicaid clients and non-eligible services for Medicaid clients (Indigent) paid by 100% GR. Therefore FMAP is not a state Medicaid match percentage. This is the state portion of both State Match and Indigent services using a blended rate. HCBS is not fully implemented.

Note 4: Mental Health Targeted Case Management and Rehabilitative Services rates adjusted effective 9-1-2011 to reflect the change in reimbursement methodology eliminating cost settlement adjusted rates to reflect a statewide prospective in lieu of provider specific rate with cost settlement.

Note 5: Substance Use Disorder for indigent services transferred to HHSC on 9/1/16. Substance Use Disorder for indigent services has requested an Exceptional Item to maintain treatment capacity in FY18-19. Additionally, a rate increase is requested to bring remaining rates up to February 2015 Rate Study recommendations. This rate increase will need to be funded 100% with State Funds. The rate under FMAP is the projected percentage of SAPT Block Grant MOE (State) funding.

Note 6: YES Waiver Program transferred to HHSC on 9/1/16. YES Waiver program is not fully implemented. Assuming Waiver Modification proposed to add Case Management is approved in FY2017, then the current FY18-19 base appropropriation will not support Rate increase and Waiver Modification.

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	Date	Percent	Date	Percent		AF	GR	2018	2019	AF	GR	AF	GR
HHSC													
Ambulance Services (Air Transportation) Notes 1 & 2	9/1/2009	29.97%	2/1/2011	2.00%	M	73,884,120	31,975,834	3.80%	3.80%	3,055,669	1,336,130	803,597	351,613
Ambulance Services (Ground Transportation) Notes 1 & 2	9/1/2009	29.97%	2/1/2011	2.00%	M	240,157,385	103,936,172	3.80%	3.80%	9,966,720	4,360,927	2,622,821	1,147,613
Ambulatory Surgical Center/Hospital Ambulatory Surgical Center	9/1/2007	2.50%	9/1/2011	5.00%	M	34,157,053	14,782,612	39.00%	39.00%	136,754,159	59,836,728	3,506,517	1,534,275
Anesthesia - Adults	1/1/2010	9.23%	2/1/2011	2.00%	M	68,374,029	29,591,157	3.80%	3.80%	2,858,427	1,250,701	752,217	329,132
Anesthesia - Children	9/1/2007	21.58%	2/1/2011	2.00%	M	79,297,887	34,318,823	3.80%	3.80%	3,301,446	1,444,544	868,802	380,143
Anesthesia - Certified Registered Nurse Anesthetist - Adults	1/1/2010	9.23%	2/1/2011	2.00%	M	47,141,391	20,402,020	3.80%	3.80%	1,969,327	861,677	518,243	226,756
Anesthesia - Certified Registered Nurse Anesthetist - Children	9/1/2007	21.58%	2/1/2011	2.00%	M	40,982,655	17,736,620	3.80%	3.80%	1,707,644	747,178	449,380	196,626
Birthing Centers - Facility Services Note 3	7/1/2012	250.00%	9/1/2011	5.00%	A, CD	599,090	259,276	3.80%	3.80%	25,167	11,012	6,623	2,898
Birthing Centers - Professional Services Note 3	7/1/2012	250.00%	NA	NA	A, CD	450,328	194,895	10.81%	10.81%	53,976	23,618	4,993	2,184
Children & Pregnant Women - Case Management -Adults	9/1/2007	55.50%	2/1/2011	2.00%	B	90,750	39,275	3.80%	3.80%	3,612	1,580	951	417
Children & Pregnant Women - Case Management - Children	9/1/2007	55.50%	2/1/2011	2.00%	B	2,153,242	931,888	3.80%	3.80%	85,704	37,500	22,553	9,868
Children's Health Insurance Program (CHIP) (including perinate, excluding pharmacy costs)	9/1/2016	4.1% (9/1/16)	NA	NA	T	1,254,327,522	103,122,728	35.56%	45.09%	505,807,373	38,542,537	12,543,276	955,798
CHIP Dental	9/1/2016	8.4% Overall	NA	NA	T	220,451,668	18,073,497	3.80%	7.74%	12,720,061	969,269	2,204,516	167,984
Clinical Laboratory Fees (non-state owned)	4/1/2008	2.60%	9/1/2011	10.50%	M	721,935,911	317,044,891	7.00%	7.00%	51,659,760	22,603,708	7,379,965	3,229,101
Dental Services - Adults	9/1/2007	52.50%	2/1/2011	2.00%	A,CD	22,858,817	9,892,921	3.80%	3.80%	955,591	418,118	251,471	110,031
Dental Services - Children's	9/1/2007	52.50%	2/1/2011	2.00%	A,CD	2,411,411,792	1,043,619,420	3.80%	3.80%	101,371,444	44,354,943	26,676,695	11,672,353

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Durable Medical Equipment, Prosthetics, Orthotics, Supplies (DMEPOS)													
Diabetic Equipment and Supplies	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	12,561,795	5,436,539	3.80%	3.80%	525,987	230,145	138,417	60,564
Hearing Services	Various 2008	10.00%	9/1/2011	Reimbursement limited to lesser of provider's acquisition cost or fees determined by HHSC	A,CD,M	10,740,422	4,648,278	3.80%	3.80%	430,077	188,180	113,178	49,521
Hospital Beds and Accessories	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	10,828,331	4,686,324	3.80%	3.80%	446,144	195,209	117,407	51,371
Incontinence Supplies	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	261,962,385	113,373,018	8.51%	8.51%	23,692,286	10,366,544	2,784,052	1,218,160
Kidney Machines and Access	Various 2008	10.00%	9/1/2011	10.00%	A,CD	2,131,525	922,489	3.80%	3.80%	87,370	38,229	22,992	10,060
Miscellaneous DME Equipment and Supplies	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	168,951,906	73,119,610	3.80%	3.80%	6,919,183	3,027,482	1,820,837	796,706
Mobility Aids	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	10,604,300	4,589,367	8.04%	8.04%	915,219	400,453	113,833	49,808
Neurostimulators	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	1,180,331	510,828	3.80%	3.80%	49,730	21,759	13,087	5,727
Nutrition (Enteral and Parenteral)	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	282,340,510	122,192,336	3.80%	3.80%	11,383,711	4,980,936	2,995,714	1,310,773
Orthotics	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	33,773,351	14,616,552	14.88%	14.88%	5,391,829	2,359,190	362,354	158,547
Oxygen and Related Respiratory Equipment	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	82,511,705	35,709,711	3.80%	3.80%	3,377,535	1,477,837	888,825	388,905
Prosthetics	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	10,774,341	4,662,958	10.97%	10.97%	1,261,724	552,066	115,016	50,325
Speech Generating Devices Augmentive	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	2,294,710	993,113	7.89%	7.89%	191,895	83,963	24,321	10,642
Wheel Chairs	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	86,050,918	37,241,424	9.17%	9.17%	8,529,362	3,732,015	930,138	406,981
Wound Therapy	Various 2008	10.00%	9/1/2011	10.00%	A,CD,M	5,139,416	2,224,255	3.80%	3.80%	215,951	94,489	56,829	24,866
Vision	5/1/2016	6.50%	5/1/2016	10.00%	A,CD,M	60,281,289	26,088,752	7.56%	7.56%	4,985,565	2,181,428	659,466	288,549
Environmental Lead Investigations	7/1/2010	New Benefit	2/1/2011	2.00%	A	3,864	1,672	3.80%	3.80%	155	68	41	18

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Family Planning Clinics - Adults	9/1/2007	4.00%	9/1/2011	5.00%	A, M	3,773,714	1,633,201	11.28%	11.28%	468,681	205,071	41,549	18,180
Family Planning Clinics - Children	9/1/2007	10.06%	9/1/2011	5.00%	A, M	4,133,886	1,789,078	10.81%	10.81%	492,230	215,375	45,535	19,923
Federally Qualified Health Centers Notes 4 & 5	1/1/2016	Medicare Economic Index (MEI) (1.1%) or MEI+0.5%	1/1/2011	1.00%	T	439,975,422	190,376,761	1.00%	1.00%	4,555,455	1,993,237	4,555,455	1,993,237
Freestanding Psychiatric Hospitals (non-state owned)	1/1/2008	18.18%	9/1/2011	8.00%	T,M	214,394,424	92,766,931	24.00%	24.00%	51,838,815	22,682,053	2,159,951	945,085
Freestanding Psychiatric Hospitals -(state owned)	NA	NA	NA	NA	M	21,748,768	9,411,853	40.00%	40.00%	8,671,876	3,794,379	216,796	94,859
HHA- Home Health Aide Services	9/1/2007	2.50%	2/1/2011	2.00%	A,CD,M	152,709	66,090	3.80%	3.80%	6,418	2,808	1,689	739
HHA - Other Services (Supplies) - Adults	9/1/2007	2.50%	2/1/2011	2.00%	A,CD,M	47,275,516	20,460,067	3.80%	3.80%	1,989,194	870,369	523,472	229,044
HHA - Other Services (Supplies) - Children	9/1/2007	2.50%	2/1/2011	2.00%	A,CD,M	42,077,907	18,210,627	3.80%	3.80%	1,774,226	776,311	466,901	204,292
HHA - Skilled Nursing Services - Adults	9/1/2007	2.50%	2/1/2011	2.00%	A,CD,M	18,909,133	8,183,562	3.80%	3.80%	796,019	348,297	209,479	91,658
HHA - Skilled Nursing Services - Children	9/1/2007	2.50%	2/1/2011	2.00%	A,CD,M	4,366,201	1,889,504	3.80%	3.80%	180,119	78,811	47,400	20,740
Inpatient Hospital Note 6	9/1/2015	$312,514,064		NA	BR	7,069,891,391	3,059,046,407	55.00%	55.00%	4,013,239,053	1,755,991,155	72,967,983	31,927,112
Laboratory Services - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	188,893,856	81,750,159	11.28%	11.28%	23,298,466	10,194,218	2,065,467	903,743
Laboratory Services - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	103,622,886	44,846,283	10.81%	10.81%	12,261,402	5,364,963	1,134,265	496,296
Long-Acting Reversible Contraceptive (LARC), Sterilization, and Associated Services - Adults	9/1/2013	18.00%	NA	NA	CD	39,868,466	17,254,417	3.80%	3.80%	1,677,644	167,764	441,485	44,149
Long-Acting Reversible Contraceptive (LARC), Sterilization, and Associated Services - Children	9/1/2013	19.00%	NA	NA	CD	33,137,090	14,341,188	3.80%	3.80%	1,393,852	139,386	366,804	36,681

F1. Rate Schedule -- Rate Change Based on Current Review of Costs, continued

F1. Rate Schedule - Rate Change Based on Current Review of Costs and Cost of One Percent Rate Change

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Maternity Service Clinic	NA	NA	9/1/2011	7.00%	A,M	377,354	163,313	11.28%	11.28%	46,693	20,430	4,139	1,811
Medicare Advantage	NA	NA	1/1/2012	Decrease in payment rate from $25 to $10.	PA	21,863,160	9,461,517	416.20%	416.20%	90,994,472	39,814,631	218,632	95,662
Orthodontics - Adults	9/1/2007	52.50%	2/1/2011	2.00%	A,CD	229,294	99,235	3.80%	3.80%	9,602	4,202	2,527	1,106
Orthodontics - Children	9/1/2007	52.50%	2/1/2011	2.00%	A,CD	13,193,098	5,709,756	3.80%	3.80%	556,087	243,315	146,338	64,030
Outpatient Hospital Note 7	9/1/2015	$29,573,966		NA	CD	2,530,235,556	1,094,814,796	38.00%	43.00%	1,057,775,937	462,826,475	26,114,206	11,426,268
Outpatient Imaging Note 8	9/1/2015	$3,000,000		NA	M	385,522,808	166,812,957	13.00%	13.00%	52,066,994	22,781,893	4,005,153	1,752,453
Physician- Administered Drugs/Biological Fees (Nononcology) - Adults	10/1/2008	3.59%	2/1/2011	24.00%	A,M	31,080,879	13,451,294	11.28%	11.28%	3,875,799	1,695,851	343,600	150,342
Physician- Administered Drugs/Biological Fees (Nononcology) - Children	10/1/2008	3.59%	2/1/2011	24.00%	A,M	20,687,338	8,953,140	10.81%	10.81%	2,463,625	1,077,956	227,903	99,719
Physician And Other Practitioners - Adults	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	A, B, M,CD	1,383,207,068	598,629,302	11.28%	11.28%	171,657,648	75,108,595	15,217,877	6,658,563
Physician And Other Practitioners - Children	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	A, B, M,CD	2,363,338,979	1,022,814,296	10.81%	10.81%	280,680,462	122,811,402	25,964,890	11,360,907
Physician-Administered Oncology Drugs - Adults	10/1/2008	3.59%	2/1/2011	2.00%	A,M	119,747,504	51,824,753	3.80%	3.80%	4,931,339	2,157,711	1,297,726	567,819
Physician-Administered Oncology Drugs - Children	10/1/2008	3.59%	2/1/2011	2.00%	A,M	31,198,805	13,502,330	3.80%	3.80%	1,311,409	573,806	345,107	151,001
Physicians Vaccine Administration - Adults	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	A	7,628,391	3,301,442	11.28%	11.28%	954,157	417,490	84,589	37,012

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Physicians Vaccine Administration - Children	1/1/2013	ACA increase to Medicare for Evaluation and Management Services for two years	1/1/2015	ACA increases expire	A	100,940,641	43,685,452	10.81%	10.81%	12,059,601	5,276,662	1,115,597	488,128
Audiologist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	255,548	110,597	11.28%	11.28%	31,964	13,986	2,834	1,240
Audiologist - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	1,237,941	535,761	10.81%	10.81%	146,616	64,152	13,563	5,935
Certified Nurse Midwife - Adults	9/1/2007	27.50%	2/1/2011	2.00%	A,M	1,275,803	552,147	11.28%	11.28%	159,447	69,765	14,135	6,185
Certified Nurse Midwife - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	236,515	102,360	10.81%	10.81%	28,237	12,356	2,612	1,143
Chiropractors - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	420,367	181,928	11.28%	11.28%	52,342	22,902	4,640	2,030
Chiropractors - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	372,929	161,398	10.81%	10.81%	44,440	19,445	4,111	1,799
Geneticist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	2,053,753	888,831	11.28%	11.28%	256,981	112,441	22,782	9,968
Geneticist - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	1,669,780	722,653	10.81%	10.81%	196,887	86,148	18,213	7,969
Licensed Clinical Social Worker/CCP Social Worker - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	2,509,858	1,086,225	11.28%	11.28%	312,771	136,853	27,728	12,133
Licensed Clinical Social Worker/CCP Social Worker - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	12,578,384	5,443,718	10.81%	10.81%	1,496,028	654,586	138,393	60,554
Licensed Marriage and Family Therapist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	153,136	66,275	11.28%	11.28%	19,005	8,315	1,685	738
Licensed Marriage and Family Therapist - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	1,541,244	667,025	10.81%	10.81%	183,173	80,147	16,945	7,415
Licensed Professional Counselors - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	30,549,465	13,221,307	11.28%	11.28%	3,783,236	1,655,350	335,393	146,751
Licensed Professional Counselors - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	116,025,461	50,213,914	10.81%	10.81%	13,798,411	6,037,478	1,276,449	558,508
Nephrology - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	78,105,928	33,802,963	11.28%	11.28%	9,758,638	4,269,880	865,128	378,535
Nephrology - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	270,662	117,138	10.81%	10.81%	31,434	13,754	2,908	1,273
Optometrist/Optician - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	26,216,012	11,345,859	11.28%	11.28%	3,222,397	1,409,956	285,674	124,996
Optometrist/Optician - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	108,179,222	46,818,191	10.81%	10.81%	12,858,704	5,626,310	1,189,519	520,473
Physician Assistants and Nurse Practitioners - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	6,891,815	2,982,664	11.28%	11.28%	856,956	374,960	75,971	33,241
Physician Assistants and Nurse Practitioners - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	40,606,844	17,573,975	10.81%	10.81%	4,846,808	2,120,715	448,363	196,181

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Podiatrist - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	6,722,052	2,909,194	11.28%	11.28%	837,005	366,230	74,202	32,467
Podiatrist - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	7,113,692	3,078,689	10.81%	10.81%	848,367	371,202	78,480	34,339
Psychologists - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	3,223,563	1,395,105	11.28%	11.28%	401,111	175,505	35,560	15,559
Psychologists - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	28,181,369	12,196,434	10.81%	10.81%	3,355,332	1,468,121	310,391	135,811
Licensed Psychological Associate - Adults	NA	NA	NA	NA	A,M	27,927	12,086	11.28%	11.28%	3,492	1,527	310	136
Licensed Psychological Associate - Children	NA	NA	NA	NA	A,M	1,413,864	611,897	10.81%	10.81%	168,867	73,888	15,621	6,835
Portable X-ray Supplier - Adults	9/1/2007	12.50%	2/1/2011	2.00%	A,M	19,213,817	8,315,424	11.28%	11.28%	2,379,730	1,041,249	210,969	92,309
Portable X-ray Supplier - Children	9/1/2007	27.50%	2/1/2011	2.00%	A,M	13,564,504	5,870,495	10.81%	10.81%	1,611,054	704,915	149,084	65,210
Provisionally Licensed Psychologist - Adults	NA	NA	NA	NA	A,M	17,161	7,427	11.28%	11.28%	2,120	927	188	82
Provisionally Licensed Psychologist - Children	NA	NA	NA	NA	A,M	179,815	77,821	10.81%	10.81%	21,343	9,338	1,975	864
Radiation Therapy Centers - Adults	NA	NA	2/1/2011	2.00%	A,M	818,775	354,352	11.28%	11.28%	99,864	43,696	8,853	3,874
Radiation Therapy Centers - Children	NA	NA	2/1/2011	2.00%	A,M	1,228,217	531,552	10.81%	10.81%	144,615	63,276	13,378	5,853
Renal Dialysis Facilities	9/1/2007	2.50%	9/1/2011	5.00%	CD	62,119,190	26,878,528	5.00%	5.00%	2,993,131	1,309,643	598,627	261,929
Rural Health Clinics Note 9	1/1/2016	Medicare Economic Index (MEI) (1.1%)	NA	NA	T	206,860,815	89,540,421	1.00%	1.00%	2,489,791	1,089,402	2,489,791	1,089,402
STAR KIDS Long Term Care - Medically Dependent Children Program Note 10	NA	NA	NA	NA	PA	199,198,167	86,205,139	17.74%	17.74%	35,337,755	15,462,035	1,991,982	871,592
STAR+PLUS Long Term Care - Community Based Alternatives Notes 10 & 11	9/1/2015	Increase of 1.28% for Attendant wage increases	NA	NA	PA	2,398,482,134	954,041,624	21.74%	28.43%	601,705,075	243,274,517	23,984,822	9,697,430
STAR+PLUS Long Term Care - Day Activity and Health Services Notes 10 & 11	9/1/2014	Increase in attendant base wage rate to $7.86 per hour	NA	NA	PA	314,036,074	133,485,470	9.45%	15.47%	39,129,270	16,853,617	3,140,360	1,352,643

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STAR+PLUS Long Term Care -- Nursing Facility Notes 10 & 11	9/1/2014	4.00% (also 2.00% eff. 9/1/2013; 6.00% total for 14-15 biennium)	NA	NA	PA	5,000,766,848	2,164,135,380	15.36%	18.82%	854,631,054	373,939,492	50,007,668	21,880,855
STAR+PLUS Long Term Care - Primary Home Care Notes 10 & 11	9/1/2015	Increase of 1.28% for Attendant wage increases	NA	NA	PA	2,928,682,240	1,244,877,764	19.77%	26.36%	675,561,058	290,978,611	29,286,822	12,614,674
Substance Use Disorder Services (Chemical Dependency Treatment Facility)	9/1/2013	19.00%	NA	NA	A, B, CD	36,083,752	15,616,455	3.80%	3.80%	1,510,799	661,048	397,578	173,960
TEFRA Based Inpatient Hospital (Cost-Based)	NA	NA	NA	NA	CB	337,620,637	146,086,031	3.00%	7.00%	17,322,301	7,579,070	3,548,521	1,552,666
Texas Women's Health Program (GR ONLY)	9/1/2007	22.50%	2/1/2011	2.00%	A,CD,M	42,724,462	18,490,445	3.80%	3.80%	1,700,542	1,700,542	447,511	447,511
Therapy Services - Comprehensive Outpatient Rehabilitation Facility (CORF) / Outpatient Rehabilitation Facility (ORF) (PT 65, PS25) - Children	1/1/2006	NA	9/1/2013	2.5% NOTE: Significant reductions for the 2016-17 biennium were pending at the time of publication	A,M	336,896,263	145,803,170	0.00%	0.00%	0	0	3,621,999	1,584,802
Therapy Services - Home Health Agency - Adults	1/1/2006	NA	9/1/2013	1.5% NOTE: Significant reductions for the 2016-17 biennium were pending at the time of publication	A,M	4,830,957	2,090,759	0.00%	0.00%	0	0	53,539	23,426

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Therapy Services - Home Health Agency - Children	1/1/2006	NA	9/1/2013	1.5% NOTE: Significant reductions for the 2016-17 biennium were pending from implementation at the time of publication	A,M	871,757,924	377,282,512	0.00%	0.00%	0	0	9,373,398	4,101,323
Therapy Services - Independent Therapists (PT 34, 35, 50) - Adults	1/1/2006	NA	9/1/2013	4.00% - office setting 1.50% - home setting NOTE: Significant reductions for the 2016-17 biennium were enjoined from implementation at the time of publication	A,M	12,947,798	5,603,594	0.00%	0.00%	0	0	143,339	62,718
Therapy Services - Independent Therapists (PT 34, 35, 50) - Children	1/1/2006	NA	9/1/2013	4.00% - office setting 1.50% - home setting NOTE: Significant reductions for the 2016-17 biennium were enjoined from implementation at the time of publication	A,M	237,671,473	102,860,310	0.00%	0.00%	0	0	2,558,161	1,119,321

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Therapy Services - Independent Therapists (Early Childhood Intervention) - Children	1/1/2006	NA	9/1/2013	1.5% NOTE: Significant reductions for the 2016-17 biennium were enjoined from implementation at the time of publication	A,M	61,397,087	26,571,651	0.00%	0.00%	0		670,437	293,349
THSteps Medical Checkups	9/1/2007	27.50%	2/1/2011	2.00%	A,M	241,761,055	104,630,214	10.81%	10.81%	28,611,389	12,518,881	2,646,752	1,158,084
THSteps Newborn	9/1/2007	27.50%	2/1/2011	2.00%	A,M	271,249,461	117,392,312	10.81%	10.81%	31,965,685	13,986,551	2,957,048	1,293,854
THSteps Other Services (Managed Care only)	NA	NA	2/1/2011	2.00%		570,370,546	246,847,005	3.80%	3.80%	24,046,331	10,521,440	6,327,981	2,768,799
THSteps Personal Care Services and Attendant Care	8/1/2009	7.00%	9/1/2010	1.00%	B	241,857,970	104,672,157	3.80%	3.80%	9,655,490	4,224,755	2,540,918	1,111,778
THSteps Private Duty Nursing	7/1/2008	15.00%	2/1/2011	2.00%	B	1,284,969,416	556,113,660	3.80%	3.80%	51,479,397	22,524,784	13,547,210	5,927,575
Tuberculosis Clinics	NA	NA	9/1/2011	5.00%	A,M	380,012	164,463	11.28%	11.28%	46,333	20,273	4,108	1,797
Total HHSC (with totals only included)										**9,142,868,074**	**3,788,118,812**	**396,086,221**	**166,938,768**
Note 1: Basic and Advanced Life Support Costs were allocated between air and ground ambulance based on number of clients served.													
Note 2: Effective September 1, 2013, Ambulance Services were fully exempted from Medicare equalization which increased revenues received for dually-eligible consumers.													
Note 3: Rural Health Centers are exempt from rate changes because they have federally mandated Medical Economic Inflators (MEI) provided annually. Estimates are based on 1 percent increase in reimbursement.													
Note 4: Federally Qualified Health Center Rate increases are limited to MEI plus .5 percent, they have federally mandated Medical Economic Inflators provided annually. Estimates are based on 1 percent increase in reimbursement.													
Note 5: Recently, some Federally Qualified Health Centers (FQHCs) have acquired physician practices and retained their client base. This activity may cause FQHC costs to increase over the next biennium as FQHC rates are significantly higher than physician reimbursement. HHSC does not have a way of predicting how many clients will be moved to the FQHC client base, and therefore it is difficult.													
Note 6: Last rate of increase percentage column for Inpatient Hospitals reflects actual dollars appropriated by the 84th legislature Trauma designated and Safety Net Hospitals.													
Note 7: Last rate of increase percentage column for Outpatient Hospitals reflects actual dollars appropriated by the 84th legislature for rural hospital outpatient reimbursement increases.													
Note 8: Last rate of increase percentage column for Outpatient Hospital Imagings reflects actual dollars appropriated by the 84th legislature for rural hospital outpatient reimbursement increases.													
Note 9: Rural Health Centers are exempt from rate changes because they have federally mandated Medical Economic Inflators provided annually													
Note 10: Reflects the impact of potential DADS fee-for-service rate increases on corresponding services delivered through managed care.													
Note 11: Costs for the Duals Demonstration program are included in the STAR+Plus costs.													
Total HHS										**10,046,916,393**	**4,209,565,678**	**585,871,744**	**249,671,746**

F2. Rate Schedule -- Attendant Wages per Hour Assumed in FY 2017 DADS and HHSC Payment Rates

Attendant Wages per Hour Assumed in FY 2017 DADS and HHSC Payment Rates

Program	Minimum Attendant Wages per Hour Assumed in FY 2017 Rates	Percent Payroll Taxes and Benefits Assumed in FY 2017 Rates	Total Attendant Compensation Assumed in FY 2017 Rates	Attendant hours per Unit of Service	Maximum Attendant Wages per Hour Assumed in FY 2017 Rates Assuming Full Participation in Enhancement Program	Per Unit Cost of Increasing Rate to support $1.00 per hour increase in attendant wages	Cost of Increasing Attendant Wages by $1.00 per Hour Plus Associated Payroll Taxes and Benefits				
							FY 2018			FY 2019	
							AF	GR	GR	AF	GR
Community Based Alternatives (CBA)	$8.00	10.25%	$8.82	1.00	9.75	$1.10	$0	$0	$0	$0	$0
Medically Dependent Children Program (Not eligible for CFC)	$8.00	10.25%	$8.82	1.00	8.00	$1.10	$5,855,507	$2,562,369.78	$2,561,784	$5,855,507	$2,561,784
CBA Assisted Living / Residential Care (Not eligible for CFC)	$8.11	10.25%	$8.94	1.37	9.39	$1.51	$0	$0	$0	$0	$0
Residential Care (Not eligible for CFC)	$8.00	10.25%	$8.82	1.02	9.72	$1.12	$137,491	$137,491	$137,491	$137,491	$137,491
Primary Home Care (PHC) Nonpriority (Not eligible for CFC)	$8.00	10.25%	$8.82	1.00	9.75	$1.10	$1,368,162	$598,708	$633,353	$1,447,665	$633,353
PHC Priority (Not eligible for CFC)	$8.02	10.25%	$8.84	1.00	9.77	$1.10	$14,099	$6,170	$6,527	$14,918	$6,527
Community Attendant Services (Not eligible for CFC)	$8.00	10.25%	$8.82	1.00	9.75	$1.10	$61,065,029	$26,722,057	$27,870,949	$63,705,026	$27,870,949
Family Care (Not eligible for CFC)	$8.00	10.25%	$8.82	1.00	9.75	$1.10	$3,639,398	$3,639,398	$3,639,398	$3,639,398	$3,639,398
Client Managed Personal Attendant Services (Not eligible for CFC)	$8.00	10.25%	$8.82	1.00	8.00	$1.10	$557,049	$557,049	$557,049	$557,049	$557,049
Day Activity and Health Services (DAHS) - Title XIX Medicaid (Not eligible for CFC)	$8.00	10.25%	$8.82	0.38	12.66	$0.41	$234,942	$102,811	$106,227	$242,804	$106,227
DAHS - Title XX (Not eligible for CFC)	$8.00	10.25%	$8.82	0.38	12.66	$0.41	$493,445	$493,445	$493,445	$493,445	$493,445
Community Living Assistance and Support Services	$9.25	10.25%	$10.20	1.00	11.00	$1.10	$15,126,932	$5,788,169	$5,786,656	$15,126,932	$5,786,656
Deaf Blind Multiple Disabilities Waiver	$9.25	10.25%	$10.20	1.00	11.00	$1.10	$271,192	$104,192	$104,165	$271,192	$104,165
Home and Community-based Services Residential Direct Service Worker (Not eligible for CFC)	$8.76	16.29%	$10.19	7.01	8.94	$8.15	$26,593,866	$11,637,476	$11,634,816	$26,593,866	$11,634,816
Home and Community-based Services Supported Home Living	$10.11	16.29%	$11.76	1.00	11.36	$1.16	$5,165,463	$1,955,438	$1,954,921	$5,165,463	$1,954,921
Texas Home Living Community Support Services	$10.11	16.29%	$11.76	1.00	11.36	$1.16	$3,539,832	$1,346,198	$1,345,844	$3,539,832	$1,345,844
Subtotal DADS							**$124,062,406**	**$55,650,970**	**$56,832,626**	**$126,790,587**	**$56,832,626**
Texas Health Steps (TxHSteps) - Personal Care Services	$8.00	10.25%	$8.82	0.25	8.00	$0.28	$5,053,384	$2,108,272	$2,201,562	$5,278,260	$2,201,562
TxHSteps - Behavioral Personal Care Services	$9.16	10.25%	$10.10	0.25	9.16	$0.28	$5,971,179	$2,455,349	$2,563,988	$6,236,896	$2,563,988
Subtotal HHSC non-STARPLUS							**$11,024,563**	**$4,563,620**	**$4,765,550**	**$11,515,156**	**$4,765,550**
STARPLUS CBA AL (including 1.75% Managed Care State Premium Tax, 2.00% Risk Margin, 5.75% Admin) (Not eligible for CFC)	$8.11	10.25%	$8.94	1.37	9.39	$1.51	$1,905,860	$834,004	$900,519	$2,058,328	$900,519
STARPLUS DAHS (including 1.75% Managed Care State Premium Tax, 2.00% Risk Margin, 5.75% Admin) (Not eligible for CFC)	$8.00	10.25%	$8.82	0.38	12.66	$0.41	$5,519,606	$2,415,379	$2,608,014	$5,961,174	$2,608,014
STARPLUS CBA attendant (including 1.75% Managed Care State Premium Tax, 2.00% Risk Margin, 5.75% Admin.)	$8.00	10.25%	$8.82	1.00	9.75	$1.10	$84,719,409	$36,702,651	$39,629,713	$91,496,962	$39,629,713
STARPLUS Attendant (including 1.75% Managed Care State Premium Tax, 2.00% Risk Margin, 5.75% Admin)	$8.00	10.25%	$8.82	1.00	9.75	$1.10	$150,612,283	$65,249,157	$70,452,824	$162,661,266	$70,452,824
STARPLUS Subtotal							**$242,757,158**	**$105,201,192**	**$113,591,069**	**$262,177,731**	**$113,591,069**
Subtotal HHSC							**$253,781,721**	**$109,764,812**	**$118,356,620**	**$273,692,887**	**$118,356,620**
HHSC and DADS Total							**$377,844,127**	**$165,415,782**	**$175,189,246**	**$400,483,474**	**$175,189,246**

G. Promoting Independence

The *Promoting Independence Initiative (Initiative)* is the direct result of four public policy actions:

- The United States Supreme Court ruling, *Olmstead v. L.C.*, June 1999, which stated in part…"that individuals living in institutions must be provided community care when the following conditions are met:
    - State's treatment professionals determine that such placement is appropriate;
    - Affected persons do not oppose such treatment; and
    - Placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services…."

- Governor Bush's Executive Order GWB 99-2, September 1999, which began the Texas Initiative by requiring the Health and Human Services Commission (HHSC) to conduct a comprehensive review of all services and support systems available to people with disabilities in Texas ensuring the involvement of consumers, advocates, providers, and relevant agency representatives in this review. Executive Order GWB 99-2 also required that a report of these findings be submitted to the Governor, the Lieutenant Governor and the Speaker of House by January 2001; this report became the first *Promoting Independence Plan (Plan)*. The Plan and Initiative includes specific requirements to provide community options for persons within the *Olmstead* population who are served in large (fourteen or more bed) community Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), state supported living centers (SSLCs), state mental health facilities (state hospitals) and nursing facilities (NFs) who are appropriate for and choose community alternatives.

- Texas statutes enacted in 2001 which codified many of the aspects of the original Plan and appropriations language which created the "Money Follows the Person" (MFP) policy whereby the funding for individuals moving from nursing facilities to community-based services could be transferred from the nursing facility budget to the community-based services budget. MFP allows individuals to be able to choose how and where they are to receive their long-term services and supports (LTSS).
    - State's treatment professionals
    - S.B. 367 established the Promoting Independence Advisory Committee, and requires updated Plans every two years prior to a new legislative session.
    - S. B. 368 impacts children (0-21 years of age) by emphasizing and providing direction to HHSC and all health and human services agencies regarding the implementation of permanency planning efforts.

- Governor Perry's Executive Order RP-13, April 2002, which enhances the Initiative and directs HHSC to continue its development and implementation of the state's Promoting Independence Initiative and Plan, including revising it on a regular basis. Additionally, Executive Order RP-13 highlights the need for housing, a viable direct service workforce, and permanency planning efforts.

In 2007, HHSC and DADS successfully competed for a Deficit Reduction Act of 2005 MFP Demonstration (Demonstration) grant award to build upon and enhance its existing Promoting Independence initiatives. The Demonstration allowed Texas to expand its Promoting Independence efforts beyond nursing facilities to include community ICF/IIDs with nine beds or more, and SSLCs. The state receives enhanced funding for 365 days that a Demonstration participant receives services in the community. As of December 2015, 10,456 individuals enrolled in the Demonstration transitioned from an institutional setting to the community.

Congressional authorization for the Demonstration ended September 30, 2016. The Centers for Medicare and Medicaid Services (CMS) awarded a supplemental grant for states to implement sustainability strategies. Supplemental funds allocated by Congress were less than previously expected. The state will close-out activities one year earlier than expected. Transitions from institutional services to home and community- based services will continue as they did before the state received the Demonstration grant. The state will no longer collect the enhanced match for individuals who transition after August 31, 2017. MFPD funded projects will conclude no later than the end of state fiscal year 2019.

The Demonstration funds direct services to support individuals as they transition from institutional services to services in the community. Services funded by the Demonstration include:

- Bexar and Travis Counties behavioral health pilot programs: Pilot and evaluation of cognitive adaptation services and substance abuse services for individuals transitioning from nursing facilities with co-occurring behavioral health needs in Bexar County, its contiguous counties, and Travis County. *Sustainability:* These pilot services will be offered statewide through managed care.
- Relocation assistance: Services and one-time funds to purchase household goods to assist in the transition from an institution to the community. *Sustainability:* Relocation activities for those exiting nursing facilities will be absorbed by the managed care organizations. HHSC Exceptional Item #14, Provide Transition to Community Services, seeks funding for additional transition support in the Home and Community-based Services (HCS) program.

Below are several MFPD projects designed to enhance the infrastructure of community based services:

- Long Term Care Ombudsman: Financial assistance to local Long Term Care Ombudsman program staff to assist nursing facility residents who want to learn more about community-based alternatives. *Sustainability:* This function will be absorbed by existing staff.
- A customized employment project: Pilot project for providers who want to assist individuals receiving services in an ICF/IID or an ICF/IID waiver program, to achieve independence through integrated employment at local businesses. *Sustainability:* This project ends 12/31/16.
- Housing specialists at the Texas Department of Housing and Community Affairs (TDHCA) to ensure the success of the Section 811 Project Rental Assistance (PRA)

Program, a new program with the potential to have a large impact on Texas' institutionalized populations, and Project Access, an existing program with a proven track record facilitating the transition of individuals out of institutions. *Sustainability:* This function will be absorbed by TDHCA.

- Transition specialists housed at each SSLC to improve the quality of the relocation process. *Sustainability:* This function will be absorbed by existing staff.
- Establishment of a Quality Reporting Office to provide additional in-house capabilities to monitor, discover, describe and create intervention strategies to promote quality across Demonstration activities and Medicaid 1915(c) waivers. *Sustainability:* This function, currently conducted by contractors, is planned to be converted to staff positions by 2019.
- Provision of enhanced, better-coordinated services for individuals with intellectual and developmental disabilities (IDD) and complex medical/behavioral health needs that are being relocated from institutional settings, including SSLCs and NFs. *Sustainability*: See HHSC Exceptional Item #7, Funding to Sustain Enhanced Community Coordination Services and Transition Support Teams, described below.

The Promoting Independence Initiative and MFPD have been very successful in shaping LTSS public policy since 2001 by providing increased community opportunities for over 44,000 individuals in NF, SSLCs, and large and medium community ICFs/IID who have transitioned to the community.

HHSC oversees the Promoting Independence Initiative and the Demonstration.

HHSC included in the 2018-2019 biennium Legislative Appropriations Request the following three Promoting Independence related exceptional items:

Exceptional Item # 7, Funding to Sustain Enhanced Community Coordination Services and Transition Support Teams. This item includes funding for Strategy Intake Access and Eligibility to Services and Supports. Originally funded by MFP grants, this item maintains an enhanced array of services and supports to help LIDDAs and community providers successfully transition individuals into community settings. The item includes: service coordination for residents of nursing facilities who take longer than 180 days to transition to the community, pre and post move monitoring, and flexible spending support for one time purchases needed to move to the community.

($ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	$6.5	$6.5	$13.0
All Funds	$6.5	$6.5	$13.0

Exceptional Item #14 Provide Transition to Community Services (formerly Promoting Independence slots). Funding under this exceptional item is linked to five HHSC strategies: Aged and Medicare Eligibility Group, Nursing Facility Payments, HCS, Health Care Facilities and Community-based Regulations, Intake, Access and Eligibility to Community Supports. The

exceptional item would provide approximately 500 HCS slots for residents of SSLCs and large ICFs/IID distributed as 400 slots for residents of SSLCs and 100 slots for large and medium ICF/IIDs, 236 HCS slots for Department of Family and Protective Services (DFPS) children aging out of foster care, 400 HCS crisis slots for persons at imminent risk of institutionalization, 120 HCS slots for the movement of individuals with IDD from Texas State Hospitals, 40 HCS slots for DFPS children transitioning from general residence operations facilities, 700 slots for individuals with IDD moving from NFs, 600 HCS slots for individuals with IDD diverted from nursing facility placement, and 550 Medically Dependent Children Program (MDCP) slots for children diverted from nursing facility placement.

($ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	$13.1	$37.2	$50.3
All Funds	$29.8	$84.7	$114.5

Exceptional Item #15 Reducing Community Programs Interest List (formerly Community Expansion). This item continues HHSC's efforts to increase services for community programs that maintain interest lists. This request would provide an additional 19,010 slots for community services formerly administered by DADS, including HCS, MDCP, Texas Home Living (TxHmL), Community Living Assistance and Supports Services (CLASS), Deaf- Blind with Multiple Disabilities (DBMD) and Title XX individuals. The request includes funding for acute care, drug and administrative costs at HHSC, as well as long term care and administrative costs at HHSC.

($ in Millions)	FY 2018	FY 2019	Biennium
General Revenue	$86.0	$260.3	$346.4
All Funds	$199.4	$603.9	$803.3

H. History of Major HHS Agencies Savings Initiatives ($ in millions)

FY 2002 - 2003	GR	FTEs
78th Legislature, HB 7 – FY 2003 Reduction Plan	$133.9	39
77th Legislature, Business Process Study – Rider Reduction	$10.0	19
77th Legislature, Medicaid Cost Containment – Rider Reduction	$205.0	-
Subtotal	**$348.9**	**58**

FY 2004 - 2005	GR	FTEs
78th Legislature – Initial GR Reduction	$320.4	664
78th Legislature – Program Savings Included in General Appropriations Act		
Maintain 6 months continuous eligibility in Medicaid	*$282.4*	-
CHIP Policy Changes	*$144.5*	-
Preferred Drug List	*$140.0*	-
Client Transportation Transfer	*$104.3*	-
Medicaid Benefit Changes	*$43.1*	-
TANF Pay for Performance	*$29.1*	-
Other Initiatives	*$89.0*	-
Subtotal – Program Savings	$832.4	-
78th Legislature – HB 2292 Reductions		
Consolidation of Agencies / Administrative Reductions	*$50.4*	*671*
Programmatic Savings Reduced in Agency Budgets	*$27.6*	*1,115*
Subtotal – HB 2292 Reductions	$78.0	1,786
78th Legislature – Additional Savings Identified by HHS Agencies	$83.8	-
Subtotal	**$1,314.6**	**2,450**

FY 2006 - 2007	GR	FTEs
79th Legislature – Rider Reduction for Services to Medicaid Aged / Blind / Disabled populations	$73.0	-
79th Legislature – Rider Reduction for Multi-State Drug Purchasing Pool	$17.6	-
79th Legislature – DSHS Reductions	$6.7	52
79th Legislature – 2% FTE Reductions	-	720
Subtotal	**$97.3**	**772**

FY 2010 - 2011	GR	FTEs
81st Legislature – Rider 59 Medicaid Cost Savings	$76.5	
Governor, Lieutenant Governor, and Speaker 5% Directive FY10-11	$205.0	
Governor, Lieutenant Governor, and Speaker 2.5% Directive FY11	$85.0	
Subtotal	**$366.5**	

FY 2012 - 2013	GR	FTEs
Medicaid Funding Reductions- Rider 61	$355.0	
Managed Care Expansion- Rider 51	$263.3	187
Provider Rates- Section 16	$486.6	
Additional Cost Containment- Section 17	$576.0	
Other Cost Containment Measures in HB1	$80.6	
Premium Tax (state revenue)	$200.0	
Federal Flexibility-Rider 59	$0.0	
Subtotal	**$1,961.5**	**187**

FY 2014 - 2015	*GR*	*FTEs*
HHSC Rider 51: Medicaid Funding Reduction and Cost Containment	$438.1	
Subtotal	**$438.1**	

FY 2016 - 2017	*GR*	*FTEs*
HHSC Rider 50: Medicaid Cost Containment Initiatives	$137.2	
Subtotal	**$137.2**	

Total GR Savings: FY 2002 - 2017	**$4,664.1**	**3,467**

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