3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Dorothy Sinclair	Date: August 18, 2014	Request Level: Base

Current Rider Number	Page Number in GAA 2014-2015	Proposed Rider Language
HHSC 1	II-84	**Performance Measure Targets.** The following is a listing of the key performance target levels for the Health and Human Services Commission. It is the intent of the Legislature that appropriations made by this Act be utilized in the most efficient and effective manner possible to achieve the intended mission of the Health and Human Services Commission. In order to achieve the objectives and service standards established by this Act, the Health and Human Services Commission shall make every effort to attain the following designated key performance target levels associated with each item of appropriation.

	2014	2015
A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY		
Outcome (Results/Impact):		
Average Medicaid and CHIP Children Recipient Months Per Month	3,327,728	3,430,172
A.1.2 Strategy: INTEGRATED ELIGIBILITY AND ENROLLMENT (IEE)		
Output (Volume):		
Average Monthly Number of Eligibility Determinations	900,191	919,629
Efficiencies:		
Average Cost Per Eligibility Determination	48.04	47.03
Explanatory:		
Total Value of SNAP Benefits Distributed	5,451,902,214	5,799,546,090
B. Goal: MEDICAID		
Outcome (Results/Impact):		
Average Medicaid Acute Care Recipient Months Per Month	3,860,020	4,193,348
Average Medicaid Acute Care (including Drug) Cost Per Recipient Month	343.47	335.93
Proportion of Medicaid Acute Care Recipient Months Enrolled in Managed Care:	82.00%	82.23%
Average Number of Members Receiving 1915(c) Waiver Services through STAR+PLUS	35,640	36,571
B.1.1 Strategy: AGED AND MEDICARE-RELATED		
Output (Volume):		
Average Aged and Medicare-Related Recipient Months Per Month	368,864	373,888
Average Aged and Medicare-Related Recipient Months Per Month: STAR+PLUS	226,228	229,421
B.1.2 Strategy: DISABILITY-RELATED		
Output (Volume):		
Average Disability-Related Recipient Months Per Month	439,823	456,117

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		~~Average Disability-Related Recipient Months Per Month: STAR+PLUS~~	~~189,823~~	~~196,856~~
		~~**B.1.3 Strategy:** PREGNANT WOMEN~~		
		~~**Output (Volume):**~~		
		~~Average Pregnant Women Recipient Months Per Month~~	~~129,465~~	~~130,560~~
		~~**Efficiencies:**~~		
		~~Average Pregnant Women Cost Per Recipient Month~~	~~677.05~~	~~682.47~~
		~~**B.1.4 Strategy:** OTHER ADULTS~~		
		~~**Output (Volume):**~~		
		~~Average TANF-Level Adult Recipient Months Per Month~~	~~131,602~~	~~139,691~~
		~~**Efficiencies:**~~		
		~~Average TANF-Level Adult Cost Per Recipient Month~~	~~404.28~~	~~412.11~~
		~~**B.1.5 Strategy:** CHILDREN~~		
		~~**Output (Volume):**~~		
		~~Average Poverty-Related Children Recipient Months Per Month~~	~~2,760,792~~	~~3,036,440~~
		~~Average Number of Qualified Alien Recipient Months per Month~~	~~17,975~~	~~18,064~~
		~~Average STAR Health Foster Care Children Recipient Months Per Month~~	~~29,652~~	~~29,652~~
		~~**Efficiencies:**~~		
		~~Average Poverty-Related Children Cost Per Recipient Month~~	~~169.44~~	~~160.65~~
		~~Average STAR Health Foster Care Children Cost Per Recipient Month~~	~~806.13~~	~~822.12~~
		~~**B.2.1 Strategy:** NON-FULL BENEFIT PAYMENTS~~		
		~~**Output (Volume):**~~		
		~~Average Number of Non-citizen Recipient Months Per Month~~	~~10,453~~	~~10,809~~
		~~**B.2.2 Strategy:** MEDICAID PRESCRIPTION DRUGS~~		
		~~**Output (Volume):**~~		
		~~Total Medicaid Prescriptions Incurred~~	~~38,657,575~~	~~40,828,388~~
		~~**Efficiencies:**~~		
		~~Average Cost Per Medicaid Prescription~~	~~83.76~~	~~87.91~~
		~~**B.2.3 Strategy:** MEDICAL TRANSPORTATION~~		
		~~**Output (Volume):**~~		
		~~Average Nonemergency Transportation (NEMT) Recipient Months Per Month~~	~~1,817,003~~	~~1,973,908~~

3.B. Rider Revisions and Additions Request

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~~**Efficiencies:**~~

~~Average Cost Per One-Way Medical Transportation Trip~~	~~24.43~~	~~24.60~~
~~Average Nonemergency Transportation (NEMT) Cost Per Recipient Month~~	~~3.33~~	~~3.49~~

~~**B.2.4 Strategy:** HEALTH STEPS (EPSDT) DENTAL~~

~~**Efficiencies:**~~

~~Average Cost Per Texas Health Steps (EPSDT) Dental Recipient Months Per Month~~	~~40.16~~	~~42.28~~

~~**B.2.5 Strategy:** MEDICARE PAYMENTS~~

~~**Output (Volume):**~~

~~Average Supplemental Medical Insurance Part B (SMIB) Recipient Months Per Month~~	~~614,070~~	~~629,931~~

~~**Efficiencies:**~~

~~Average Supplemental Medical Insurance Part B (SMIB) Premium Per Month~~	~~106.91~~	~~111.19~~

~~**C. Goal:** CHIP SERVICES~~

~~**Outcome (Results/Impact):**~~

~~Average CHIP Programs Recipient Months Per Month (Includes all CHIP programs)~~	~~573,798~~	~~373,594~~
~~Average CHIP Programs Benefit Cost with Prescription Benefit Per Recipient Month (Includes all CHIP programs)~~	~~164.84~~	~~185.22~~

~~**C.1.1 Strategy:** CHIP~~

~~**Output (Volume):**~~

~~Average CHIP Children Recipient Months Per Month~~	~~536,903~~	~~336,698~~

~~**Efficiencies:**~~

~~Average CHIP Children Benefit Cost Per Recipient Month~~	~~114.37~~	~~120.89~~

~~**C.1.2 Strategy:** CHIP PERINATAL SERVICES~~

~~**Output (Volume):**~~

~~Average Perinatal Recipient Months Per Month~~	~~36,895~~	~~36,896~~

~~**C.1.3 Strategy:** CHIP PRESCRIPTION DRUGS~~

~~**Output (Volume):**~~

~~Total Number of CHIP Prescriptions (Includes all CHIP programs)~~	~~2,295,460~~	~~1,440,704~~

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~~**Efficiencies:**~~

~~Average Cost Per CHIP Prescription (Includes all CHIP programs) 82.50 88.09~~

~~**D Goal:** ENCOURAGE SELF SUFFICIENCY~~

~~**D.1.1 Strategy:** TANF (Cash Assistance) Grants~~

~~**Output (Volume):**~~

~~Average Number of TANF Basic Cash Assistance Recipients Per Month 95,168 96,119~~

~~Average Number of State Two Parent Cash Assist Recipients Per Month 3,571 3,607~~

~~**Efficiencies:**~~

~~Average Monthly Grant: Temporary Assistance for Needy Families (TANF) Basic Cash Assistance 73.49 74.71~~

~~Average Monthly Grant: State Two Parent Cash Assistance Program 70.81 72.05~~

~~**D.2.1 Strategy:** FAMILY VIOLENCE SERVICES:~~

~~**Output (Volume):**~~

~~Number of Persons Served by Family Violence Programs/Shelters 80,686 80,686~~

~~**Efficiencies:**~~

~~Health and Human Services Average Cost Per Person Receiving Emergency Shelter Services through the Family Violence Program 951.69 951.69~~

~~**D.2.2 Strategy:** ALTERNATIVES TO ABORTION~~

~~**Output (Volume):**~~

~~Number of Persons Receiving Pregnancy Support Services as an Alternative to Abortion 20,223 20,223~~

	2016	2017
A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY		
Outcome (Results/Impact):		
Average Medicaid and CHIP Children Recipient Months Per Month	3,743,510	3,821,727
A.1.2 Strategy: INTEGRATED ELIGIBILITY AND ENROLLMENT (IEE)		
Output (Volume):		
Average Monthly Number of Eligibility Determinations	1,010,000	1,045,000

Efficiencies:

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		Average Cost Per Eligibility Determination	$40.25	$38.90
		Explanatory:		
		Percent Poverty Met by TANF, SNAP and Medicaid Benefits	72.87%	72.87%
		Total Value of SNAP Benefits Distributed	$5,106,482,420	$5,207,854,531
		B. Goal: MEDICAID		
		Outcome (Results/Impact):		
		Average Medicaid Acute Care Recipient Months Per Month	4,547,470	4,651,577
		Average HHSC Medicaid Client Services (including Drug) Cost Per Recipient Month	$402.23	$403.93
		Medical Recipient Months: Proportion in Managed Care:	86.58%	90.02%
		Average Number of Members Receiving Waiver Services through STAR+PLUS	49,783	51,512
		B.1.1 Strategy: AGED AND MEDICARE-RELATED		
		Output (Volume):		
		Average Aged and Medicare-Related Recipient Months Per Month: Total Eligibility Group	390,311	404,449
		Average Aged and Medicare-Related Cost Per Recipient Month	$949.92	$939.15
		B.1.2 Strategy: DISABILITY-RELATED		
		Output (Volume):		
		Average Disability-Related Recipient Months Per Month: Total Eligibility Group	446,873	460,247
		Average Disability-Related Recipient Cost Per Recipient Month	$1,021.97	$1,048.44
		B.1.3 Strategy: PREGNANT WOMEN		
		Output (Volume):		
		Average Pregnant Women Recipient Months Per Month	145,467	146,880
		Efficiencies:		
		Average Pregnant Women Cost Per Recipient Month	$665.57	$665.45
		B.1.4 Strategy: OTHER ADULTS		
		Output (Volume):		
		Average TANF-Level Adult Recipient Months Per Month	192,051	195,357
		Efficiencies:		
		Average TANF-Level Adult Cost Per Recipient Month	$379.90	$376.78
		B.1.5 Strategy: CHILDREN		

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		Output (Volume):		
		Average Poverty-Related Children Recipient Months Per Month	3,352,596	3,423,144
		Average STAR Health Foster Care Children Recipient Months Per Month	33,605	34,314
		Efficiencies:		
		Average Poverty-Related Children Cost Per Recipient Month	$153.69	$153.75
		Average STAR Health Foster Care Children Cost Per Recipient Month	$781.68	$781.34
		B.2.1 Strategy: NON-FULL BENEFIT PAYMENTS		
		Output (Volume):		
		Average Number of Non-citizen Recipient Months Per Month	9,403	9,618
		B.2.2 Strategy: MEDICAID PRESCRIPTION DRUGS		
		Efficiencies:		
		Average Cost Per Medicaid Recipient Month for Prescription Drugs	$65.04	$63.89
		B.2.3 Strategy: MEDICAL TRANSPORTATION		
		Output (Volume):		
		Average Nonemergency Transportation (NEMT) Cost per Recipient Months	$4.11	$4.12
		B.2.4 Strategy: HEALTH STEPS DENTAL		
		Efficiencies:		
		Average Cost Per Texas Health Steps (EPSDT) Dental Recipient Months Per Month	$34.55	$34.54
		B.2.5 Strategy: MEDICARE PAYMENTS		
		Output (Volume):		
		Average Part B Recipient Months Per Month	560,068	588,447
		Efficiencies:		
		Average Part B Premium Per Month	$111.20	$111.20
		C. Goal: CHIP SERVICES		
		Outcome (Results/Impact):		
		Average CHIP Programs Recipient Months Per Month (Includes all CHIP programs)	395,822	404,186
		Average CHIP Programs Benefit Cost with Prescription Benefit	$180.37	$180.85
		C.1.1 Strategy: CHIP		

3.B. Rider Revisions and Additions Request

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		Output (Volume):		
		Average CHIP Children Recipient Months Per Month	356,897	363,668
		Efficiencies:		
		Average CHIP Children Benefit Cost Per Recipient Month	$122.69	$122.69
		C.1.2 Strategy: CHIP PERINATAL SERVICES		
		Output (Volume):		
		Average Perinatal Recipient Months Per Month	38,823	40,236
		C.1.3 Strategy: CHIP PRESCRIPTION DRUGS		
		Efficiencies:		
		Average Cost Per CHIP Recipient Month for Prescription Drugs	$25.69	$25.76
		D Goal: ENCOURAGE SELF SUFFICIENCY		
		D.1.1 Strategy: TANF (Cash Assistance) Grants		
		Output (Volume):		
		Average Number of TANF Basic Cash Assistance Recipients Per Month	72,308	73,752
		Average Number of State Two-Parent Cash Assist Recipients Per Month	3,183	3,246
		Efficiencies:		
		Average Monthly Grant: TANF Basic Cash Assistance	$75.30	$75.30
		Average Monthly Grant: State Two-Parent Cash Assistance Program	$77.30	$77.29
		D.2.1 Strategy: FAMILY VIOLENCE SERVICES:		
		Output (Volume):		
		Number of Persons Served by Family Violence Programs/Shelters	80,686	80,686
		Efficiencies:		
		HHSC Average Cost Per Person Receiving Family Violence Services	$850.09	$850.09
		D.2.2 Strategy: ALTERNATIVES TO ABORTION. NONTRANSFERRABLE		
		Output (Volume):		
		Number of Persons Receiving Services as an Alternative to Abortion	19,309	19,309
		D.2.3 Strategy: TEXAS WOMEN'S HEALTH SERVICES		
		Output (Volume):		
		Average Number of Women's Health Program Recipient Months	114,222	114,793

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Efficiencies:

Average Women's Health Program Cost per Recipient Month	$17.06	$17.06

G Goal: OFFICE OF INSPECTOR GENERAL

G.1.1 Strategy: Office of Inspector General

Output (Volume):

Number of Completed Provider and Recipient Investigations	107,761	112,795
Number of Audits and Reviews Performed	3,448	3,841
Total Dollars Removed (millions)	$254.7	$266.4

Rider is revised to incorporate 2016-2017 targets and projected performance. Performance associated with exceptional budget requests begin on page 65.

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Capital Budget. None of the funds appropriated above may be expended for capital budget items except as listed below. The amounts shown below shall be expended only for the purposes shown and are not available for expenditure for other purposes. Amounts appropriated above and identified in the provision as appropriations either for "Lease Payments to the Master Equipment Purchase Program" or for items with an "(MLPP)" notation shall be expended only for the purpose of making lease-purchase payments to the Texas Public Finance Authority pursuant to the provisions of Government Code § 1232.103.

	2014	2015
~~a. Acquisition of Information Resource Technologies~~		
~~(1) Seat Management Services (PCs, Laptops, & Servers)~~	~~11,763,050~~	~~11,718,754~~
~~(2) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations~~	~~4,921,304~~	~~95,312~~
~~(3) Enterprise Telecom Managed Services~~	~~12,438,387~~	~~12,391,056~~
~~(4) Enterprise Info & Asset Mgt (Data Warehouse)~~	~~28,503,702~~	~~28,128,317~~
~~(5) Texas Integrated Eligibility Redesign System~~	~~69,153,846~~	~~54,027,582~~
~~(6) Medicaid Eligibility and Health Information~~	~~6,006,129~~	~~2,782,337~~
~~(7) Implement Information Security Improvements & Application Provisioning Enhancements~~	~~4,049,500~~	~~1,988,000~~
~~(8) Upgrade HSAS Financials – Hardware Remediation (HHS Agencies)~~	~~1,293,155~~	~~323,467~~
~~(9) Secure Mobility Infrastructure & Enterprise Communications~~	~~5,426,196~~	~~0~~
~~(10) Winters Data Center Infrastructure Upgrade~~	~~4,000,000~~	~~0~~
~~(11) IT Systems for State Operated Facilities~~	~~1,539,925~~	~~0~~
~~(12) Case Management System for OIG~~	~~4,335,202~~	~~2,813,528~~
~~(13) BIP - Implement IT Enhancement to Support No Wrong Door Eligibility~~	~~24,270,000~~	~~8,090,000~~

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		~~(14) BIP - Secure Provider Web Portal~~	~~1,300,000~~	~~0~~
		~~(15) BIP – Changes to Your Texas Benefits for Children with Special Needs~~	~~1,425,000~~	~~475,000~~
		~~(16) BIP – Changes to Your Texas Benefits~~	~~10,575,000~~	~~3,525,000~~
		~~Total, Acquisition of Information Resource Technologies~~	~~$ 191,000,396~~	~~$ 126,358,353~~
		~~b. Acquisition of Capital Equipment and Items~~		
		~~(1) Facility Support Services – Fleet Operations~~	~~546,637~~	~~463,751~~
		~~(1) Improve Security Infrastructure for Regional HHS Client Delivery Facilities~~	~~1,527,000~~	~~0~~
		~~Total, Acquisition of Capital Equipment and Items~~	~~$ 2,073,637~~	~~$ 463,751~~
		~~c. Other Lease Payments to the Master Lease Purchase Program (MLPP)~~		
		~~(1) TIERS Lease Payments to Master Lease Program~~	~~$ 2,572,531~~	~~$ 1,937,913~~
		~~d. Data Center Consolidation~~		
		~~(1) Data Center Consolidation~~	~~$ 32,854,922~~	~~$ 33,527,595~~
		~~Total, Capital Budget~~	~~$ 228,501,486~~	~~$ 162,287,612~~
		~~Method of Financing (Capital Budget):~~		
		~~General Revenue Fund~~		
		~~General Revenue Fund~~	~~$ 10,361,006~~	~~$ 3,389,255~~
		~~GR Match for Medicaid~~	~~48,062,149~~	~~31,272,506~~
		~~GR Match for Title XXI (CHIP)~~	~~1,064,136~~	~~982,686~~
		~~GR Match for Food Stamp Administration~~	~~23,899,465~~	~~21,561,757~~
		~~Subtotal, General Revenue Fund~~	~~$ 83,386,756~~	~~$ 57,206,204~~
		~~Federal Funds~~	~~114,583,376~~	~~83,939,009~~
		~~Interagency Contracts~~	~~30,531,354~~	~~21,142,399~~
		~~Total, Method of Financing~~	~~$ 228,501,486~~	~~$ 162,287,612~~
			2016	2017
		a. Acquisition of Information Resource Technologies		
		(1) Seat Management Services (PCs, Laptops, & Servers)	$ 11,763,053	$ 11,718,754

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		(2) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations	2,162,794	0
		(3) Enterprise Info & Asset Mgmt (Data Warehouse)	35,511,443	42,521,282
		(4) Texas Integrated Eligibility Redesign System	53,391,893	61,049,622
		(5) Secure Mobility Infrastructure & Enterprise Communications	2,075,000	2,075,000
		(6) Case Management System for OIG	18,920,000	9,145,000
		(7) Network Performance and Capacity	2,134,793	0
		Total, Acquisition of Information Resource Technologies	$ 125,958,976	$ 126,509,658
		b. Acquisition of Capital Equipment and Items		
		(1) Improve Security Infrastructure for Regional HHS Client Delivery Facilities	1,908,750	0
		c. Other Lease Payments to the Master Lease Purchase Program (MLPP)		
		(1) TIERS Lease Payments to Master Lease Program	$ 556,181	$ 0
		d. Data Center Consolidation		
		(1) Data Center Consolidation	$ 34,627,264	$ 35,483,510
		e. CAPPS / Enterprise Resource Planning / ProjectONE		
		(1) CAPPS - Enterprise Resource Planning	$ 9,717,048	$ 9,672,659
		(2) CAPPS - PeopleSoft Licenses	1,268,244	1,312,632
		Total, CAPPS / Enterprise Resource Planning / ProjectONE	$ 10,985,292	$ 10,985,291
		Total, Capital Budget	$ 174,036,463	$ 172,978,459
		Method of Financing (Capital Budget):		
		General Revenue Fund		
		General Revenue Fund	$ 1,141,700	$ 356,624
		GR Match for Medicaid	30,700,342	32,328,487
		GR Match for Title XXI (CHIP)	1,682,744	1,876,107
		GR Match for Food Stamp Administration	23,142,749	23,122,049
		Subtotal, General Revenue Fund	$ 56,667,535	$ 57,683,267
		Federal Funds	94,868,092	95,929,115
		Interagency Contracts	22,500,836	19,366,077

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		Total, Method of Financing $ 174,036,463 $ 172,978,459 *Rider is revised to reflect requested 2016-2017 base capital projects. Additional capital associated with exceptional item requests begin on page 72.*
HHSC 4	II-87	**Reimbursement of Advisory Committee Members.** Pursuant to Government Code § 2110.004, reimbursement of expenses for advisory committee members, out of funds appropriated above not to exceed $85,000 per year, is limited to the following advisory committees: • Hospital Payment Advisory Committee, • Medical Care Advisory Committee, • Physician Payment Advisory Committee, • Drug Use Review Board, • Pharmaceutical and Therapeutics Committee, • Public Assistance Health Benefits Review and Design Committee, • Guardianship Advisory Board, • Children's Policy Council, • ~~Volunteer Advocate Program Advisory Committee and the~~ • Task Force on Health Information Technology~~.~~, • Perinatal Advisory Council, • State Medicaid Managed Care Advisory Committee, • Intellectual and Developmental Disability System Redesign Advisory Committee, and the • Consumer Direction Workgroup. To the maximum extent possible, the commission shall encourage the use of videoconferencing and teleconferencing and shall schedule meetings and locations to facilitate the travel of participants so that they may return the same day and reduce the need to reimburse members for overnight stays. *Rider is revised to reflect the deletion of the Volunteer Advocate Program Advisory Committee as this committee no longer exists. Additionally, the rider is revised to add advisory committees whose members can be reimbursed for travel and expenses during the 2016-2017 biennium. The current rider specifies advisory committees whose members may be reimbursed for expenses related to their membership responsibilities. Committees created by SB 7 and SB 58, 83rd Legislature, were not included in the current rider and following the session, HHSC received approval to reimburse members for the Perinatal Advisory Council, State Medicaid Managed Care Advisory Committee, and the Intellectual and Developmental Disability System Redesign Advisory Committee. Finally, the rider is revised to also add members of the Consumer Direction Workgroup whose expenses have been reimbursed by the Council for Developmental Disabilities Texas to ensure a reimbursement and funding source is guaranteed for the future.*
HHSC 5	II-87	**Vendor Drug Rebates – Medicaid, ~~and~~ CHIP, and TWHP.** All references in this rider to rebate revenue refer to vendor

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drug rebates as well as supplemental rebates earned via the preferred drug lists (methods of finance include Vendor Drug Rebates – Medicaid, Vendor Drug Rebates – CHIP, Vendor Drug Rebates – TWHP, and Vendor Drug Rebates-Supplemental Rebates).

a. **Medicaid.** The Health and Human Services Commission is authorized to expend Medicaid rebate revenues appropriated above in Strategy B.2.2, Medicaid Prescription Drugs, pursuant to the federal requirements of the Omnibus Budget and Reconciliation Act of 1990 as well as rebates collected in excess of federal requirements pursuant to state law.

b. **CHIP.** The Health and Human Services Commission is authorized to expend CHIP rebate revenues and related interest earnings appropriated above in Strategy C.1.3, CHIP Prescription Drugs.

c. **TWHP**. The Health and Human Services Commission is authorized to expend Texas Women's Health Program (TWHP) rebate revenues and related interest earnings appropriated above in Strategy D.2.3, Texas Women's Health Program.

~~b.~~d. **Rebates as a First Source of Funding.** Expenditures for Medicaid ~~and~~ CHIP, and TWHP Prescription Drugs shall be made from rebates received in fiscal years 2016~~2014~~ and 2017~~2015~~. As rebates are generated, expenditures to support Medicaid, ~~and~~ CHIP, and TWHP Prescription Drugs shall be made from rebate revenues. In the event rebate revenues are not available for expenditure, General Revenue may be used to support both Prescription Drugs expenditures until rebate revenues are available.

~~c.~~e. **Appropriation.** In addition to rebate revenues appropriated above in Strategy B.2.2, Medicaid Prescription Drugs, and Strategy D.2.3, Texas Women's Health Program, and Strategy C.1.3, CHIP Prescription Drugs, the Health and Human Services Commission is appropriated Medicaid, ~~and~~ CHIP and TWHP vendor drug rebates generated in excess of those amounts, subject to the following requirements:

(1) Prescription drug rebates shall be expended prior to utilization of any General Revenue available for the purpose of the CHIP, ~~or~~ Medicaid or TWHP Prescription Drugs.

(2) In the event General Revenue has been expended prior to the receipt of vendor drug rebates, the commission shall reimburse General Revenue. The commission shall reimburse the General Revenue Fund with vendor drug rebates on a monthly basis in order to prevent accumulation of vendor drug rebates.

(3) Program Benefit Agreement revenues collected in lieu of state supplemental rebates will be expended prior to utilization of any General Revenue available for the purpose of the Medicaid program specified in the Agreement.

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		f. **Limited Use of Rebates.** Rebates generated by the Medicaid program shall only be used for the Medicaid program. Rebates generated by the CHIP program shall only be used for the CHIP program. Rebates generated by TWHP shall only be used for TWHP. *Rider is revised to add the Texas Women's Health Program (TWHP) to the VDP rebate rider to give HHSC authority to expend TWHP rebate revenues and related interest earnings. Drug manufacturers will be less likely to participate in the TWHP rebate program if the rebate revenue does not return to the program. TWHP rebates will go into effect August 2014.*
HHSC 6	II-88	**Medicaid Subrogation Receipts (State Share).** For the purposes of this provision, Medicaid Subrogation Receipts are defined as tort settlements related to the Medicaid program. Amounts defined as Medicaid Subrogation Receipts are to be deposited into the General Revenue Fund, Object No. 3802. The Health and Human Services Commission is authorized to receive and expend Medicaid Subrogation Receipts. Expenditures shall be made from recoupments and interest earnings received in fiscal year 2016~~2014~~ and fiscal year 2017~~2015~~. The use of the state's share of Medicaid Subrogation Receipts is limited to funding services for Medicaid clients. Medicaid Subrogation Receipts shall be expended as they are received as a first source, and General Revenue shall be used as a second source, to support the Medicaid program. In the event that these revenues should be greater than the amounts identified in the method of finance above as Medicaid Subrogation Receipts (State Share), the commission is hereby appropriated and authorized to expend these Other Funds thereby made available, subject to the following requirements: a. Amounts available shall be expended prior to utilization of any General Revenue available for the same purposes. b. In the event General Revenue has been expended prior to the receipt of the state's share of Medicaid Subrogation Receipts, the commission shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent accumulation of Medicaid Subrogation Receipt balances. The preceding paragraph shall be the exclusive appropriation authority for receipts from the above identified sources, and none of these receipts shall be appropriated by a provision of Article IX of this Act. *Rider is updated for biennial date changes*.
HHSC 7	II-88	**Appropriation Transfers between Fiscal Years.** In addition to the transfer authority provided elsewhere in this Act and in order to provide for unanticipated events that increase costs associated with providing Medicaid, ~~or~~ CHIP or Texas Women's Health Program (TWHP) services for eligible clients, the Health and Human Services Commission is authorized to transfer General Revenue from funds appropriated in Medicaid, ~~or~~ CHIP or TWHP strategies in fiscal year 2017~~2015~~ to fiscal year 2016~~2014~~ and such funds are appropriated to the commission for fiscal year 2016~~2014~~. Such transfers may only be made subject to the following:

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		a. Transfers under this section may be made only: (1) if costs associated with providing Medicaid, ~~or~~ CHIP or TWHP services exceed the funds appropriated for these services for fiscal year 2016~~2014~~, or (2) for any other emergency expenditure requirements, including expenditures necessitated by public calamity. b. A transfer authorized by this section must receive the prior written approval of the Governor and the Legislative Budget Board. c. The Comptroller of Public Accounts shall cooperate as necessary to assist the completion of a transfer and spending made under this section. *Rider is updated for biennial date changes. Additionally, rider revised to provide similar flexibility between fiscal years for the Texas Women's Health Program.*
HHSC 13	II-91	**Use of Additional Medicaid Program Income.** For the purposes of this provision, Medicaid program income is defined as: 1) refunds/rebates of previously paid premiums and interest earnings generated in relationship to accounts listed below; 2) refunds/rebates received from the Medicaid claims payment contractor or other sources; and 3) managed care rebates as described below. Amounts defined as program income are to be deposited into the General Revenue Fund, Object No. 3639. The Health and Human Services Commission is authorized to receive and spend program income and interest earnings generated from fund balances with the Disbursement Account, and the STAR (Managed Care) Account, as defined in the contractual agreement with the fiscal agent and/or insurance carrier for purchased health services except for those interest earnings related to the Cash Management Improvement Act (CMIA). The commission is also authorized to receive and spend experience rebates generated in accordance with its contractual agreements with health maintenance organizations who participate in Medicaid managed care. Expenditures shall be made from credits, managed care rebates, and interest earnings received in fiscal years 2016~~2014~~ and 2017~~2015~~. The use of the credits, managed care rebates, and interest earnings is limited to funding services for Medicaid clients. Medicaid program income shall be expended as they are received as a first source, and General Revenue shall be used as a second source, to support the Medicaid program. In the event that these revenues should be greater than the amounts identified in the method of finance above as Medicaid Program Income, the commission is hereby appropriated and authorized to expend these General Revenue Funds thereby made available, subject to the following requirements: a. Amounts available shall be expended prior to utilization of any General Revenue available for the same purposes; and b. In the event General Revenue has been expended prior to the receipt of program income, the commission shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent

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		accumulation of program income balances. The preceding paragraph shall be the exclusive appropriation authority for receipts from the above identified sources and none of these receipts shall be appropriated by a provision of Article IX of this Act. *Rider is updated for biennial date changes.*
HHSC 14	II-91	**Use of Additional CHIP Experience Rebates.** For the purposes of this provision, CHIP Experience Rebates are defined as: 1) refunds/rebates of previously paid CHIP premiums and related interest earnings; and 2) managed care rebates and related interest earnings as described below. Amounts defined as CHIP Experience Rebates are to be deposited into the General Revenue Fund. The Health and Human Services Commission is authorized to receive and spend experience rebates generated in accordance with its contractual agreements with managed care organizations and other providers who participate in the CHIP and CHIP Perinatal programs. Expenditures shall be made from CHIP Experience Rebates generated in fiscal years 2016~~2014~~ and 2017~~2015~~. The method of financing item, Experience Rebates - CHIP, for appropriations made above, includes unexpended and unobligated balances of Experience Rebates - CHIP remaining as of August 31, 2015~~2013~~, and receipts earned in fiscal years 2016~~2014~~ and 2017~~2015~~. The use of CHIP Experience Rebates is limited to health care services for CHIP clients. CHIP Experience Rebates shall be expended as they are received as a first source, and General Revenue shall be used as a second source, to support CHIP-related programs. In the event that these revenues should be greater than the amounts identified in the method of finance above as Experience Rebates - CHIP, the department is hereby appropriated and authorized to expend these General Revenue Funds thereby made available, subject to the following requirements: a. Amounts available shall be expended prior to utilization of any General Revenue available for the same purposes; and b. In the event General Revenue has been expended prior to the receipt of CHIP Experience Rebates, the Commission shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent accumulation of CHIP Experience Rebate balances. The preceding paragraph shall be the exclusive appropriation authority for receipts from the above identified sources and none of these receipts shall be appropriated by a provision of Article IX of this Act. *Rider is updated for biennial date changes.*
HHSC 15	II-92	**CHIP: Unexpended Balances and Allocation of Funds.** a. **Unexpended Balances between Biennia.** Unexpended balances in General Revenue Funds appropriated for

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		Goal C (CHIP) strategies to the Health and Human Services Commission (HHSC) for the fiscal year ending August 31, 2015~~2013~~ (estimated to be $0) are appropriated to the agency and included above for the fiscal year beginning September 1, 2015~~2013~~, only upon prior written approval by the Legislative Budget Board and the Governor. These General Revenue Funds are contingent on an unexpended balance from fiscal year 2015~~2013~~. The amount of the appropriation is limited to the amount of the unexpended balance. b. **Unexpended Balances within the Biennium.** Unexpended balances in General Revenue Funds appropriated for Goal C (CHIP) strategies to HHSC for the fiscal year ending August 31, 2016~~2014~~ (estimated to be $0) are appropriated to the agency for the fiscal year beginning September 1, 2016~~2014~~, only upon prior written approval by the Legislative Budget Board and the Governor. c. For authorization to expend the funds, HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request must be organized by fiscal year as follows: (1) The following information shall be provided for the fiscal year with an unexpended balance: (i) an explanation of the causes of the unexpended balance(s); (ii) the amount of the unexpended balance(s) by strategy; and (iii) the associated incremental change in service levels compared to performance targets in this Act for that fiscal year. (2) The following information shall be provided for the fiscal year receiving the funds: (i) an explanation of purpose for which the unexpended balance(s) will be used and whether the expenditure will be one-time or ongoing; (ii) the amount of the expenditure by strategy; (iii) the incremental change in service levels compared to performance targets in this Act for that fiscal year; and (iv) the capital budget impact. The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board

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		concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. The Comptroller of Public Accounts shall not allow the use of unexpended balances authorized by any of the above subsections if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied. d. It is the intent of the Legislature that tobacco settlement receipts appropriations made above in Goal C, CHIP Services, include $<u>75.4</u>~~315.2~~ million for fiscal year <u>2016</u>~~2014~~ and $<u>60.5</u>~~234.5~~ million for fiscal year <u>2017</u>~~2015~~ in tobacco settlement receipts paid to the State pursuant to the Comprehensive Tobacco Settlement and Release. In the event that the state has not received a tobacco settlements payment for fiscal year <u>2016</u>~~2014~~ and fiscal year <u>2017</u>~~2015~~ by September 1 of each year of the biennium, the Comptroller of Public Accounts is hereby authorized to use general revenue funds as needed for program expenditures for cash flow purposes between the beginning of the fiscal year and the receipt by the state of the tobacco settlement payment for the fiscal year. Upon receipt of the tobacco settlement payment, the general revenue fund shall be reimbursed with tobacco settlement receipts for all expenditures made pursuant to this provision. *Rider is updated for biennial date changes and estimated tobacco settlement appropriations for the 2016-2017 biennium.*
HHSC 22	II-94	**Temporary Assistance for Needy Families (TANF) Maintenance of Effort.** It is the intent of the Legislature that all General Revenue appropriated above for TANF maintenance of effort shall be expended within the appropriate fiscal year for that purpose in order to secure the TANF federal block grant for the state. Out of funds appropriated above in Strategy D.1.1, TANF (Cash Assistance) Grants, $62,851,931 in General Revenue is appropriated for TANF maintenance of effort for fiscal year <u>2016</u>~~2014~~, and $62,851,931 in General Revenue is appropriated for TANF maintenance of effort for fiscal year <u>2017</u>~~2015~~. None of the General Revenue appropriated for TANF maintenance of effort in Strategy D.1.1, TANF (Cash Assistance) Grants, may be transferred to any other item of appropriation or expended for any purpose other than the specific purpose for which the funds are appropriated. However, General Revenue appropriated for TANF maintenance of effort may be transferred to Strategy A.1.2, Integrated Eligibility and Enrollment, subject to the following limitations: a. Declines or shifts in TANF caseloads prevent the Health and Human Services Commission from expending all General Revenue appropriated for TANF maintenance of effort in Strategy D.1.1, TANF (Cash Assistance) Grants, within the appropriate fiscal year; a. The amount of TANF MOE General Revenue transferred from Strategy D.1.1, TANF Cash Assistance) Grants, shall be expended as TANF maintenance of effort within Strategy A.1.2, Integrated Eligibility and Enrollment, for TANF program operating costs, within the appropriate fiscal year; and

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		b. At least 30 days prior to transferring General Revenue Funds between Strategy D.1.1, TANF (Cash Assistance) Grants, and Strategy A.1.2, Integrated Eligibility and Enrollment, the Health and Human Services Commission shall notify the Legislative Budget Board and the Governor. *Rider is updated for biennial date changes.*
HHSC 24	II-95	**Performance Reporting for the Prescription Drug Rebate Program.** The Health and Human Services Commission shall report on an annual basis the following information to the Legislative Budget Board, the State Auditor's Office and the Governor: the outstanding prescription drug rebate balances for the Medicaid, CHIP, TWHP, Kidney Health, and Children with Special Health Care Needs programs. The report shall include rebate principal and interest outstanding, age of receivables, and annual collection rates. The reports shall specify amounts billed, dollar value of pricing and utilization adjustments, and dollars collected. The Health and Human Services Commission shall report these data on each year for which the Prescription Drug Rebate program has collected rebates and also on a cumulative basis for all years. *Rider is revised to add TWHP to the reporting requirement. TWHP rebates will go into effect August 2014.*
HHSC 29	II-96	**Prohibition on Abortions.** a. It is the intent of the Legislature that no funds shall be used to pay the direct or indirect costs (including overhead, rent, phones and utilities) of abortion procedures provided by contractors of the commission. b. It is also the intent of the Legislature that no funds appropriated for Texas Women's Health Program ~~Medicaid Family Planning~~, shall be distributed to individuals or entities that perform elective abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective abortion procedures. c. The commission shall include in its financial audit a review of the use of appropriated funds to ensure compliance with this section. *Rider is revised to update the rider to replace "Medicaid Family Planning" with "Texas Women's Health Program". The program was created to provide family planning services to women following the expiration of the 1115(a) Family Planning Research and Demonstration Waiver.*
HHSC 30	II-96	**Family Planning.** Of funds appropriated for Texas Women's Health Program~~Medicaid Family Planning~~, no state funds may be used to dispense prescription drugs to minors without parental consent. An exemption shall be allowed for emancipated 16- and 17-year old parents. *Rider is revised to update the rider to replace "Medicaid Family Planning" with "Texas Women's Health Program". The program was created to provide family planning services to women following the expiration of the 1115(a) Family*

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		Planning Research and Demonstration Waiver.
HHSC 35	II-97	**Limited~~Continued~~ Medicaid Coverage for Clients ~~Unable to Access~~ with Medicare Part D Benefit ~~and~~ for Certain Excluded Medicare Part D Drug Categories.** It is the intent of the Legislature that from funds appropriated above in Strategy B.2.2, Medicaid Prescription Drugs, the Health and Human Services Commission shall continue to provide limited Medicaid coverage for dual eligible clients ~~who are unable to access their Medicare Part D drug benefit~~. The Health and Human Services Commission shall recoup funds for these expenditures from Part D drug plans that are determined to be responsible for the dual eligible clients' drug costs. It is also the intent of the Legislature that from funds appropriated above in Strategy B.2.2, Medicaid Prescription Drugs, the Health and Human Services Commission shall continue to provide Medicaid coverage for certain categories of drugs not covered under the federal Medicare Part D program, under Section 1935(d)(2) of the Social Security Act, for full dual eligible clients. This coverage is limited to only those categories of excluded Medicare Part D drugs that continue to be eligible for federal Medicaid matching funds and that are currently covered under the Medicaid Vendor Drug Program (e.g., certain prescribed over-the-counter medications, smoking cessation medications and vitamins). *Rider is revised to clarify that HHSC does not pay for clients' drugs that opt out of Medicare Part D. With the current language, HHSC believes there is a significant risk that HHSC would erroneously pay for drugs that are Medicare part D liable, due to the open interpretation of the phrase, 'unable to access' the Medicare D benefit.*
HHSC 36	II-93	**Hospital Uncompensated Care.** No funds appropriated under this Article for medical assistance payments may be paid to a hospital if the Health and Human Services Commission determines that the hospital has not complied with the Commission's reporting requirements. The Commission shall ensure that the reporting of uncompensated care (defined to include bad debt, charity care and unreimbursed care) by Texas hospitals is consistent for all hospitals and subjected to a standard set of adjustments that account for payments to hospitals that are intended to reimburse uncompensated care. These adjustments are to be made in such a way that a reliable determination of the actual cost of uncompensated care in Texas is produced. The commission shall conduct an appropriate number of audits to assure the accurate reporting of the cost of uncompensated hospital care. The commission shall submit a biennial report on uncompensated care costs, which considers the impact of patient specific and lump sum funding as offsets to uncompensated costs, to the Governor and Legislative Budget Board no later than December 1, 2016~~2014~~. The commission may report by hospital type. The commission shall also review the impact of health care reform efforts on the funding streams that reimburse uncompensated care, assess the need for those funding streams in future biennia, and consider which funds might be redirected to provide direct health coverage. *Rider is updated for biennial date change.*

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HHSC 38	II-98	**Payments to Rural Hospital Providers.** In order to ensure that access to emergency and outpatient services remain in rural parts of Texas, it is the intent of the Legislature that when HHSC changes its outpatient reimbursement methodology to an Enhanced Ambulatory Patient Groups or similar methodology, HHSC shall promulgate a separate or modified payment level for ~~It is the intent of the Legislature that out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission (HHSC) shall rebase~~ rural hospitals, which are defined as hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census, and Medicare-designated Rural Referral Centers (RRC), Sole Community Hospitals (SCH), and Critical Access Hospitals (CAH). ~~rates as follows:~~ ~~a. These provisions shall apply to hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census, and Medicare-designated Rural Referral Centers (RRC), Sole Community Hospitals (SCH), and Critical Access Hospitals (CAH).~~ ~~b. Inpatient:~~ ~~(1) Hospitals defined above shall be reimbursed based on a facility-specific prospective full cost standard dollar amount (SDA) based on their historical costs limited by a floor and a ceiling. The ceiling should be equal to approximately two standard deviations above the average full-cost SDA for providers with more than 50 claims; the floor should be equal to approximately 1.5 standard deviations below that same average.~~ ~~(2) In calculating the facility specific prospective full cost SDA, the rates will be trended forward by the CMS Market Basket inflation factor to adjust for inflation.~~ ~~(3) It is the intent of the Legislature that for patients enrolled in managed care including but not limited to health maintenance organizations (HMO), inpatient services provided at hospitals meeting the above criteria shall be reimbursed based on the above considerations and rates, in order to maintain access to care.~~ ~~c. Outpatient: In order to ensure that access to emergency and outpatient services remain in rural parts of Texas, it is the intent of the Legislature that when HHSC changes its outpatient reimbursement methodology to an Enhanced Ambulatory Patient Groups or similar methodology, HHSC shall promulgate a separate or modified payment level for the above defined providers.~~ ~~d. The commission may consider a phase down schedule for a hospital which met the definition of "rural hospital" in the preceding biennium, but does not meet the definition provided in paragraph a. above.~~ *Rider is revised to delete instructions relating to the inpatient reimbursement methodology for rural hospitals since the methodology described in the rider was implemented effective September 1, 2013, and is currently laid out in the Texas*

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		Administrative Code.
HHSC 41	II-99	**Enterprise Data Warehouse.** Out of funds appropriated above in Strategy A.2.1, Consolidated System Support, the Health and Human Services Commission (HHSC) may expend $10,560,731~~728~~ in General Revenue and any associated matching Federal Funds to develop/implement an enterprise data warehouse for data related to Medicaid services, human services, and public health services. In order to ensure maximum accountability, HHSC shall contract with a single vendor for the data warehouse. HHSC shall submit reports to the Legislative Budget Board and the Governor on September 1, 2015~~2013~~ and September 1, 2016~~2014~~ reflecting actual expenditures and accomplishments to date. The reports shall also reflect an estimate of planned expenditures and accomplishments for the remainder of the 2016-2017~~2014-2015~~ biennium. *Rider is updated for biennial date changes and requested 2016-2017 base capital project amount.*
HHSC 43	II-99	~~**Local Reporting on DSH, Uncompensated Care and Delivery System Reform Incentive Payment Expenditures.** Out of funds appropriated above, and as the state Medicaid operating agency, the Health and Human Services Commission shall develop a report that non-state public hospitals, private hospitals, hospital districts, physicians and private administrators shall use to describe any expenditures they make through the Disproportionate Share Hospital (DSH) program, and Uncompensated Care (UC) Pool, and the Delivery System Reform Incentive Payment (DSRIP) Pool. And the Indigent Care Program. The commission shall determine the format of the report, which must include expenditures by method of finance per year. In addition, the commission annually shall require contracted hospital providers to report payments to entities who provide consultative services regarding revenue maximization under the medical assistance program and any other governmentally funded program, including UC, DSRIP, and DSH. Information included in the reports of payments to entities providing consultative services from contracted hospitals shall include: a. the total amount of aggregated payments to all such entities by county; b. the purpose of the payment(s); c. the source of the payment(s); d. the program for which consultative services were provided; and e. any other information the commission believes pertinent.~~ *Rider is deleted as the supplemental programs are for reimbursement of costs that are already incurred by the hospitals for patient care. For example, Disproportionate Share Hospital (DSH) and Uncompensated Care waiver payments made in FFY 2013 were reimbursement for the estimated costs for the care of uninsured and Medicaid eligible patients in that*

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		year. The estimated costs are based on two year lagged data. Audits are conducted three years after each program year to ensure that payments are made for care of uninsured and Medicaid eligible patients. The audit reports are submitted to the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, the Senate Finance Committee members, the House Appropriations Committee members, and the Legislative Budget Board by March 1 each year, as required in Rider 55. *Payments that are from the Delivery System Reform Incentive Payments (DSRIP) pool are based on the achievement of metrics and milestones for reform of health care delivery systems. These metrics and milestones are determined through negotiation among the providers, HHSC and the Centers for Medicare and Medicaid Services (CMS). The DSRIP payments are incentive-based and take into consideration the value of delivery system reforms and not the short term cost of such reform efforts. In addition, providers often meet their metrics and milestones to qualify for payment after a significant lapse of time from when expenditures are incurred. For example, the cost of a DSRIP activity might be incurred early in the second demonstration year of the waiver. However, the agreed-upon metrics and milestones might only be achieved toward the end of the third demonstration year, which makes attempted tracking of payments with expenditures in that year misleading.*
HHSC 45	II-100	**Medication Therapy Management.** ~~Out of funds appropriated above to the Health and Human Services Commission in Strategy B.2.2, Medicaid Prescription Drugs, the commission shall use existing resources to determine the effectiveness of the medication therapy management pilot program in reducing adverse drug events and related medical costs for high-risk Medicaid clients, including those receiving treatment for asthma and COPD, and submit a report to the Governor and the Legislative Budget Board by December 1, 2014.~~ *Rider is deleted as the rider required HHSC to operate a medication therapy management pilot program that will end December 31, 2014. HHSC will submit an interim report to meet the December 1 report requirement.*
HHSC 46	II-96	**Use of PARIS Data and Appropriation of Savings to the Texas Veterans Commission Realized from the Use of PARIS Data.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Service Commission shall: a. Submit information quarterly to the U.S. Health and Human Services Department's Administration for Children and Families for participation in the federal Public Assistance Reporting Information System's (PARIS) Veterans and Federal Files information exchange. The Health and Human Services Commission Office of the Inspector General shall submit the necessary state data from all state health and human services programs that may serve veterans to receive results from the federal PARIS system and shall forward the necessary information received from the PARIS system to the appropriate state agencies for follow up and further investigation. b. Transfer $50,000 of General Revenue Funds in fiscal year 2016~~2014~~ and $50,000 in fiscal year 2017~~2015~~ to the Texas Veterans Commission to partially fund 2.0 full-time equivalents who will work as veteran benefit counselors to investigate and analyze the information/data received from the federal Public Assistance Reporting Information System (PARIS). The PARIS information will be used by the Texas Veterans Commission to assist and facilitate

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		claims for veterans receiving Medicaid or other state public benefits for which veterans are entitled from the Department of Veterans Affairs. c. Ten percent of the General Revenue savings during fiscal year 2016~~2014~~ that was the result of pursuing information from the Public Assistance Reporting Information System (PARIS) as calculated by the Health and Human Services Commission (HHSC) according to procedures or rules for making the calculations adopted by HHSC shall be credited by the Comptroller to the Texas Veterans Commission Veterans' Assistance Fund Account No. 368 from which expenditures were originally made and such funds are hereby appropriated to the Texas Veterans Commission in fiscal year 2017~~2015~~. *Rider is updated for biennial date changes.*
HHSC 47	II-101	**Unexpended Balances: Social Services Block Grant Funds.** As single state agency for the Social Services Block Grant, the Health and Human Services Commission shall coordinate with other agencies appropriated Social Services Block Grant and shall report to the Legislative Budget Board and the Governor by October 15 of each fiscal year of the 2016-2017~~2014-2015~~ biennium the actual amount of federal Social Services Block Grant funds expended and the actual amount of unexpended and unobligated balances. Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The notification and information provided shall be prepared in a format specified by the Legislative Budget Board. *Rider is updated for biennial date changes.*
HHSC 48	II-101	**Medicaid Substance Abuse Treatment.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall provide coverage for comprehensive substance abuse treatment services under Medicaid to persons who are at least 21 years of age, have a substance abuse disorder, and otherwise qualify for Medicaid. ~~The commission shall analyze data relating to the provision of those treatment services and provide the data to the Legislative Budget Board in a format and at times requested by the Legislative Budget Board. The commission may not provide those treatment services if the Legislative Budget Board determines that the treatment services have resulted in an increase in overall Medicaid spending.~~ *Rider is revised as the analysis required in the rider language has been conducted in coordination with the LBB, and the LBB anticipates submission of the final report by January, 2015. The continued inclusion of the language maintains the potential of eventual benefit termination, while removal of the language would provide HHSC and its clients more certainty around the continuation of the benefit.*
HHSC 49	II-101	~~**Capitated Managed Care Model of Dental Services Reporting.** Out of funds appropriated above to the Health and Human Services Commission in Strategy B.2.4, Health Steps (EPSDT) Dental, the Health and Human Services Commission shall evaluate the impact of providing dental services through a capitated managed care model on access,~~

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		~~quality and cost outcomes. The evaluation shall address issues including but not limited to utilization trends, penetration rates, provider to client ratios, retention of dental providers, services provided, premium insurance revenue and managed care premium cost growth. The Health and Human Services Commission shall submit findings to the Governor and the Legislative Budget Board by March 1, 2015.~~ *Rider is deleted as the report requires an evaluation of the impact of providing dental services through a capitated, managed care model on access, quality and cost outcomes. Since the program has been fully operational since March 1, 2012, the results of this time and resource intensive report would likely not be utilized for future program decision making. HHSC currently reports quarterly to the Centers for Medicare and Medicaid Services (CMS) information on access to care in the dental program, and reductions in utilization can be addressed by the program analysis of this report. HHSC requires the dental maintenance organizations (DMOs) to report on over 15 performance measures designed to measure items like access, utilization, and client satisfaction. In January 2014, HHSC placed several performance measures related to access and utilization "at-risk," meaning that the DMOs must achieve quality benchmarks or forfeit a percentage of their capitation payments. Additionally, the Rider requests an evaluation on the retention of dental providers. This is monitored by Health Plan Management staff quarterly, and the number of dental providers has continued to grow since program launch in 2012.*
HHSC 50	II-101	**Medicaid Emergency Room Use.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall take steps to reduce non-emergent use of the emergency room in the Medicaid program. These steps shall include~~,~~: if feasible, use of financial incentives and disincentives to encourage the health maintenance organizations participating in the Medicaid STAR and STAR+PLUS managed care programs to reduce non-emergent use of the emergency room among their clients. Financial incentives and disincentives may include adding a performance indicator that measures non-emergent use of the emergency room to the performance measures for the State's financial incentive/disincentive quality program. ~~a. evaluating whether the cost of the physician incentive programs implemented by the health maintenance organizations participating in the Medicaid STAR and STAR+PLUS managed care programs has been offset by reduced use of the emergency room;~~ ~~b. determining the feasibility of amending the Texas Medicaid State Plan to permit freestanding urgent care centers to enroll as clinic providers; and~~ ~~c. using financial incentives and disincentives to encourage the health maintenance organizations participating in the Medicaid STAR and STAR+PLUS managed care programs to reduce non-emergent use of the emergency room among their clients. Financial incentives and disincentives may include adding a performance indicator that measures non-emergent use of the emergency room to the performance measures for the one percent at-risk premium and the performance measures used to evaluate health maintenance organization performance for purposes of distributing funds under the Quality Challenge Award program.~~

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		~~The Health and Human Services Commission shall submit a report on steps taken to reduce non-emergent use of the emergency room in the Medicaid program, including findings on the evaluation of the physician incentive programs and the urgent care center feasibility analysis, to the Legislative Budget Board and the Governor by August 31, 2014.~~ *Rider is revised as software and metrics used for the state's incentive/disincentive program regularly vary in usability. For example, 3M software used to measure potentially preventable hospital visits undergo regular updates that may preempt its use in an incremental improvement program. Because HHSC will use this software whenever feasible, but may be unable to due to unforeseen circumstances, HHSC suggests changing this language to be permissive.* *Staff recommends edits to details about the State's incentive/disincentive program because it has changed from the time when the original legislation was drafted. For example, the Quality Challenge Award has ended and the premium amount at-risk has increased. These factors may change in the future so more general language is recommended.* *The urgent care and physician incentive components of the analysis will be completed for the report submitted in August 2014 so the revision removes the report requirement.*
HHSC 51	II-102	~~**Medicaid Funding Reduction and Cost Containment.**~~ ~~a. Included in appropriations above in Goal B, Medicaid, Strategy B.1.5, Children, is a reduction of $200,000,000 in General Revenue Funds and $284,730,974 in Federal Funds in fiscal year 2014 and $200,000,000 in General Revenue Funds and $276,871,722 in Federal Funds in fiscal year 2015, a biennial total of $400,000,000 in General Revenue Funds and $561,602,696 in Federal Funds. The Health and Human Services Commission (HHSC) is authorized to transfer these reductions between fiscal years and to allocate these reductions among health and human services agencies as listed in Chapter 531, Government Code, pursuant to the notification requirements included in Subsection (c) of this rider.~~ ~~b. This reduction shall be achieved through the implementation of the plan described under subsection (c) which may include any or all of the following initiatives:~~ ~~(1) Implement payment reform and quality based payment adjustments in fee-for-service and in managed care premiums,~~ ~~(2) Improve birth outcomes, including improving access to information and payment reform,~~ ~~(3) Increase efficiencies in the vendor drug program,~~ ~~(4) Continue to adjust outpatient Medicaid payments to a fee schedule that is a prospective payment system and that maximizes bundling of outpatient services, including hospital imaging rates,~~

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		~~(5) Expand efforts to develop more appropriate emergency department hospital rates for non-emergency related visits,~~ ~~(6) Maximize co-payments in all Medicaid programs,~~ ~~(7) Increase efficiency and reduce fraud in Medicaid transportation service through the most appropriate transportation model, including the transfer of transportation for dialysis patients to the Medical Transportation Program and non-emergency ambulance services,~~ ~~(8) Implement statewide monitoring of community care and home health through electronic visit verification in Medicaid fee-for-service and managed care,~~ ~~(9) Renegotiate more efficient contracts,~~ ~~(10)Phase down Medicaid rates which are above Medicare rates, with separate consideration for an accurate and appropriate evaluation of the service delivery model when developing the rate for Medicaid rates for pediatric therapy services that have no equivalent Medicare service,~~ ~~(11)Develop a more appropriate fee schedule for therapy services, requiring providers to submit the National Provider Identification (NPI) on each claim,~~ ~~(12)Strengthen prior authorization requirements,~~ ~~(13)Strengthen and expand utilization and prior authorization reviews,~~ ~~(14)Incentivize appropriate neonatal intensive care unit utilization and coding,~~ ~~(15)Improve care coordination through a capitated managed care program for remaining fee-for-service populations,~~ ~~(16)Increase fraud, waste, and abuse prevention and detection,~~ ~~(17)Expand initiatives to pay more appropriately for outlier payments,~~ ~~(18)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,~~

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		~~(19)Adjust inpatient hospital reimbursement for labor and delivery services provided to adults at children's hospitals,~~ ~~(20)Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services,~~ ~~(21)Implement dually eligible Medicare/Medicaid integrated care model and long-term services and supports quality payment initiative,~~ ~~(22)Reestablish hospital thirty-day spell of illness limitations in STAR+PLUS,~~ ~~(23)Align Texas Home Living with Home and Community-based Services (HCS) rates,~~ ~~(24)Enforce appropriate payment practices for non-physician services, and~~ ~~(25)Implement additional initiatives identified by the Health and Human Services Commission.~~ ~~c. HHSC shall develop a plan to allocate the reductions required by Subsection (a) of this rider by taking actions such as those suggested under Subsection (b) of this rider to the budgets of the health and human services agencies as listed in Chapter 531, Government Code. The plan shall include reduction amounts by strategy and fiscal year and shall be submitted in writing before December 1, 2013 to the Legislative Budget Board, the Governor, and the Comptroller of Public Accounts.~~ *Rider is deleted as the cost containment items apply to the funding in the 2014-2015 biennium and are reflected in the base funding levels.*
HHSC 52	II-103	**Client Assessment for ~~Acute~~ Nursing Services in Medicaid.** Out of funds appropriated above to the Health and Human Services Commission (HHSC) in Goal B, Medicaid, the commission shall develop an objective assessment process to assess Medicaid clients' needs for ~~acute~~ Medicaid state plan acute nursing services, including home health skilled nursing, home health aide services, and private duty nursing. ~~HHSC shall use the appropriated funds to pay an employee or a contractor independent of the service provider to conduct these assessments.~~ The assessment process must include an assessment of specific criteria documented on a standard form and any documents required for prior authorization of nursing services. HHSC shall implement this assessment process within Medicaid fee-for-service, ~~primary care case management; and~~ STAR, STAR kids, and STAR+PLUS Medicaid managed care programs.

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		~~HHSC shall consider the feasibility and benefit of implementing a similar process for therapy services.~~ *Rider is revised to conform to current policy direction:* • *Change "acute nursing services" to "Medicaid state plan nursing services" to clarify scope* • *Remove requirement to study feasibility of a therapy assessment, as HHSC has determined that this is likely not feasible* • *Remove reference to primary care case management, as the program no longer exists* *With the expansion of managed care, the intent of the Rider will likely be met by the managed care organizations' (MCOs) individual assessment and prior authorization processes by 2015. HHSC also recommends removing direction to pay an HHSC employee or independent contractor to conduct assessments, as MCOs will largely be responsible. Finally, HHSC recommends adding a reference to STAR Kids, which will have a prescribed assessment process for nursing services.*
HHSC 53	II-103	**Quality-Based Payment and Delivery Reforms in the Medicaid and Children's Health Insurance Programs.** Out of funds appropriated to the Health and Human Services Commission (HHSC) in Goal B, Medicaid, and Goal C, Children's Health Insurance Program, HHSC may implement the following quality-based reforms in the Medicaid and CHIP programs: a. develop quality-based outcome and process measures that promote the provision of efficient, quality health care and that can be used to implement quality-based payments for acute and long-term care services across delivery models and payment systems; b. implement quality-based payment systems for compensating a health care provider or facility participating in the Medicaid and CHIP programs; c. implement quality-based payment initiatives to reduce potentially preventable readmissions and potentially preventable complications; and d. implement a bundled payment initiative in the Medicaid program, including a shared savings component for providers that meet quality-based outcomes. The executive commissioner may select high-cost and/or high-volume services to bundle and may consider the experiences of other payers and other state of Texas programs that purchase healthcare services in making the selection. e. Under the Health and Human Services Commission's authority in 1 T.A.C. Sec. 355.307(c), the commission may implement a Special Reimbursement Class for long term care commonly referred to as "small house facilities." Such a class may include a rate reimbursement model that is cost neutral and that adequately addresses the cost differences that exist in a nursing facility constructed and operated as a small house facility, as well as the

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		potential for off-setting cost savings through decreased utilization of higher cost institutional and ancillary services. The payment increment may be based upon a provider incentive payment rate. ~~Required Reporting: The commission shall provide annual reports to the Governor's Office of Budget, Planning, and Policy and Legislative Budget Board on December 1, 2013 and December 1, 2014 that include (1) the quality-based outcome and process measures developed; (2) the progress of the implementation of quality-based payment systems and other related initiatives; (3) outcome and process measures by health service region; and (4) cost-effectiveness of quality-based payment systems and other related initiatives.~~ *Rider is revised to delete the reporting section because HHSC has other mechanisms for sharing this information with the public, which is also accessible to the Governor's Office of Budget, Planning, and Policy and Legislative Budget Board. These include the Quality of Care Reports produced by the State's external quality review organization, information in the Uniform Managed Care Manual related to Texas financial incentive/disincentive program, and the newly launched quality website which provides details and progress of HHSC quality initiatives.*
HHSC 54	II-104	**Texas Office for the Prevention of Developmental Disabilities.** Out of General Revenue Funds appropriated above in Strategy A.1.1, Enterprise Oversight and Policy, the Health and Human Services Commission shall expend an amount not to exceed $200,000 each fiscal year for salaries, travel expenses, and other costs in order to support the Texas Office for Prevention of Developmental Disabilities. Grants and donations for the Office for Prevention of Developmental Disabilities received through the authority provided by Article IX, Sec. 8.01, Acceptance of Gifts of Money, are not subject to this limit and shall be expended as they are received as a first source, and General Revenue shall be used as a second source to support the office. *Rider revised to reflect programs name.*
HHSC 58	II-104	~~**FQHC Affiliate Agreements.** To the extent allowable by law, no funds appropriated under this Act may be expended to reimburse the costs of a federally qualified health center (FQHC) for services performed or provided by a provider or group of providers pursuant to an affiliation agreement executed between the FQHC and provider unless the Health and Human Services Commission determines the reimbursement complies with criteria promulgated by the Secretary of Health and Human Services, the Centers for Medicare and Medicaid Services, or administrative rules adopted by the commission.~~ *Rider is deleted as rules implementing this provision at 1 TAC 354.1322 were adopted effective October 13, 2013. No further action is required to comply with this rider.*
HHSC 59	II-104	~~**FQHC Reimbursement in Managed Care.** To the extent allowable by law, in developing the premium rates for Medicaid and CHIP Managed Care Organizations (MCOs), the Health and Human Services Commission shall include provisions for payment of the FQHC Prospective Payment System (PPS) rate and establish contractual requirements that require MCOs to reimburse FQHCs at the PPS rate.~~

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		Rider is deleted as the managed care contract language already requires MCOs to pay according to the allowable FQHC rates under the Social Security Act.
HHSC 61	II-105	**~~Medicaid In-Office Diagnostic Ancillary Services.~~** ~~Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall collect data necessary to allow the agency to quantify the amount of in-office diagnostic ancillary services provided to clients in the Texas Medicaid fee-for-service and managed care programs and routinely analyze this data. The agency shall review methodologies used by the federal government and national researchers to estimate the amount of in-office diagnostic ancillary services provided to Medicare clients and adopt a similar methodology for quantifying the amount of these services provided to Texas Medicaid clients. The agency shall submit a report on in-office diagnostic ancillary service use in the Texas Medicaid program, including strategies implemented by the agency to reduce unnecessary diagnostic ancillary services, to the Legislative Budget Board and the Governor by December 1, 2014.~~ *Rider is deleted as the report requirements will be completed during the 2014-2015 biennium.*
HHSC 63	II-105	**Reporting Fiscal Impact of the Federal Eligibility Modernization Program on the Texas Integrated Eligibility Redesign System.** Out of funds appropriated above, the Health and Human Services Commission shall report the fiscal impact of the federal Eligibility Modernization Program from fiscal year 2012 through fiscal year 2017~~2015~~ in Section 2.2 (Description of Method Used to Track Progress) of the Texas Project Delivery Framework, Project Monitoring Report to the Quality Assurance Team. *Rider is updated for biennial date change.*
HHSC 64	II-105	**Federal Provider Enrollment and Screening Fee**. For the purpose of this provision, Provider Screening and Enrollment Fees are defined as payments from medical providers and suppliers required by the U.S. Centers for Medicare and Medicaid Services as a condition for enrolling as a provider in the Medicaid and CHIP programs but collected and received by the Health and Human Services Commission. The method of finance Appropriated Receipts-Match for Medicaid, for appropriations made above, includes unexpended and unobligated balances of provider enrollment and screening fees remaining as of August 31, 2014~~2012~~, and receipts collected in fiscal years 2016~~2014~~ and 2017~~2015~~. The Provider Enrollment and Screening Fees may be expended only as authorized by federal law. In the event that these revenues should be greater than the amounts identified in the method of finance above as Appropriated Receipts for Medicaid, the commission is hereby appropriated and authorized to expend these receipts thereby made available, subject to the following requirements: a. Amounts available shall be expended prior to utilization of any other appropriated funds required to support provider enrollment,

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		b. Amounts collected shall also be used to fund applicable employee benefits pursuant to Article IX provisions elsewhere in this Act. c. Any unused fee balances shall be disbursed to the federal government, as required by federal law. This rider shall be the exclusive appropriation authority for receipts from the above identified sources, and none of these receipts shall be appropriated by a provision of Article IX of this Act. *Rider is updated for biennial date changes.*
HHSC 65	II-106	~~**Contract Management and Oversight.** Out of funds appropriated above in A.1.1, Enterprise Oversight and Policy, the Health and Human Services Commission shall conduct a thorough review of the agency's contract management and oversight function for Medicaid and CHIP managed care and fee-for-service contracts in order to make recommendations to improve the state's ability to identify anomalies in service utilization and their underlying cause. The review may be conducted by agency personnel or by an independent contractor (including under contract with the State Auditor's Office), but should be performed by reviewers who are not a part of agency contract administration or the Office of Inspector General. The review should consider the effectiveness and frequency of audits, the appropriateness of existing contract requirements including penalties, the availability of necessary data, the need for additional training and resources, and the adequacy of current prior authorization and utilization review functions. The agency shall report its findings and recommendations to the Legislature no later than September 1, 2014.~~ *Rider is deleted as the rider requirements will be completed during the 2014-2015 biennium.*
HHSC 66	II-106	~~**Contingency for STAR+PLUS Utilization Review.** Contingent on enactment of Senate Bill 348, or similar legislation relating to the implementation of a utilization review process for STAR+PLUS managed care organizations, by the Eighty-third Legislature, Regular Session, out of funds appropriated above in Goal B, Medicaid, Strategy B.1.2, Disability-Related, $394,697 in fiscal year 2014 and $367,044 in fiscal year 2015 in General Revenue Funds is transferred and appropriated to Strategy B.3.1, Medicaid Contracts and Administration. The number of "Full-Time Equivalents (FTE)" is increased by 9.0 FTEs in fiscal year 2014 and 9.0 FTEs in fiscal year 2015.~~ *Rider is deleted as the Senate Bill has been implemented and the nine FTEs have been filled.*
HHSC 67	II-106	~~**Information Technology Funding.** Included in appropriations above to the Health and Human Services Commission is $3,162,977 in General Revenue Funds and $15,192,049 in All Funds in fiscal year 2014 and $315,371 in General Revenue Funds and $2,681,299 in All Funds in fiscal year 2015 and authority for 2.0 FTEs in fiscal year 2014 and 4.0 FTEs in fiscal year 2015 for the purposes of implementing information security improvements and application provisioning enhancements, upgrading the Winters Data Center facilities, upgrading to the international Classification of Diseases (ICD-10) system, securing mobile infrastructure and enterprise communications, remediating hardware for HHSAS financial system, and retiring the CARE system across enterprise agencies. The agency may transfer funding and FTEs,~~

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		~~not to exceed the amounts noted above, to the appropriate health and human services agency for implementation of these projects.~~ ~~Contingent on the agency requiring additional funding for these projects, the executive commissioner may request approval from the Legislative Budget Board and the Governor to transfer up to $20,000,000 in General Revenue Funds from Goal B, Medicaid to the respective agency and strategy requiring funds to complete the above stated projects.~~ ~~To request a transfer, HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information:~~ ~~a. a detailed explanation of the purpose(s) of the transfer.~~ ~~b. the names of the originating and receiving strategies and the method of financing for each strategy by fiscal year;~~ ~~c. an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and the receiving strategies; and~~ ~~d. the capital budget impact.~~ ~~The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.~~ ~~The Comptroller of Public Accounts shall not allow the transfer of funds authorized by the above subsection if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.~~ *Rider is deleted as the contingency approval applies to 2014-2015 capital budget projects.*
HHSC 68	II-107	~~**Health Homes Health Teams State Plan Amendment.**~~ ~~a. It is the intent of the Legislature that out of funds appropriated above in Strategy B.3.1, Medicaid Contracts and Administration, the Health and Human Services Commission may apply for approval of a State Plan Amendment pursuant to Section 1945 of the Social Security Act to authorize Medicaid reimbursement for patient-centered care rendered by health teams to chronically homeless individuals who are eligible for Medicaid under the state's existing Medicaid plan. Contingent on approval of a State Plan Amendment proposed in this provision by the~~

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		~~Centers for Medicare and Medicaid Services, the Health and Human Services Commission may allocate funding from appropriations above in Strategy B.1.2, Disability-related, to provide such services, contingent upon prior written approval from the Legislative Budget Board and the Governor.~~ ~~b. To request approval to expend the funds for these purposes, HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information:~~ ~~(1) a copy of the approval from CMS of the State Plan Amendment;~~ ~~(2) the estimated number of health teams to provide the services;~~ ~~(3) the estimated fiscal impact by year and method of finance for the services and providers in the Medicaid program and any projected savings from the provision of these services; and~~ ~~(4) an estimate of performance levels and, where relevant, a comparison to targets included in this Act.~~ ~~c. The request shall be considered to be disapproved unless the Legislative Budget Board or the Governor issues a written approval within 45 calendar days of the date on which the Legislative Budget Board receives the request.~~ *Rider is deleted as this issue was discussed with the Centers for Medicare & Medicaid Services (CMS), and CMS indicated a State Plan amendment pursuant to Section 1945 would not be authorized for chronically homeless individuals. Federal law limits health homes to individuals who have at least: two chronic conditions; one chronic condition and is at risk of having a second chronic condition; or one serious and persistent mental health condition. CMS does not recognize chronic homelessness as a health condition. The health home benefit is limited to a service coordination benefit and may not be duplicative of other coordination benefits offer by the state, such as targeted case management or service coordination. HHSC currently provides target case management for individuals with certain mental health conditions and service coordination is a benefit of a STAR+PLUS program.*
HHSC 69	II-107	**Pediatric Long Term Care Facility Rate Setting.** It is the intent of the Legislature that the Executive Commissioner of HHSC shall develop and implement a Medicaid reimbursement methodology for the Pediatric Long Term Care facility rate class that includes a facility-specific prospective cost-based interim reimbursement rate and an annual cost-based retrospective cost settlement process. It is the intent of the Legislature that an annual settlement payment shall only be made for fiscal years in which the average daily census for the facility in that year was less than the average daily census of the prior fiscal year, except that no settlement shall be made for fiscal years in which the Medicaid-contracted bed occupancy rate~~average daily census~~ for the facility exceeded 85 percent or for fiscal years in which the facility's Medicaid revenues exceeded its Medicaid allowable costs. *Rider is revised as the language of the rider erroneously states that "no settlement shall be made for fiscal years in which*

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		the average daily census for the facility exceeded 85 percent"; the intent was that no settlement be made for fiscal years in which the average daily occupancy rate exceeded 85 percent.
HHSC 70	II-107	**Texas Home Visiting Program and Nurse Family Partnership Program.** Included in appropriations above to the Health and Human Services Commission in Strategy A.1.1, Enterprise Oversight and Policy, is $3,955,272~~2,681,099~~ in General Revenue Funds and $7,441,041~~10,483,330~~ in Federal Funds in fiscal year 2016~~2014~~ and $3,966,555~~5,229,445~~ in General Revenue Funds and $546,218~~10,483,330~~ in Federal Funds in fiscal year 2017~~2015~~ for the Texas Home Visiting Program and $5,624,999 in General Revenue Funds and $3,250,000 in TANF Federal Funds in each fiscal year for the Nurse Family Partnership Program. *Rider is updated for biennial date changes and revised to reflect 2016-2017 projections.*
HHSC 71	II-107	~~**Inpatient Payments to Children's Hospitals.** It is the intent of the Legislature that out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall implement an APR-DRG prospective payment system for inpatient services provided by a children's hospital to patients served in the Medicaid fee-for-service program, effective September 1, 2013. It is the intent of the Legislature that the Health and Human Services Commission shall update the rates for 2014 and 2015 using an appropriate measure of medical cost increases.~~ *Rider is deleted as APR-DRG prospective payment system for inpatient services provided by a children's hospital served in the Medicaid fee-for-service program was implemented September 1, 2013.*
HHSC 72	II-108	~~**Promote Innovative Nursing Home Care Models.** From funds appropriated above in A.1.1 Strategy: Enterprise Oversight & Policy, the Health and Human Services Commission, with the Department of Aging and Disability Services, shall identify additional opportunities to encourage culture change in Texas nursing homes and to encourage the development of Green House Project homes and similar small house models, as an alternative to traditional skilled nursing facilities. The Health and Human Services Commission shall report its findings to the Governor, Lieutenant Governor, the Senate Finance Committee, the Senate Health and Human Services Committee, the House Appropriations Committee, and the House Human Services Committee by September 1, 2014.~~ *Rider is deleted as the reporting requirements will be completed during the 2014-2015 biennium.*
HHSC 74	II-108	~~**Ambulance Transportation Services Funding.** It is the intent of the Legislature that out of funds appropriated above in Strategy B.3.1, Medicaid Contracts and Administration, the Health and Human Services Commission conducts a thorough analysis, inclusive of funding mechanisms used in other states, of opportunities to leverage local funds expended for emergency transport services for the purpose of enhancing ambulance transport payments. The commission shall submit the results of their findings with potential funding mechanism options to the Legislative Budget Board no later than December 1, 2014.~~ *Rider is deleted as the reporting requirements will be completed during the 2014-2015 biennium.*

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HHSC 75	II-108	~~**Reporting on Gestational Diabetes in Medicaid.** Out of funds appropriated above, and as the state Medicaid operating agency, the Health and Human Services Commission shall develop a report to identify the impact of gestational diabetes on the Medicaid population. The report shall include an analysis of cost implications, the number of pregnant women screened and diagnosed, and patient outcome measures. In consultation with the Texas Diabetes Council, the published report shall recommend strategies to reduce the impact of the condition and to improve outcomes for this population. The report is due to the Legislature and Governor by August 31, 2014.~~ *Rider is deleted as the reporting requirement will be completed during the 2014-2015 biennium.*
HHSC 77	II-108	**Umbilical Cord Blood Bank Funding.** Included in appropriations above in Strategy A.1.1, Enterprise Oversight and Policy, is $1,000,000 in General Revenue Funds in fiscal year 2016~~2014~~ and $1,000,000 in General Revenue Funds in fiscal year 2017~~2015~~ for the purpose of entering into a contract with a public cord blood bank in Texas for gathering from live births umbilical cord blood and retaining the blood at an unrelated cord blood bank for the primary purpose of making umbilical cord blood available for transplantation purpose. The contracting blood bank must be accredited by the American Association of Blood Banks and the International Organization for Standardization. *Rider is updated for biennial date changes.*
HHSC 78	II-108	**Interagency Grant and Resource Coordination to Improve Service Delivery to Children and Families.** Out of funds appropriated above to the Health and Human Services Commission, the amount of $300,000 in General Revenue for the state fiscal biennium ending August 31, 2017~~2015~~, may be used to fund 1.0 FTE for Community Resource Coordination Groups and to facilitate cross-agency grant and resource coordination aimed at improving service delivery to and outcomes for children and families. *Rider is updated for biennial date change.*
HHSC 79	II-108	**Primary Care Access Funding for Health Related Institutions.** The Health and Human Services Commission may spend appropriated receipts comprising interagency transfers from or interagency agreements with Health Related Institutions (HRIs) and the Higher Education Coordinating Board and matching Federal Funds to fund ~~per-member per-month payments to HRIs and to establish~~ capitation primary care quality incentive payments to HRIs for the provision of primary care services to Medicaid ~~and CHIP~~ clients. Participation of the entities in subsection (c) is voluntary. a. **Medicaid.** The Health and Human Services Commission may fund the capitation ~~per-member, per-month~~ payments and primary care incentive payments described in this section with Appropriated Receipts - Match for Medicaid, state appropriated funding or intergovernmental transfers and matching Medicaid Federal Funds out of risk groups in Goal B~~Strategy B.2.1, Non-Full Benefit Payments~~. b. **CHIP.** The Health and Human Services Commission may fund the per-member, per-month payments and primary care incentive payments described in this section with matching Children's Health Insurance Program

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		(CHIP) Federal Funds out of Strategy C.1.1, Children's Health Insurance Program (CHIP). c. **Eligible HRIs.** The following entities are eligible for the capitation ~~per-member, per-month~~ payments and primary care incentive payments described in this section: (1) Baylor College of Medicine; (2) Public Health Related Institutions; and (3) A family practice, primary care, or other residency program that receives funds appropriated to the Higher Education Coordinating Board under Article III of this Act. *Rider is revised to delete references to per member per month to allow more flexibility. Managed care organizations (MCOs) and HRIs may want to negotiate lump sum payments and this approach may be less risky to State general revenue since the Centers for Medicare and Medicaid Services (CMS) is requiring the carve-in of supplemental payments into the capitation rates.*
HHSC 80	II-109	**Federal Funding for Health Related Institutions.** It is the intent of the Legislature that the Health and Human Services Commission maximize federal funding for Health Related Institutions should they transfer 2016-2017~~2014-15~~ appropriations to the commission for such purposes. *Rider is updated for biennial date changes.*
HHSC 81	II-109	**Receipt of Transfers for Participation in the Healthcare Transformation and Quality Improvement Program.** The Health and Human Services Commission may receive in Strategy B.2.6, Transformation Payments, intergovernmental transfers of funds from institutions of higher education as the non-federal share of uncompensated care or delivery system reform incentive payments or monitoring costs under the Healthcare Transformation and Quality Improvement Program 1115 Waiver. *Rider is revised to clarify that consistent with HHSC rule that all DSRIP IGT entities pay a proportionate share of the non-federal share for DSRIP monitoring contract costs, institutions of higher education that provide funds to HHSC through this rider may provide those funds for UC and DSRIP payments and DSRIP monitoring costs.*
HHSC 83	II-109	~~**Children's Hospital DSH.** Out of funds appropriated above, the Health and Human Services Commission (HHSC) may adjust rates for Medicaid outpatient hospital, outpatient surgical and emergency department services and to make payments for Medicaid allowable costs for pediatric graduate medical education to mitigate Medicaid reimbursement shortfalls at children's hospitals that are not reimbursed through the Disproportionate Share Hospital (DSH) Program due to policy interpretation by the federal Centers for Medicare and Medicaid Services (CMS) on the calculation of the Medicaid shortfall. Rate adjustments to mitigate the related loss of DSH payments are subject to the prior written approval~~

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		~~required under Special Provisions Relating to All Health and Human Services Agencies, Section 44, Rate Limitations and Reporting Requirements.~~ *Rider is deleted as HHSC completed implementation of this rider on September 1, 2013, by exempting Children's Hospitals from certain outpatient reimbursement reductions. As well, litigation between Texas Children's Hospital and HHSC regarding the DSH policy interpretation referred to in the rider was decided in HHSC's favor by Judge Tim Sulak of the 200th Judicial District Court of Travis County and the plaintiff notified the Office of the Attorney General that they would not file a notice of appeal or a motion for new trial. Finally, the Centers for Medicare and Medicaid Services (CMS) has indicated to HHSC that it will deny HHSC's request to use a policy interpretation different from that promulgated by CMS in its calculation of the Medicaid shortfall.*
HHSC 84	II-109	**Prescription Drug Carve Into Managed Care Organizations.** It is the intent of the Legislature that capitated managed care organizations in STAR, STARHealth, STAR+PLUS and CHIP exclusively employ the vendor drug program formulary and adhere to the applicable HHSC preferred drug list including the prior authorization and program procedures during fiscal years 2016~~2014~~ and 2017~~2015~~. *Rider is updated for biennial date changes.*
HHSC 85	II-110	~~**Study and Report on Sepsis Infections in Medicaid.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall study and submit a report to the Legislature of the health outcomes and fiscal impact of sepsis and septicemia on the Medicaid program. The report shall also investigate the use of evidence based protocols such as early goal directed therapy by health care facilities in Texas and the success and prevalence of such protocols in reducing the incidence, mortality, and related costs in the Medicaid program. The report shall include recommendations from the commission for the implementation of a plan to improve the health of Texans and decrease costs in Medicaid by decreasing the impact of sepsis and septicemia. The commission shall submit the report by September 1, 2014.~~ *Rider is deleted as the reporting requirements will be completed during the 2014-2015 biennium.*
HHSC 86	II-110	~~**Transitional Medicaid DSH and Related Payments.** Out of funds appropriated above to the Health and Human Services Commission in Goal B, Medicaid, the Health and Human Services Commission may expend up to $160,000,000 in General Revenue Funds in fiscal year 2014 and $140,000,000 in General Revenue Funds in fiscal year 2015 to stabilize and improve Medicaid hospital payments, including providing a portion of the non-federal share of Medicaid Disproportionate Share Hospital (DSH) payments and/or rate adjustments to recognize improvements in quality of patient care, the most appropriate use of care, and patient outcomes. Expenditure of General Revenue Funds under this provision is contingent upon: a. Measurable progress by the commission towards a plan to stabilize and improve the system for providing hospital payments for Medicaid services and for uncompensated care in fiscal year 2014. No funds may be expended in~~

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		~~fiscal year 2015 under this provision before the plan is finalized. The plan should address:~~ ~~(1) The appropriate balance and a proportional allocation of supplemental hospitals payments, including DSH and Uncompensated Care (UC) payments, among large public, small public, and non-public providers taking into consideration the provision of care to Medicaid and low income patients and the ongoing availability of DSH funding support (IGT) provided by large public hospitals;~~ ~~(2) The Medicaid shortfall that occurs due to state Medicaid rates paid to hospitals and the impact of such rates on hospitals that provide a disproportionate share of Medicaid and uncompensated care;~~ ~~(3) Mechanisms though which Medicaid payments are made through managed care organizations;~~ ~~(4) Recommended statutory changes and any other legislative direction needed to fully implement the plan;~~ ~~(5) An assessment of the extent to which supplemental payments are needed to cover Medicaid and uninsured/uncompensated care costs;~~ ~~(6) A plan to transition from supplemental payments to rates that recognize improvements in quality of patient care, the most appropriate use of care, and patient outcomes, and;~~ ~~(7) Steps to ensure General Revenue Funds appropriated to the Health and Human Services Commission will no longer be used as the non-federal share of DSH supplemental payments by the end of fiscal year 2015.~~ ~~b. Approval of a request from the commission to expend the funds by the Legislative Budget Board and the Governor. The request shall be considered approved unless the Legislative Budget Board or the Governor issues a written disapproval within 45 calendar days of the date on which the Legislative Budget Board receives the request.~~ ~~(1) For fiscal year 2014, the request shall demonstrate progress toward the plan under section (a), and include how hospital reimbursement rates may be impacted by subsection a(6), the proposed state appropriations to be expended by fiscal year for supplemental payments and rate enhancements respectively, estimated IGT expected to be transferred to the commission in each fiscal year for the purpose of drawing down the available DSH allotment, and allocation to the major categories of hospitals.~~ ~~(2) For fiscal *year* 2015, the request shall include the final plan under section (a) in addition to all other information under section b(1).~~

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		Rider is deleted as the rider specifically refers to contingency appropriations for the disproportionate share hospital (DSH) program for fiscal years 2014 and 2015 and should not be retained for the 2016-17 biennium.
HHSC 87	II-111	**The Center for Elimination of Disproportionality and Disparities Center.** Out of funds appropriated above in Strategy A.2.1, Consolidated System Support, it is the intent of the Legislature that the Center for Elimination of Disproportionality and Disparities (CEDD) shall advise each health and human services, education, juvenile justice, child welfare, and mental health agency on the implementation of cultural competency training and develop partnerships with community groups and agencies to support the delivery of culturally competent services to children and families. The CEDD shall only contract with entities that have been screened, reviewed, and approved by the executive commissioner of the Health and Human Services Commission. ~~The CEDD and the Interagency Council for Addressing Disproportionality shall also develop and recommend to the executive commissioner policies for addressing disproportionality and disparities in the education, juvenile justice, child welfare, health and mental health systems, and implement those policies statewide. The CEDD and the Interagency Council for Addressing Disproportionality shall report on the status of the implementation of the policies to the Lieutenant Governor, Speaker of the House of Representatives, and the Legislature by December 1, 2014.~~ *Rider is revised as the Interagency Council's formal term, as described in SB 501 (2011, 82nd Texas Legislature), legally expired on December 31, 2013, and CEDD and HHSC are finalizing a report as required by this statute and will submit it in advance of the statutory deadline.*
Article IX, Section 17.14	IX-77	~~**Sec. 17.14. Eligible Expenses in the Medicaid Program.**[1] In addition to amounts appropriated elsewhere in this Act for fiscal years 2014 and 2015 by the Eighty-third Legislature, Regular Session, the amount of $160,000,000 in fiscal year 2014 and $140,000,000 in fiscal year 2015 is appropriated out of General Revenue Dedicated account number 5111, Trauma Facility and EMS Account, to the Department of State Health Services, for the purpose of entering into an interagency contract with the Health and Human Services Commission to provide for eligible expenses in the Medicaid program. Appropriations elsewhere in this Act to the Health and Human Services Commission in Goal B, Medicaid, are reduced in the amount of $160,000,000 in fiscal year 2014 and $140,000,000 in fiscal year 2015 in General Revenue Funds.~~ *This Article IX Section is tied to HHSC Article II, Rider 86. Since the requirement in Rider 86 has been met, this agency specific rider is deleted as this section is no longer relevant. Rider is deleted as the agency specific rider specifically refers to contingency appropriations for the disproportionate share hospital (DSH) program for fiscal years 2014 and 2015 and should not be retained for the 2016-17 biennium.*
HHSC 701	II	**Re-Investing for HHSC Eligibility Business Process Improvements.** Notwithstanding any other provisions in this Act, as efficiencies are realized as a result of business process improvements or cost saving initiatives within eligibility operations, the Executive Commissioner is authorized to reinvest General Revenue or Other funds savings in Strategy A.2.1 Integrated Eligibility and Enrollment to the support retention of

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		eligibility determination staff including, but not limited to enhancement of career ladders. a. The authority granted by this provision is contingent upon written notification from the commission to the Legislative Budget Board, Governor, and Comptroller of Public Accounts at least 30 days prior to the investment and expenditure of funds that includes the following information: (1) a detailed explanation of the source of funds and the impact to the program by agency, including any performance measures; (2) a description of how the funds are to be invested with any identifiable outcomes for the current and future fiscal year; (3) the impact on Full-time equivalent positions by agency; (4) the impact to general revenue and any other method of financing by agency strategy by fiscal year; and (5) any estimated increase in capital expenditures by method of financing by agency by fiscal year. b. The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. c. The Comptroller of Public Accounts shall not allow the transfer of funds or the adjustment of capital authority limitations authorized by this provision if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied. *This new rider would allow the HHSC Executive Commissioner to use funds to support retention of eligibility determination staff.*

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Sec. 7	II-115	**Federal Match Assumptions and Limitations on use of Available General Revenue Funds.**

a. **Federal Match Assumptions.** The following percentages reflect federal match assumptions used in Article II of this Act.

Federal Medical Assistance Percentage (FMAP)

	2016	2017
Federal Fiscal Year	57.23%	57.23%
State Fiscal Year	57.30%	57.23%

Enhanced Federal Medical Assistance Percentage (EFMAP)

	2016	2017
Federal Fiscal Year	93.06%	93.06%
State Fiscal Year	91.19%	93.06%

~~**Federal Medical Assistance Percentage (FMAP)**~~

	~~2014~~	~~2015~~
~~Federal Fiscal Year~~	~~58.69%~~	~~58.00%~~
~~State Fiscal Year~~	~~58.74%~~	~~58.06%~~

~~**Enhanced Federal Medical Assistance Percentage (EFMAP)**~~

	~~2014~~	~~2015~~
~~Federal Fiscal Year~~	~~71.08%~~	~~70.60%~~
~~State Fiscal Year~~	~~71.12%~~	~~70.64%~~

b. **Limitations on Use of Available General Revenue Funds.** In the event the actual FMAP and EFMAP should be greater than shown in section (a), the health and human services agencies listed in Chapter 531, Government Code, are authorized to expend the General Revenue Funds thereby made available only upon prior written approval from the Legislative Budget Board and Governor.

To request authorization to expend available General Revenue Funds, an agency shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information, by fiscal year:

(1) a detailed explanation of the proposed use (s) of the available General Revenue Funds and whether the expenditure (s) will be one-time or ongoing;

(2) the amount available by strategy;

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		(3) the strategy (ies) in which the funds will be expended and the associated amounts, including any matching federal funds; (4) an estimate of performance levels and, where relevant, a comparison to targets included in this Act; and (5) the capital budget and/or full-time equivalent impact. Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board. The request shall be considered to be approved unless the Legislative Budget Board or the Governor issue a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. The Comptroller of Public Accounts shall not allow the expenditure of General Revenue Funds made available if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied. *Rider is updated for biennial date changes. Will need to be updated to reflect FFIS' estimated rates (unofficial numbers added above). Super EFMAP used for CHIP under ACA.*
Sec. 12	II-117	**Medicaid Informational Rider.** This rider is informational only and does not make any appropriations. The Health and Human Services Commission is the single state agency for Title XIX, the Medical Assistance Program (Medicaid) in Texas. Other agencies receive appropriations for and responsibility for the operations of various Medicaid programs. Appropriations made elsewhere in this Act related to the Medicaid program include the following: **A. <u>Agency Name</u>** — **<u>FY ~~2014~~2016</u>** — **<u>FY ~~2015~~2017</u>** Department of Aging and Disability Services — ~~$ 6,187,886,453~~ — ~~$ 6,870,047,038~~ Department of Assistive and Rehabilitative Services — ~~78,030,643~~ — ~~82,409,398~~ Department of Family and Protective Services — ~~19,203,249~~ — ~~19,225,089~~

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		Department of State Health Services ~~162,263,636~~ ~~178,559,857~~ Health and Human Services Commission ~~21,901,613,405~~ ~~22,731,503,050~~ **Total, Medical Assistance Program** **~~$ 28,348,997,386~~** **~~$ 29,881,744,432~~** **Method of Finance:** General Revenue for Medicaid ~~$ 10,874,494,464~~ ~~$ 11,602,090,343~~ Tobacco Settlement Receipts for Medicaid ~~146,584,718~~ ~~225,153,518~~ Subtotal General Revenue Funds ~~11,021,079,182~~ ~~11,827,243,861~~ General Revenue - Dedicated Funds ~~55,100,000~~ ~~55,100,000~~ Federal Funds ~~16,914,028,669~~ ~~17,660,640,879~~ Interagency Contracts ~~230,100,542~~ ~~210,100,621~~ Medicaid Subrogation Receipts ~~80,000,000~~ ~~80,000,000~~ Appropriated Receipts Match for Medicaid ~~16,761,782~~ ~~16,731,293~~ Foundation School Funds as Match for Medicaid ~~16,498,102~~ ~~16,498,102~~ MR Collections for Patient Support and Maintenance ~~15,429,109~~ ~~15,429,676~~ Subtotal, Other Funds ~~358,789,535~~ ~~338,759,692~~ **Total, All Funds** **~~$ 28,348,997,386~~** **~~$ 29,881,744,432~~** *Rider is updated for biennial date changes. Informational rider will need to be updated to reflect 2016-2017 appropriated levels.*
Sec. 16	II-120	**General Revenue Funds for Medicaid Mental Health and Intellectual Disability Services.** For the purposes of this section and appropriation authority for the Medicaid mental health and intellectual disability program responsibilities of the Department of State Health Services and the Department of Aging and Disability Services, the following subsections provide governance relating to appropriate use, classification and expenditure of funds. a. **General Revenue Match for Medicaid.** ABEST Method of Financing Code 758 – GR Match for Medicaid shall be used to report General Revenue expenditures and request General Revenue appropriations for the state's share of Medicaid payments for the following Medicaid mental health and intellectual disability services: (1) Community-based Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID) that are

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		privately operated through contractual arrangements between private providers and the Department of Aging and Disability Services; (2) Community-based Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID), also known as Bond Homes, that are operated by the Department of Aging and Disability Services; (3) Home and Community-based Services (HCS) authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and the Department of Aging and Disability Services; (4) Texas Home Living services authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and the Department of Aging and Disability Services; (5) Mental health services provided through contracts with Behavioral Health Organizations as a component of the NorthSTAR Project; (6) Rehabilitation Services as approved in the State Medicaid Plan which are provided by Mental Health Authorities and IDD Local Authorities; (7) Targeted Case Management Services as approved in the State Medicaid Plan provided by Mental Health Authorities and IDD Local Authorities; (8) Service Coordination Services as approved in the State Medicaid Plan provided by Mental Health Authorities and IDD Local Authorities; and (9) Salaries and operating costs related to direct program administration and indirect administration of the departments. (10) Home and Community-based Services (HCS) authorized by a 1915 (c) Youth Empowerment Services (YES) federal waiver and provided through contractual arrangements between provider agencies and Department of State Health Services. b. **General Revenue Certified as Match for Medicaid**. The Department of State Health Services and the Department of Aging and Disability Services shall use ABEST Method of Financing code 8032 - General Revenue Certified Match for Medicaid to identify General Revenue funds requested and reported as expended for the purpose of drawing Federal Funds and to document that State funds have been spent for Medicaid

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		mental health and intellectual disability services and administrative expenditures for the following services: (1) Intermediate care facilities for individuals with intellectual disabilities that are operated by the State and known as "state supported living centers"; (2) Services delivered in state hospitals operated by the Department of State Health Services including inpatient services for clients under the age of 21 and services that qualify under the federally approved Institutions for Mental Diseases (IMD) option for clients over the age of 65; and (3) Medicaid Administrative Claims as approved in the State Medicaid Plan which are based on certain activities of Mental Health Authorities and IDD Local Authorities. c. **Reporting requirements related to General Revenue Matching Funds for Medicaid Mental Health and Intellectual Disability Services.** The Department of State Health Services and the Department of Aging and Disability Services shall report monthly to the Legislative Budget Board, Comptroller of Public Accounts and Governor on the expenditures of General Revenue for Medicaid federal matching purposes by the method of financing codes identified above and the amounts of local, non-profit expenditures certified as state match for Medicaid Federal Funds by the departments for services provided by Mental Health Authorities and IDD Local Authorities. d. **Medicaid Federal Funds.** The Department of State Health Services and the Department of Aging and Disability Services shall report their expenditures and request legislative appropriations for federal Medicaid matching funds for client services, program administration and agency indirect administration. Automated Budgeting and Evaluation System of Texas (ABEST) Method of Financing Code (MOF) 555 and Medicaid CFDA 93.778 shall be used for the following: (1) Federal Funds drawn from the U.S. Centers for Medicare and Medicaid Services (CMS) using General Revenue funds classified as General Revenue Match for Medicaid (ABEST MOF Code 758), General Revenue Certified as Match for Medicaid (ABEST MOF Code 8032), Tobacco Settlement Receipts Match for Medicaid (ABEST MOF Code 8024) or Tobacco Receipts Certified as Match for Medicaid (ABEST MOF Code 8023); (2) Federal Funds drawn from CMS using the departments' certification of local, non- profit expenditures made by the Mental Health Authorities and IDD Local Authorities on behalf of Medicaid-eligible individuals; (3) Federal Funds received from CMS for services rendered to certain Medicaid-eligible individuals over the age of 65 by federally recognized Institutions for Mental Diseases (IMD Medicaid option) based on billings

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from state hospitals operated by the Department of State Health Services to the claims processing agent for the Texas Medicaid program in its capacity as the State's fiscal agent for certain Medicaid payments; and

(4) Federal Funds received from CMS for general Medicaid health services including the Comprehensive Care Program for children based on billings from the state hospitals and state supported living centers operated by the Department of State Health Services and the Department of Aging and Disability Services to the claims processing agent for the Texas Medicaid program in its capacity as the State's fiscal agent for certain Medicaid payments.

e. **Appropriation authority and accounting for Federal Funds for Medicaid Mental Health and Intellectual Disability Services.** Amounts defined as Medicaid Federal Funds shall be used as a first source, and General Revenue which was not used as matching funds shall not be used to fund Medicaid-eligible services. In the event that these revenues should be greater than the amounts included above in Federal Funds for mental health and intellectual disability services for the Department of State Health Services and the Department of Aging and Disability Services, the departments are hereby appropriated and authorized to expend these Federal Funds made available, subject to the following requirements:

(1) Amounts made available shall be expended prior to utilization of any General Revenue made available for the same purpose;

(2) In the event General Revenue has been expended prior to the receipt of Medicaid Federal Funds, the departments shall reimburse General Revenue upon receipt of the revenue. This process shall be completed on a monthly basis in order to not have an excess balance of Medicaid Federal Funds; and

(3) The departments shall report monthly to the Legislative Budget Board, Comptroller of Public Accounts and Governor on the amounts of Medicaid Federal Funds drawn

f. **Responsibility for proportionate share of indirect costs and benefits**. Nothing in this provision shall exempt the departments from provisions of Article IX of this Act which apply equally to direct recoveries of benefits and indirect costs and to amounts recovered through an approved rate structure for services provided. Specifically, the departments do not have appropriation authority for Medicaid Federal Funds claimed on behalf of services provided by other agencies, including:

(1) Health and retirement services for active and retired Department of State Health Services and Department of Aging and Disability Services employees paid by the Employee Retirement System;

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		(2) Social Security payments, salary increases authorized in General Provisions, and Benefit Replacement Pay for Department of State Health Services and Department of Aging and Disability Services employees paid by the Comptroller of Public Accounts; (3) Debt service amounts paid on behalf of the Department of State Health Services and Department of Aging and Disability Services by the Texas Public Finance Authority; and (4) Indirect cost allocation plans negotiated with CMS for the purposes of the State-wide Cost Allocation Plan (SWCAP). g. **Exclusive Appropriation Authority.** The preceding subsections of this provision shall be the exclusive appropriation authority for Medicaid mental health and intellectual disability services Federal Fund receipts from the above identified sources, and none of these receipts shall be appropriated by a provision of Article IX of this Act. *Rider is revised to add section a(10) to ensure that Home and Community-based Services (Youth Empowerment Services Waiver) is included in Section 16 a – General Revenue Match for Medicaid.*
Sec. 32	II-126	~~**Limit on Spending New Generation Medication Funds.**~~ ~~a. It is the intent of the Legislature that the Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS) utilize funds appropriated for New Generation Medications for no other purpose than the provision, prescribing, and monitoring of New Generation Medications. This limitation shall apply to funds appropriated for New Generation Medications in the following strategies at DSHS: B.2.1, Mental Health Services for Adults, B.2.2, Mental Health Services for Children, B.2.4, NorthSTAR Behavioral Health Waiver, and C.1.3, Mental Health State Hospitals; and in the following strategy at DADS: A.8.1, State Supported Living Centers.~~ ~~b. Notwithstanding the limitation described above, the department shall allow a local mental health authority or DADS local authority to expend an amount not to exceed 15 percent of its New Generation Medication funds on support programs that are related to the administration of New Generation Medications, provided, however, that an authority using its New Generation Medication funds for support services must meet its contracted performance target for persons served with New Generation Medications and that the availability of New Generation Medication funds to expend on services must result from cost efficiencies achieved by the authority.~~ ~~c. To the extent that the local authorities or state contracted managed care organizations are able to obtain cost savings associated with cost effective purchasing arrangements, private sector donations of medications for clients and/or financial contributions for the purchase of New Generation Medications in DSHS Strategies B.2.1, Mental Health Services for Adults, B.2.2, Mental Health Services for Children, and B.2.4, NorthSTAR Behavioral Health~~

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		~~Waiver, and they meet or exceed their contracted performance targets for persons served with New Generation Medications, they may expend up to an equivalent amount from these strategies on direct services to clients.~~ *Rider is deleted as it is out of date. DSHS related performance measures were recently approved for removal.*
Sec. 36	II-127	**Limitation on Unexpended Balances: General Revenue for Medicaid.** Unexpended balances in General Revenue Funds appropriated for the Medicaid program (GR Match for Medicaid and GR Certified as Match for Medicaid) to the Health and Human Services Commission, the Department of Aging and Disability Services, and the Department of State Health Services for fiscal year ~~2014~~2016 are appropriated for the same purposes to the respective agencies for fiscal year ~~2015~~2017 only upon prior written approval by the Legislative Budget Board and the Governor. For authorization to expend the funds, an agency shall submit a written request to the Legislative Budget Board and the Governor by April 1, ~~2014~~2016. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request must be organized by fiscal year as follows: a. The following information shall be provided for fiscal year ~~2014~~2016: (1) a detailed explanation of the cause(s) of the unexpended balance(s); (2) the amount of the unexpended balance(s) by strategy; and (3) an estimate of performance levels and, where relevant, a comparison to targets in this Act. b. The following information shall be provided for fiscal year ~~2015~~2017: (1) a detailed explanation of the purpose(s) for which the unexpended balance(s) will be used and whether the expenditure will be one-time or ongoing; (2) the amount of the expenditure by strategy; (3) an estimate of performance levels and, where relevant, a comparison to targets in this Act; and (4) the capital budget impact. An agency shall submit a revised written request by October 1, ~~2014~~2016 if the amount of the estimated unexpended balance(s) varies by more than five percent from the amount estimated in the original request. Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner.

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		The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board. The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. The Comptroller of Public Accounts shall not allow the use of unexpended balances if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied. *Rider is updated for biennial date changes.*
Sec. 37	II-126	**Appropriation of Receipts: Civil Monetary Damages and Penalties.** Included in the amounts appropriated above for the ~~2014~~2016 ~~2015~~2017 biennium are the following: ~~a. $2,660,000 in General Revenue Match for Medicaid for the Department of Aging and Disability Services;~~ ~~b.~~a. $1,414,870 in General Revenue Match for Medicaid for the Health and Human Services Commission; and ~~c.~~b. $780,000 in General Revenue for the Department of State Health Services. These amounts are contingent upon the collection of civil monetary damages and penalties under Human Resources Code §§ 32.021 and 32.039, and Health and Safety Code § 431.0585. Any amounts collected above these amounts by the respective agency are hereby appropriated to the respective agency in amounts equal to the costs of the investigation and collection proceedings conducted under those sections, and any amounts collected as reimbursement for claims paid by the agency. *DADS is no longer allowed to spend these funds this way per CMS guidance.*
Sec. 39	II-128	**Appropriation of Unexpended Balances: Funds Recouped from Local Authorities.** Notwithstanding other provisions of this Act, any state funds appropriated for fiscal year 2014 recouped by the Department of Aging and Disability Services or the Department of State Health Services from a local mental health authority or DADS local authority for failing to fulfill its performance contract with the State, are hereby appropriated to the respective agency for the same strategy, to reallocate to other local mental health authorities or DADS local authorities in the following fiscal year ~~2015~~. Each agency shall provide a report to the Legislative Budget Board and the Governor by June 1, 2016~~2014~~ that

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		includes the amount of the recoupment by strategy, the reasons for the recoupment, the local authorities involved, any performance contract requirements that were not met, and the purposes of the reallocation. *Rider is revised to account for funds recouped following the last year of the biennium.*
Sec. 41	II-129	~~**Appropriation Authority for Intergovernmental Transfers.**~~ ~~a. In addition to funds appropriated above and in an effort to maximize the receipt of federal Medicaid funding, the Health and Human Services Commission and the Department of Aging and Disability Services may expend intergovernmental transfers (IGTs) received as Appropriated Receipts-Match for Medicaid for the purpose of matching Medicaid Federal Funds for payments to Medicaid providers.~~ ~~b. For authorization to expend the funds, HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include information regarding the strategy allocation of the IGT, the amount requested in each fiscal year, the All Funds impact to the budget, the impact to the rate or premium for which the IGT will be used (subject to Special Provisions, Section 44 approval), and the specific purpose and program for which the funds will be used. The request must also include a copy of a written agreement from the governmental entity that is transferring the funds that the funding be spent in the manner for which it is being requested.~~ ~~The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.~~ ~~The Comptroller of Public Accounts shall not allow the use of the funds if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.~~ *Rider is deleted as this Section added to allow DADS to expend IGTs received as Appropriated Receipts-Match for Medicaid for purposes of matching Medicaid Federal Funds for payments to Medicaid nursing facility providers under the Nursing Facility (NF) Upper Payment Limit (UPL) program. The section was never accessed during the 2014-15 biennium because all NF UPL IGTs were off budget and not received as Appropriated Receipts. The NF UPL program will end upon NF carve-in to managed care. Any possible replacement program will be funded the same way as the NF UPL program, so this Section is not necessary.*
Sec. 42	II-130	**HHS Office Consolidation and Co-location.** No funds appropriated under this Act may be expended for Health and Human Services Commission or health and human services agencies listed in Chapter 531, Government Code, for office or building space leased by the Texas Facilities Commission (TFC) on behalf of these agencies where the determination

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		has been made that the leased space is no longer needed due to: 1) a change in client demographics resulting in the ability to relocate staff to other locations, 2) a change in service delivery model or improvement in business processes, or 3) consolidations of office or building space to achieve cost or operational efficiencies. Prior to vacating any space and asking TFC to cancel a lease, HHSC will perform subsections (a) and (b) below: a. Conduct an evaluation of the space to be vacated and document the factors that substantiate the decision to vacate the space. This evaluation may include client demographics, employee usage and travel status, facility costs, facility location, facility condition, Texas Accessibility Standards, and safety. b. Provide written notification to the Texas Facility Commission at least 270 days prior to the date of the lease cancellation. At the same time, HHSC shall provide notification to the Legislative Budget Board and the Governor's office of the intent to terminate a lease and the anticipated savings to be realized from consolidation and efficiencies. c. The Executive Commissioner is authorized, contingent upon approval from the Legislative Budget Board and the Governor, to utilize any of the freed-up General Revenue Funds or Other Funds reported under section (b) or funds freed up because of business process improvements or cost saving initiatives within eligibility operations for the purposes of reinvesting in improveding business practicesprocesses and technologyoffice modernization projects that promote more efficient use of space, state staff and resources across the HHS system. d. To request approval to utilize the freed-up funding for purposes under section (c) office modernization and business process improvements, HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information: (1) a detailed explanation of the project to be undertaken and the efficiencies to be realized; (2) the names of the originating and receiving strategies and agencies and the method of financing for each strategy by fiscal year; (3) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and the receiving strategies; and (4) the capital budget impact. e. The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.

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		f. The Comptroller of Public Accounts shall not allow the transfer of funds authorized by the above subsection if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied. *Rider is revised to authorize the HHSC Executive Commissioner to transfer funds between strategies and HHS agencies to allow agencies to use freed-up funding to implement modernization initiatives or business process redesigns.*
Sec. 44	II-132	**Rate Limitations and Reporting Requirements.** Notwithstanding other provisions of this Act, the use of appropriated funds for a rate paid by a health and human services agency as listed in Chapter 531, Government Code, shall be governed by the specific limitations included in this provision. For purposes of this provision, "rate" is defined to include all provider reimbursements (regardless of methodology) that account for significant expenditures by a health and human services agency as listed in Chapter 531, Government Code. "Fiscal impact" is defined as an increase in expenditures due to either a rate change or establishment of a new rate, including the impact on all affected programs. Additionally, estimates of fiscal impacts should be based on the most current caseload forecast submitted by the Health and Human Services Commission (HHSC) pursuant to other provisions in this Act and should specify General Revenue-related Funds, TANF Federal Funds, and All Funds. Fiscal estimates that impact multiple risk groups may be reported at an aggregate level and acute care services may be reported by rate category. a. **Notification of Change to Managed Care Rates**. (1) No later than 45 calendar days prior to implementation of a change to premium rates for managed care organizations (MCO) contracting with HHSC, the Executive Commissioner of the HHSC shall submit the following information in writing to the Legislative Budget Board, the Governor, and the State Auditor: (i) a schedule showing the original and revised rate, which should include information on the rate basis for the MCO reimbursements to providers; (ii) a schedule and description of the rate-setting process for all rates listed for subsection (1); and (iii) an estimate of the fiscal impact, by agency and by fiscal year, including the amount of General Revenue Funds, TANF Federal Funds, and All Funds for each rate change listed for subsection (1). (2) Within seven days of the submission requirements listed above in subsections (i) through (iii), the Executive Commissioner of the HHSC shall submit a schedule identifying an estimate of the amount of General Revenue Funds, TANF Federal Funds, and All Funds by which expenditures at such rate levels would

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exceed appropriated funding.

b. **Quarterly Notification**. On a quarterly basis, HHSC shall provide notice of changed rates for:

(1) new procedure codes required to conform to Federal Healthcare Common Procedure Coding System (HCPCS) updates;

(2) revised rates occurring as a result of a biennial calendar fee review;

(3) new procedure codes and revised rates for physician-administered drugs;

~~(3)~~(4) any rate change estimated to have an annual fiscal impact of less than $500,000 in General Revenue-related Funds or TANF Federal Funds; and

~~(4)~~(5) Any rate change for which approval is obtained under section (c).

c. **Limitation on Rates that Exceed Appropriated Funding.** With the exception of those rates specified in subsections (1) - (4~~3~~) of section (b), Quarterly Notification, no agency listed in Chapter 531, Government Code, may pay a rate that would result in expenditures that exceed, in any fiscal year, the amounts appropriated by this Act to a strategy for the services to which the rate applies without the prior written approval of the Legislative Budget Board and the Governor.

To request authorization for such a rate, the Executive Commissioner of the HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information:

(1) a list of each new rate and/or the existing rate and the proposed changed rate;

(2) an estimate of the fiscal impacts of the new rate and/or rate change, by agency and by fiscal year; and

(3) the amount of General Revenue Funds, TANF Federal Funds, and All Funds, by fiscal year, by which each rate would exceed appropriated funding for each fiscal year.

The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the request for authorization for the rate and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.

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		d. Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. Notifications, requests and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board. e. The Office of the State Auditor may review the fiscal impact information provided under sections (a) through (c) along with supporting documentation, supporting records, and justification for the rate increase provided by the Health and Human Services Commission and report back to the Legislative Budget Board and the Governor before the rate is implemented by the Health and Human Services Commission or operating agency. f. The Comptroller of Public Accounts shall not allow the expenditure of funds for a new or increased rate if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied. *Rider is updated as a decision to add a certain physician-administered drug as a Medicaid-covered benefit should be a medical decision rather than fiscal decision. Section 44 does not apply to non-physician-administered drugs and it would be logical to exclude physician-administered drugs as well.*
Sec. 46	II-133	**~~Balancing Incentive Program Reporting.~~** ~~The Health and Human Services Commission, the Department of Aging and Disability Services, and any other health and human services agency listed in Chapter 531, Government Code, as applicable, shall submit to the Legislative Budget Board and the Governor the monthly expenditures eligible for enhanced federal match under the Balancing Incentive Program. The data shall be submitted on a monthly basis in a format specified by the Legislative Budget Board.~~ ~~a. Each report submitted pursuant to this provision must contain a certification by the person submitting the report that the information provided is true and correct based upon information and belief together with supporting documentation.~~ ~~b. The Comptroller of Public Accounts shall not allow the expenditure of funds appropriated by this Act to the Department of Aging and Disability Services if the Legislative Budget Board or the Governor certify to the Comptroller of Public Accounts that the Department of Aging and Disability Services is not in compliance with this provision.~~ *Rider is deleted as the Balancing Incentive Program ends in the fiscal year 2015 and the provision is no longer necessary.*
~~Sec. 47~~	~~II-134~~	**~~Contingent Revenue, Appropriation of Cost.~~** ~~a. Contingent upon the Comptroller of Public Accounts receiving funds and certifying collection of Medicaid fraud-~~

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		related settlements, judgments or recoveries under the Human Resources Code, Chapter 36 submitted by the Office of the Attorney General in Revenue Code 3714, Judgments and Settlements, in excess of $124,606,000 contained in the Comptroller of Public Account's Biennial Revenue Estimate (BRE) for the 2016-172014-15 biennium, the Health and Human Services Commission is appropriated the amount of collections above the BRE that are recovered under the Human Resources Code, Chapter 36, not to exceed $25,000,000 in General Revenue Funds in fiscal year 20162014 and $25,000,000 in General Revenue Funds in fiscal year 20172015 to Strategy B.1.5, Children, for the purpose of reimbursing the agency for the general revenue portion of investigative, legal, personnel, technology, consulting, and expert witness costs incurred in support of a judgment or settlement relating to Medicaid fraud, abuse, or waste. b. The commission may transfer any portion of this appropriation to the appropriate Medicaid strategy pursuant to HHSC Rider 12, Transfers: Authority and Limitations, or to another Medicaid strategy at an appropriate HHS agency pursuant to Special Provisions Relating to All Health and Human Services Agencies, Section 10, Limitations on Transfer Authority. c. Notwithstanding any other provision of this Act, the remainder of such recoveries under the Human Resources Code, Chapter 36 that are deposited to the Comptroller of Public Accounts shall be credited to the appropriate Medicaid strategies to the HHS agency listed in Article II of this Act for the provision of Medicaid services. To the extent that such recoveries exceed $25 million in General Revenue Funds in fiscal year 20162014 or $25 million in General Revenue Funds in fiscal year 20172015 anticipated in section (a), and that amount is appropriated to the Health and Human Services Commission under this section, the General Revenue Match for Medicaid appropriated to HHSC in that specific year shall be reduced by the same amount. *Rider is updated for biennial date changes. Consider deleting. HHSC request in FY14-15 was to provide additional funding. As the Legislative implemented (and due to Comptrollers BRE, it became a budget reduction to HHSC.* *Rider is deleted as the rider specifically refers to contingency appropriations for fiscal years 2014 and 2015.*
Sec. 48	II-134	**Program of All-inclusive Care for the Elderly (PACE).** a. **Expansion of PACE Sites.** The Department of Aging and Disability Services (DADS) may use funds appropriated in Strategy A.5.1, Program of All-inclusive Care for the Elderly (PACE) to add up to three additional PACE sites, each serving up to 150 participants beginning in fiscal year 2015. b. **Additional Participants at Existing PACE Sites.** DADS may use funds appropriated in Strategy A.5.1, Program of All-inclusive Care for the Elderly (PACE) to serve up to 96 additional participants at existing PACE sites in Amarillo, Lubbock, and El Paso.

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		~~c. **Funding for Additional Sites and Participants.** Notwithstanding other provisions of this Act, if funds appropriated elsewhere in this Act to DADS in Strategy A.5.1, Program of All-inclusive Care for the Elderly (PACE) are not sufficient to pay for services described in subsections (a) and/or (b), the Health and Human Services Commission (HHSC) shall transfer funds from Goal B, Medicaid, Strategy B.1.1, Aged and Medicare-related, or Goal B, Medicaid, Strategy B.1.2, Disability-Related, in an amount not to exceed $369,839 in General Revenue Funds in fiscal year 2014 and $3,419,426 in General Revenue Funds in fiscal year 2015. The Executive Commissioner of HHSC must certify that funds appropriated to DADS in Strategy A.5.1, Program of All-inclusive Care for the Elderly (PACE) were insufficient due to an increase in the number of participants served, not due to an increase in rates for existing PACE sites. The Executive Commissioner of HHSC shall provide written notification to the Legislative Budget Board and the Governor of the certification and the transfer amounts within 30 business days of the date on which any transfer occurs.~~ ~~d. **Additional Funding for PACE program.** Should transfer authority provided in subsection (c) be insufficient to serve the increase in participants described by subsections (a) and/or (b), the Executive Commissioner of HHSC shall submit a written request to the Legislative Budget Board and the Governor for approval to transfer additional funds from HHSC Goal B, Medicaid, Strategy B.1.1, Aged and Medicare-related, or Goal B, Medicaid, Strategy B.1.2. Disability-Related to DADS Strategy A.5.1, Program of All-inclusive Care for the Elderly (PACE). The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the request and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.~~ *Rider is deleted as it applies to funding appropriated in current biennium only.*
Sec. 49	II-135	~~**Workgroup on Nursing Facility Residents' Applied Income.** Out of funds appropriated elsewhere in this Act to the Health and Human Services Commission, in Strategy A.1.1, Enterprise Oversight & Policy, the Executive commissioner of the Health and Human Services Commission shall appoint a workgroup on nursing facility residents' applied income by January 31, 2014. It is the intention of the Legislature that the members of the workgroup shall include, but are not limited to, representation from the Office of the Attorney General's Division of Medicaid Fraud Control and/or Consumer Protection, the Department of Aging and Disability Services Division of Long Term Regulatory, the Texas Health Care Association, the Texas Silver Haired Legislature, and the Texas Senior Advocacy Coalition. The purpose of the workgroup is to study the extent of misapplication of Medicaid nursing facility residents' applied income and to develop a set of recommendations to more effectively manage applied income payments to ensure those funds are used for their intended legal purposes. The workgroup shall report the results of its finding and recommendations to the chairs of the Senate Health and Human Services Committee and the House Human Services Committee by September 30, 2014.~~ *Rider is deleted as it applies to work in the current biennium. The workgroup will complete a report within the 2014-15 biennium.*

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Sec. 51	II-135	~~**Texas Women's Health Program Contingency.** Contingent upon a decision by the Health and Human Services Commission (HHSC) or other authorized health and human services agency listed under Chapter 531, Government Code, to cease operations of the program funded in Strategy D.2.3, Texas Women's Health Program, whatever unexpended or unobligated General Revenue Funds remaining in the strategy at the termination of the program shall be transferred by HHSC to the Department of State Health Services, Strategy B.1.4, Community Primary Care Services, for the purpose of providing women's health services.~~ *Rider is deleted as the Texas Women's Health Program is not planned to be eliminated.*
Sec. 52	II-135	~~**Fiscal Impact Analysis of Health and Medical Insurance for Eligible Employees of Contracted Long-Term Care Medicaid Providers.** It is the intent of the Legislature that out of funds available, the Health and Human Services Commission in coordination with the Legislative Budget Board shall determine the impact of the employer mandate in the Affordable Care Act on Medicaid long-term care providers through consideration of the following: a. Current number of contracted long-term care Medicaid providers with 50 or more full-time equivalent employees; b. Estimated percentage of employees that would qualify for the Medicaid exchange; c. Estimated percentage of employees by wage rate who would enroll in a plan offered by their employer; d. Estimated cost of providing health insurance per employee; and e. Current number of employees and employee health insurance costs on current cost reports, requiring this information to be included on future cost reports. is the intent of the Legislature that the Health and Human Services Commission shall report these findings to the Governor and Legislative Budget Board no later than November 1, 20142016, and HHSC shall take this impact into consideration when setting rates should additional funds become available through funds provided or additional state or federal Medicaid funds that become available.~~ *Rider is deleted as HHSC is required to report the findings of the impact of the employer mandate in the Affordable Care Act on Medicaid long-term care providers through a report to the Governor and Legislative Budget Board no later than November 1, 2014. This one-time requirement section will not be needed for the 2016-2017 biennium.*
Sec. 54	II-136	~~**Transfer Authority Related to STAR+PLUS Managed Care Expansion.** From funds appropriated elsewhere in this act, the Executive Commissioner is authorized to transfer staff, General Revenue and Federal Funds in fiscal year 20162014 and fiscal year 2015 in the Department of Aging and Disability Services (DADS) in Strategy A.1.1, Intake, Access and Eligibility, Strategy A.2.1, Primary Home Care, Strategy A.2.3, Day Activity and Health Services, Strategy A.3.1, Community-Based Alternatives, and Strategy A.6.4, Promoting Independence Services to the Health and Human~~

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		~~Services Commission (HHSC), Strategy B.1.1 Aged and Medicare-Related in amounts necessary to expand the STAR+PLUS managed care model for the provision of Medicaid services to all areas of the state. HHSC shall notify the Legislative Budget Board and Governor's Office of the actual transfer amounts and estimated impact on performance measures at least thirty days prior to transferring funds.~~ *Rider is deleted as HHSC will expand STAR+PLUS to the Medicaid Rural Service Area in this biennium.*
Sec. 55	II-136	~~**Appropriation of Additional Funds Available under the Balancing Incentive and Money Follows the Person Programs.**~~ ~~a. In the event the enhanced federal matching funds earned under the Balancing Incentive Program and Money Follows the Person demonstration program exceed $219,631,272 for fiscal years 2014-15, the General Revenue Funds thereby made available at the health and human services agencies listed in Chapter 531, Government Code, are directed to the following purposes, in priority order, subject to the approval provisions contained in (b):~~ ~~(1) increase access to community-based long-term services and supports,~~ ~~(2) increase wages in community-based long-term services and supports, and,~~ ~~(3) any other projects to improve the effectiveness and quality of, and access to community-based long-term services and supports.~~ ~~b. To request authorization to expend available General Revenue Funds on the purposes identified in (a), an agency shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information, by fiscal year:~~ ~~(1) a detailed explanation of the proposed use(s) of the available General Revenue Funds and whether the expenditure(s) will be one-time or ongoing;~~ ~~(2) the amount available by strategy and agency;~~ ~~(3) the strategy(ies) and agencies in which the funds will be expended and the associated amounts, including any matching Federal Funds, and a transfer authority request between health and human services agencies if applicable as authorized in (c);~~ ~~(4) an estimate of performance levels and, where relevant, a comparison to targets included in this Act; and~~

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		~~(5) the capital budget and/or full-time equivalent impact.~~ ~~Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board.~~ ~~The request shall be considered to be approved unless the Legislative Budget Board or the Governor issue a written disapproval within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.~~ ~~c. Notwithstanding the general transfer provisions of this Act, the Executive Commissioner of the Health and Human Services Commission is authorized to make transfers of General Revenue Funds made available due to enhanced federal matching funds under the Balancing Incentive Program and Money Follows the Person exceeding $219,631,272 in fiscal years 2014-15 within and between health and human services agencies for the purposes identified in (a), subject to the requirements in (b).~~ ~~d. The Comptroller of Public Accounts shall not allow the expenditure of General Revenue Funds made available if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.~~ *Rider is deleted as the specific uses identified for these funds relate to 2014-15 appropriations. Future use of MFP funds could use general Article IX federal funds authority (S.B. 1, Sec 8.02 Federal Funds/Block Grants).*
Sec. 56	II-137	~~**Transfer Authority Related to Attendant and Habilitation Services.** Notwithstanding other provisions in this Act, from funds appropriated elsewhere in this act for fiscal year 2015, the Executive Commissioner is hereby authorized to transfer funds in the Department of Aging and Disability Services Strategy A.2.4, Habilitation Services to the Health and Human Services Commission, Strategies B.1.1, Aged and Medicare-Related and B.1.2, Disability-Related, for the purpose of providing personal attendant services, habilitative services and emergency response services to individuals with intellectual and developmental disabilities in the STAR+PLUS program. At least thirty days prior to transferring funds, HHSC shall notify the Legislative Budget Board and Governor's Office of the transfer amounts and impact on performance measures.~~ *Rider is deleted as this one-time requirement is complete.*
Sec. 57	II-137	~~**Transfers to the Department of Assistive and Rehabilitative Services.** Notwithstanding limitations on transfer provisions elsewhere in this Act, out of funds appropriated to the Health and Human Services Commission in Strategy A.1.1, Enterprise Oversight and Policy, General Revenue Funds in the amount of $1,615,951 per fiscal year may be transferred to the Department of Assistive and Rehabilitative Services (DARS) with the following restrictions.~~

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		~~a. **Autism Program.** A transfer to DARS Strategy A.3.1, Autism Program, of $1,187,800 per fiscal year shall be authorized by the executive commissioner only upon determination that DARS has developed a plan to increase the number of children receiving autism services. In development of the plan, DARS shall consider the following criteria:~~ ~~(1) evidence-based treatment modalities,~~ ~~(2) the average number of treatment service hours necessary to make a measurable impact on behavior and the most appropriate duration of time to ensure progress is maintained,~~ ~~(3) which age range of children benefits most from treatment;~~ ~~(4) which provider qualifications are most appropriate for the delivery of treatment services;~~ ~~(5) best practices for including parental and caregiver training and involvement in treatment services;~~ ~~(6) best practices for inclusion of treatment services in an educational setting;~~ ~~(7) state and federal laws related to insurance coverage of treatment services for autism; and~~ ~~(8) funding options for treatment services that include maximizing non-State payer sources such as public and private insurance and family participation.~~ ~~b. **Deaf and Hard of Hearing Services.** Upon a determination by the executive commissioner that DARS has met all requirements relating to processes and procedures identified by the executive commissioner, funds shall be transferred to the following DARS strategies in the amounts indicated:~~ ~~(1) $105,000 per fiscal year in Strategy B.2.1, Contract Services - Deaf, to serve 750 additional consumers; and~~ ~~(2) $323,151 per fiscal year in Strategy B.2.2, Educ., Training, Certification - Deaf, to serve 1,175 additional consumers.~~ *Rider is deleted as funding was transferred in 2014-15 and is included in the DARS base.*
Sec. 58	II-138	~~**Funding Transfer for Comprehensive Rehabilitation Services.** Notwithstanding limitations on transfer provisions elsewhere in this Act, out of funds appropriated above to the Health and Human Services Commission (HHSC) in Strategy A.1.1, Enterprise Oversight and Policy, $2,950,000 per fiscal year in General Revenue Funds may be~~

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		~~transferred to the Department of Assistive and Rehabilitative Services (DARS) to reduce the waiting list for the Comprehensive Rehabilitation Program. The funds shall be transferred to DARS Strategy B.3.4, Comprehensive Rehabilitation, to serve an additional 103 consumers per fiscal year from the waiting list only upon a determination by the executive commissioner that expenditures for existing CRS clients are within appropriated funding levels, and that DARS has met all requirements relating to processes and procedures identified by the executive commissioner.~~ *Rider is deleted as funding was transferred in 2014-15 and is included in the DARS base.*
Sec. 59	II-138	~~**Contingency for Attendant and Habilitation Services.**~~ ~~a. Included in appropriations above at Department of Aging and Disability Services (DADS) is $99,935,393 in General Revenue Funds and $270,678,923 in Federal Funds ($370,614,316 in All Funds) in fiscal year 2015 2017 for the purpose of providing attendant and habilitation services to individuals with intellectual and developmental disabilities (Community First Choice program). The appropriation also assumes a reduction of $64,612,979 in General Revenue Funds and an increase of $65,414,318 in Federal Funds at the Health and Human Services Commission (HHSC) in fiscal year 2015 2017 as a result of the enhanced federal matching funds available under the Community First Choice program and its impact on existing services provided at HHSC.~~ ~~b. The appropriations and reductions in subsection (a) are contingent on the enactment of Senate Bill 7, or similar legislation that redesigns the long-term care service delivery system, by the Eighty-third Legislature, Regular Session. If Senate Bill 7, or similar legislation, is not enacted:~~ ~~(1) the appropriations made in strategies above at DADS are reduced by $99,935,393 in General Revenue Funds and $270,678,923 in Federal Funds ($370,614,316 in All Funds) in fiscal year 2015 2017; and,~~ ~~(2) the General Revenue appropriations at HHSC are increased by $64,612,979 and Federal Funds are reduced by $65,414,318 (net reduction of $801,339 in All Funds) in fiscal year 2015 2017.~~ *Rider is deleted as this one-time requirement is no longer needed since the Community First Choice (CFC) program is scheduled to become effective on March 1, 2015.*
Sec. 60	II-139	~~**Expansion of Community-based Services.** Subject to the limitations in Department of Aging and Disability Services Rider 27, Limits for Waivers and Other Programs, appropriations made above in this Act related to expansion of community-based services include:~~ ~~a. Appropriations for the Promoting Independence Initiative at the Department of Aging and Disability Services (DADS):~~

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		~~(1) $6,660,573 in General Revenue ($25,759,607 in All Funds) to Strategy A.3.2, Home and Community-based Services to add 400 slots for persons moving out of large and medium Intermediate Care Facilities for Individuals with Intellectual Disabilities;~~ ~~(2) $4,900,139 in General Revenue ($12,315,328 in All Funds) to Strategy A.3.2, Home and Community-based Services to add 192 slots for children aging out of foster care;~~ ~~(3) $7,668,729 in General Revenue ($19,273,705 in All Funds) to Strategy A.3.2, Home and Community-based Services to add 300 slots to prevent institutionalization/crisis;~~ ~~(4) $628,769 in General Revenue ($1,580,195 in All Funds) to Strategy A.3.1, Community-based Alternatives to add 100 slots to prevent institutionalization/crisis;~~ ~~(5) $4,818,952 in General Revenue ($19,401,091 in All Funds) to Strategy A.3.2, Home and Community-based Services to add 360 slots for persons with intellectual and developmental disabilities moving out of nursing facilities; and,~~ ~~(6) $641,190 in General Revenue ($1,611,366 in All Funds) to Strategy A.3.2, Home and Community-based Services to add 25 slots for children moving out of Department of Family and Protective Services general residential operations.~~ ~~b. Appropriations for the purpose of reducing the interest lists at DADS and the Health and Human Services Commission (HHSC):~~ ~~(1) $853,599 in General Revenue ($2,171,866 in All Funds) to DADS Strategy A.3.1, Community-based Alternatives to add 262 slots;~~ ~~(2) $22,183,742 in General Revenue ($55,740,295 in All Funds) to DADS Strategy A.3.2, Home and Community-based Services to add 1,324 slots;~~ ~~(3) $12,692,585 in General Revenue ($31,899,651 in All Funds) to DADS Strategy A.3.3, Community Living Assistance and Support Services to add 712 slots;~~ ~~(4) $2,077,413 in General Revenue ($5,220,916 in All Funds) to DADS Strategy A.3.4, Deaf-Blind Multiple Disabilities to add 100 slots;~~ ~~(5) $871,942 in General Revenue ($2,191,433 in All Funds) to DADS Strategy A.3.5, Medically Dependent~~

3.B. Rider Revisions and Additions Request

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		~~Children Program to add 120 slots;~~ ~~(6) $12,504,620 in General Revenue ($31,427,375 in All Funds) to DADS Strategy A.3.6, Texas Home Living to add 3,000 slots;~~ ~~(7) $5,082,587 in General Revenue ($12,584,586 in All Funds) to HHSC Strategies B.1.1, Aged and Medicare-Related and B.1.2, Disability Related to add 490 STAR+PLUS slots; and,~~ ~~(8) $8,650,072 in General Revenue ($20,712,805 in All Funds) to HHSC Strategies B.1.1, Aged and Medicare-Related and B.1.2, Disability Related for acute care costs for persons served in DADS waivers as identified in (1) - (6).~~ *Rider is deleted as funding applies to 2014-15 appropriations.*
Sec. 61	II-140	~~**Information on Funding Provided for Direct Care Workers and Attendant Wages.** Appropriations made elsewhere in this Act for the 2014-15 biennium for certain pay increases include:~~ ~~a. State-operated Facilities. Appropriations provide for a 10 percent pay increase for certain direct care workers.~~ ~~(1) Appropriations at the Department of Aging and Disability Services include $13,751,152 in General Revenue Funds ($32,721,362 in All Funds) for the FY 2014-15 biennium for salary increases for direct service professionals at state supported living centers.~~ ~~(2) Appropriations at the Department of State Health Services include $14,790,336 in General Revenue Funds ($14,790,336 in All Funds) for the FY 2014-15 biennium for salary increases for psychiatric nursing assistants at state hospitals.~~ ~~b. Community based Programs. Appropriations provide for an increase in the base wage of personal attendants to $7.50 per hour in fiscal year 2014 and $7.86 per hour in fiscal year 2015, and include an additional $20.0 million in General Revenue Funds for rate enhancement across community-based programs.~~ ~~(1) Appropriations at the Department of Aging and Disability Services include $40,866,318 in General Revenue Funds ($95,595,909 in All Funds) for the FY 2014-15 biennium for this purpose.~~ ~~(2) Appropriations at the Health and Human Services Commission include $47,886,539 in General Revenue Funds ($120,800,570 in All Funds) for the FY 2014-15 biennium for this purpose.~~ *Rider is deleted as pay increases for direct-care staff of state-operated facilities and for personal attendants of*

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		community-based programs is required to occur during the 2014-15 biennium.
Sec. 62	II-140	~~**Medicaid Unexpended Balances between Biennia.**~~ ~~a. Unexpended balances as of August 31, 2013 in General Revenue appropriations made to the Department of Aging and Disability Services (estimated to be $36,244,385) in House Bill 10, Eighty-Third Legislature, Regular Session, are appropriated and included elsewhere in this Act to the Department of Aging and Disability Services for the purpose of funding the Medicaid program for the biennium beginning September 1, 2013.~~ ~~b. Unexpended balances as of August 31, 2013 in General Revenue appropriations made to the Health and Human Services Commission (estimated to be $218,312,329) in House Bill 10, Eighty-Third Legislature, Regular Session, are appropriated and included elsewhere in this Act to the Health and Human Services Commission for the purpose of funding the Medicaid program for the biennium beginning September 1, 2013.~~ ~~c. In the event that either unexpended balance is less than the amount listed herein, the respective agency must provide an explanation of the variance to the Legislative Budget Board and the Office of the Governor. The department and the commission must report the amount of the unexpended balance, and any required explanation of variance, to the Legislative Budget Board and the Governor by October 1, 2013.~~ *Rider is deleted. This one-time requirement section will not be needed for the 2016-2017 biennium.*
HHSC 702	II	**Locality Pay.** Out of funds appropriated above, the health and human services agencies listed in Chapter 531, Government Code are hereby authorized to pay a salary supplement, not to exceed $1,200 per month, to each employee whose duty station is located in an area of the state in which the high cost of living is causing excessive employee turnover, as determined by the agency. This salary supplement shall be in addition to the maximum salary rate authorized for that position elsewhere in this Act. In the event that an employee so assigned works on a less than full-time basis, the maximum salary supplement shall be set on a basis proportionate to the number of hours worked. *This rider will allow HHS agencies to pay a salary supplement to employees whose duty station is in an area of the state with a high cost of living (such as the Midland area). DFPS has a similar authority in the current biennium. This rider, which is modeled after a Railroad Commission rider, would give all HHS agencies the ability to pay this salary supplement.*

3.B. Rider Revisions and Additions Request

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HHSC 1	II-84	**Performance Measure Targets.** The following is a listing of the key performance target levels for the Health and Human Services Commission. It is the intent of the Legislature that appropriations made by this Act be utilized in the most efficient and effective manner possible to achieve the intended mission of the Health and Human Services Commission. In order to achieve the objectives and service standards established by this Act, the Health and Human Services Commission shall make every effort to attain the following designated key performance target levels associated with each item of appropriation.

	2014	2015
A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY		
Outcome (Results/Impact):		
Average Medicaid and CHIP Children Recipient Months Per Month	3,327,728	3,430,172
A.1.2 Strategy: INTEGRATED ELIGIBILITY AND ENROLLMENT (IEE)		
Output (Volume):		
Average Monthly Number of Eligibility Determinations	900,191	919,629
Efficiencies:		
Average Cost Per Eligibility Determination	48.04	47.03
Explanatory:		
Total Value of SNAP Benefits Distributed	5,451,902,214	5,799,546,090
B. Goal: MEDICAID		
Outcome (Results/Impact):		
Average Medicaid Acute Care Recipient Months Per Month	3,860,020	4,193,348
Average Medicaid Acute Care (including Drug) Cost Per Recipient Month	343.47	335.93
Proportion of Medicaid Acute Care Recipient Months Enrolled in Managed Care:	82.00%	82.23%
Average Number of Members Receiving 1915(c) Waiver Services through STAR+PLUS	35,640	36,571
B.1.1 Strategy: AGED AND MEDICARE-RELATED		
Output (Volume):		
Average Aged and Medicare-Related Recipient Months Per Month	368,864	373,888
Average Aged and Medicare-Related Recipient Months Per Month: STAR+PLUS	226,228	229,421
B.1.2 Strategy: DISABILITY-RELATED		
Output (Volume):		
Average Disability-Related Recipient Months Per Month	439,823	456,117

3.B. Rider Revisions and Additions Request

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~~Average Disability-Related Recipient Months Per Month: STAR+PLUS 189,823 196,856~~

~~**B.1.3 Strategy:** PREGNANT WOMEN~~

~~**Output (Volume):**~~
~~Average Pregnant Women Recipient Months Per Month 129,465 130,560~~

~~**Efficiencies:**~~
~~Average Pregnant Women Cost Per Recipient Month 677.05 682.47~~

~~**B.1.4 Strategy:** OTHER ADULTS~~

~~**Output (Volume):**~~
~~Average TANF-Level Adult Recipient Months Per Month 131,602 139,691~~

~~**Efficiencies:**~~
~~Average TANF-Level Adult Cost Per Recipient Month 404.28 412.11~~

~~**B.1.5 Strategy:** CHILDREN~~

~~**Output (Volume):**~~
~~Average Poverty-Related Children Recipient Months Per Month 2,760,792 3,036,440~~
~~Average Number of Qualified Alien Recipient Months per Month 17,975 18,064~~
~~Average STAR Health Foster Care Children Recipient Months Per Month 29,652 29,652~~

~~**Efficiencies:**~~
~~Average Poverty-Related Children Cost Per Recipient Month 169.44 160.65~~
~~Average STAR Health Foster Care Children Cost Per Recipient Month 806.13 822.12~~

~~**B.2.1 Strategy:** NON-FULL BENEFIT PAYMENTS~~

~~**Output (Volume):**~~
~~Average Number of Non-citizen Recipient Months Per Month 10,453 10,809~~

~~**B.2.2 Strategy:** MEDICAID PRESCRIPTION DRUGS~~

~~**Output (Volume):**~~
~~Total Medicaid Prescriptions Incurred 38,657,575 40,828,388~~

~~**Efficiencies:**~~
~~Average Cost Per Medicaid Prescription 83.76 87.91~~

~~**B.2.3 Strategy:** MEDICAL TRANSPORTATION~~

~~**Output (Volume):**~~

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Dorothy Sinclair	Date: August 18, 2014	Request Level: Exceptional

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~~Average Nonemergency Transportation (NEMT) Recipient Months Per Month 1,817,003 1,973,908~~

~~**Efficiencies:**~~

~~Average Cost Per One Way Medical Transportation Trip 24.43 24.60~~

~~Average Nonemergency Transportation (NEMT) Cost Per Recipient Month 3.33 3.49~~

~~**B.2.4 Strategy:** HEALTH STEPS (EPSDT) DENTAL~~

~~**Efficiencies:**~~

~~Average Cost Per Texas Health Steps (EPSDT) Dental Recipient Months Per Month 40.16 42.28~~

~~**B.2.5 Strategy:** MEDICARE PAYMENTS~~

~~**Output (Volume):**~~

~~Average Supplemental Medical Insurance Part B (SMIB) Recipient Months Per Month 614,070 629,931~~

~~**Efficiencies:**~~

~~Average Supplemental Medical Insurance Part B (SMIB) Premium Per Month 106.91 111.19~~

~~**C. Goal:** CHIP SERVICES~~

~~**Outcome (Results/Impact):**~~

~~Average CHIP Programs Recipient Months Per Month (Includes all CHIP programs) 573,798 373,594~~

~~Average CHIP Programs Benefit Cost with Prescription Benefit Per Recipient Month (Includes all CHIP programs) 164.84 185.22~~

~~**C.1.1 Strategy:** CHIP~~

~~**Output (Volume):**~~

~~Average CHIP Children Recipient Months Per Month 536,903 336,698~~

~~**Efficiencies:**~~

~~Average CHIP Children Benefit Cost Per Recipient Month 114.37 120.89~~

~~**C.1.2 Strategy:** CHIP PERINATAL SERVICES~~

~~**Output (Volume):**~~

~~Average Perinatal Recipient Months Per Month 36,895 36,896~~

~~**C.1.3 Strategy:** CHIP PRESCRIPTION DRUGS~~

~~**Output (Volume):**~~

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Dorothy Sinclair	Date: August 18, 2014	Request Level: Exceptional

Current Rider Number	Page Number in GAA 2014-2015	Proposed Rider Language		
		~~Total Number of CHIP Prescriptions (Includes all CHIP programs)~~	~~2,295,460~~	~~1,440,704~~
		~~**Efficiencies:**~~		
		~~Average Cost Per CHIP Prescription (Includes all CHIP programs)~~	~~82.50~~	~~88.09~~
		~~**D Goal:** ENCOURAGE SELF SUFFICIENCY~~		
		~~**D.1.1 Strategy:** TANF (Cash Assistance) Grants~~		
		~~**Output (Volume):**~~		
		~~Average Number of TANF Basic Cash Assistance Recipients Per Month~~	~~95,168~~	~~96,119~~
		~~Average Number of State Two-Parent Cash Assist Recipients Per Month~~	~~3,571~~	~~3,607~~
		~~**Efficiencies:**~~		
		~~Average Monthly Grant: Temporary Assistance for Needy Families (TANF) Basic Cash Assistance~~	~~73.49~~	~~74.71~~
		~~Average Monthly Grant: State Two-Parent Cash Assistance Program~~	~~70.81~~	~~72.05~~
		~~**D.2.1 Strategy:** FAMILY VIOLENCE SERVICES:~~		
		~~**Output (Volume):**~~		
		~~Number of Persons Served by Family Violence Programs/Shelters~~	~~80,686~~	~~80,686~~
		~~**Efficiencies:**~~		
		~~Health and Human Services Average Cost Per Person Receiving Emergency Shelter Services through the Family Violence Program~~	~~951.69~~	~~951.69~~
		~~**D.2.2 Strategy:** ALTERNATIVES TO ABORTION~~		
		~~**Output (Volume):**~~		
		~~Number of Persons Receiving Pregnancy Support Services as an Alternative to Abortion~~	~~20,223~~	~~20,223~~
			2016	2017
		A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY		
		Outcome (Results/Impact):		
		Average Medicaid and CHIP Children Recipient Months Per Month	3,743,510	3,821,727
		A.1.2 Strategy: INTEGRATED ELIGIBILITY AND ENROLLMENT (IEE)		
		Output (Volume):		
		Average Monthly Number of Eligibility Determinations	1,010,000	1,045,000

3.B. Rider Revisions and Additions Request

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		Efficiencies:		
		Average Cost Per Eligibility Determination	$40.94	$38.56
		Explanatory:		
		Percent Poverty Met by TANF, SNAP and Medicaid Benefits	72.87%	72.87%
		Total Value of SNAP Benefits Distributed	$5,106,482,420	$5,207,854,531
		B. Goal: MEDICAID		
		Outcome (Results/Impact):		
		Average Medicaid Acute Care Recipient Months Per Month	4,547,470	4,651,577
		Average HHSC Medicaid Client Services (including Drug) Cost Per Recipient Month	$423.00	$439.77
		Medical Recipient Months: Proportion in Managed Care:	86.58%	90.02%
		Average Number of Members Receiving Waiver Services through STAR+PLUS	49,783	51,512
		B.1.1 Strategy: AGED AND MEDICARE-RELATED		
		Output (Volume):		
		Average Aged and Medicare-Related Recipient Months Per Month: Total Eligibility Group	390,311	404,449
		Average Aged and Medicare-Related Cost Per Recipient Month	$949.92	$939.15
		B.1.2 Strategy: DISABILITY-RELATED		
		Output (Volume):		
		Average Disability-Related Recipient Months Per Month: Total Eligibility Group	446,873	460,247
		Average Disability-Related Recipient Cost Per Recipient Month	$1,074.49	$1,143.20
		B.1.3 Strategy: PREGNANT WOMEN		
		Output (Volume):		
		Average Pregnant Women Recipient Months Per Month	145,467	146,880
		Efficiencies:		
		Average Pregnant Women Cost Per Recipient Month	$683.53	$697.20
		B.1.4 Strategy: OTHER ADULTS		
		Output (Volume):		
		Average TANF-Level Adult Recipient Months Per Month	192,051	195,357
		Efficiencies:		
		Average TANF-Level Adult Cost Per Recipient Month	$401.48	$419.86

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Current Rider Number	Page Number in GAA 2014-2015	Proposed Rider Language		
		B.1.5 Strategy: CHILDREN		
		Output (Volume):		
		Average Poverty-Related Children Recipient Months Per Month	3,352,596	3,423,144
		Average STAR Health Foster Care Children Recipient Months Per Month	33,605	34,314
		Efficiencies:		
		Average Poverty-Related Children Cost Per Recipient Month	$162.55	$167.80
		Average STAR Health Foster Care Children Cost Per Recipient Month	$835.07	$876.72
		B.2.1 Strategy: NON-FULL BENEFIT PAYMENTS		
		Output (Volume):		
		Average Number of Non-citizen Recipient Months Per Month	9,403	9,618
		B.2.2 Strategy: MEDICAID PRESCRIPTION DRUGS		
		Efficiencies:		
		Average Cost Per Medicaid Recipient Month for Prescription Drugs	$68.65	$70.57
		B.2.3 Strategy: MEDICAL TRANSPORTATION		
		Output (Volume):		
		Average Nonemergency Transportation (NEMT) Cost per Recipient Months	$4.32	$4.54
		B.2.4 Strategy: HEALTH STEPS DENTAL		
		Efficiencies:		
		Average Cost Per Texas Health Steps (EPSDT) Dental Recipient Months Per Month	$36.60	$38.44
		B.2.5 Strategy: MEDICARE PAYMENTS		
		Output (Volume):		
		Average Part B Recipient Months Per Month	560,068	588,447
		Efficiencies:		
		Average Part B Premium Per Month	$115.69	$122.66
		C. Goal: CHIP SERVICES		
		Outcome (Results/Impact):		
		Average CHIP Programs Recipient Months Per Month (Includes all CHIP programs)	395,822	404,186
		Average CHIP Programs Benefit Cost with Prescription Benefit	$180.37	$180.85

3.B. Rider Revisions and Additions Request

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		C.1.1 Strategy: CHIP		
		Output (Volume):		
		Average CHIP Children Recipient Months Per Month	356,897	363,668
		Efficiencies:		
		Average CHIP Children Benefit Cost Per Recipient Month	$127.48	$132.47
		C.1.2 Strategy: CHIP PERINATAL SERVICES		
		Output (Volume):		
		Average Perinatal Recipient Months Per Month	38,924	40,518
		C.1.3 Strategy: CHIP PRESCRIPTION DRUGS		
		Efficiencies:		
		Average Cost Per CHIP Recipient Month for Prescription Drugs	$26.62	$27.64
		D Goal: ENCOURAGE SELF SUFFICIENCY		
		D.1.1 Strategy: TANF (Cash Assistance) Grants		
		Output (Volume):		
		Average Number of TANF Basic Cash Assistance Recipients Per Month	72,308	73,752
		Average Number of State Two-Parent Cash Assist Recipients Per Month	3,183	3,246
		Efficiencies:		
		Average Monthly Grant: TANF Basic Cash Assistance	$75.30	$75.30
		Average Monthly Grant: State Two-Parent Cash Assistance Program	$77.30	$77.29
		D.2.1 Strategy: FAMILY VIOLENCE SERVICES:		
		Output (Volume):		
		Number of Persons Served by Family Violence Programs/Shelters	82,862	82,862
		Efficiencies:		
		HHSC Average Cost Per Person Receiving Family Violence Services	$850.09	$850.09
		D.2.2 Strategy: ALTERNATIVES TO ABORTION. NONTRANSFERRABLE		
		Output (Volume):		
		Number of Persons Receiving Services as an Alternative to Abortion	19,309	19,309
		D.2.3 Strategy: TEXAS WOMEN'S HEALTH SERVICES		

3.B. Rider Revisions and Additions Request

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Current Rider Number	Page Number in GAA 2014-2015	Proposed Rider Language
		Output (Volume): Average Number of Women's Health Program Recipient Months 114,222 114,793 **Efficiencies:** Average Women's Health Program Cost per Recipient Month $17.06 $17.06 **G Goal:** OFFICE OF INSPECTOR GENERAL **G.1.1 Strategy:** Office of Inspector General **Output (Volume):** Number of Completed Provider and Recipient Investigations 107,761 112,795 Number of Audits and Reviews Performed 3,448 3,841 Total Dollars Removed (millions) $254.7 $266.4 *Rider is revised to incorporate 2016-2017 targets and projected performance for exceptional item requests.*
HHSC 2	II-86	**Capital Budget.** None of the funds appropriated above may be expended for capital budget items except as listed below. The amounts shown below shall be expended only for the purposes shown and are not available for expenditure for other purposes. Amounts appropriated above and identified in the provision as appropriations either for "Lease Payments to the Master Equipment Purchase Program" or for items with an "(MLPP)" notation shall be expended only for the purpose of making lease-purchase payments to the Texas Public Finance Authority pursuant to the provisions of Government Code § 1232.103. ~~2014 2015~~ ~~a. Acquisition of Information Resource Technologies~~ ~~(1) Seat Management Services (PCs, Laptops, & Servers) 11,763,050 11,718,754~~ ~~(2) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations 4,921,304 95,312~~ ~~(3) Enterprise Telecom Managed Services 12,438,387 12,391,056~~ ~~(4) Enterprise Info & Asset Mgt (Data Warehouse) 28,503,702 28,128,317~~ ~~(5) Texas Integrated Eligibility Redesign System 69,153,846 54,027,582~~ ~~(6) Medicaid Eligibility and Health Information 6,006,129 2,782,337~~ ~~(7) Implement Information Security Improvements & Application Provisioning Enhancements 4,049,500 1,988,000~~ ~~(8) Upgrade HSAS Financials – Hardware Remediation (HHS Agencies) 1,293,155 323,467~~ ~~(9) Secure Mobility Infrastructure & Enterprise Communications 5,426,196 0~~ ~~(10) Winters Data Center Infrastructure Upgrade 4,000,000 0~~ ~~(11) IT Systems for State Operated Facilities 1,539,925 0~~ ~~(12) Case Management System for OIG 4,335,202 2,813,528~~

3.B. Rider Revisions and Additions Request

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~~(13) BIP - Implement IT Enhancement to Support No Wrong Door Eligibility 24,270,000 8,090,000~~
~~(14) BIP – Secure Provider Web Portal 1,300,000 0~~
~~(15) BIP – Changes to Your Texas Benefits for Children with Special Needs 1,425,000 475,000~~
~~(16) BIP – Changes to Your Texas Benefits 10,575,000 3,525,000~~

~~Total, Acquisition of Information Resource Technologies $ 191,000,396 $ 126,358,353~~

~~b. Acquisition of Capital Equipment and Items~~
~~(1) Facility Support Services – Fleet Operations 546,637 463,751~~
~~(1) Improve Security Infrastructure for Regional HHS Client Delivery Facilities 1,527,000 0~~

~~Total, Acquisition of Capital Equipment and Items $ 2,073,637 $ 463,751~~

~~c. Other Lease Payments to the Master Lease Purchase Program (MLPP)~~
~~(1) TIERS Lease Payments to Master Lease Program $ 2,572,531 $ 1,937,913~~

~~d. Data Center Consolidation~~
~~(1) Data Center Consolidation $ 32,854,922 $ 33,527,595~~

~~Total, Capital Budget $ 228,501,486 $ 162,287,612~~

~~Method of Financing (Capital Budget):~~
~~General Revenue Fund~~
~~General Revenue Fund $ 10,361,006 $ 3,389,255~~
~~GR Match for Medicaid 48,062,149 31,272,506~~
~~GR Match for Title XXI (CHIP) 1,064,136 982,686~~
~~GR Match for Food Stamp Administration 23,899,465 21,561,757~~
~~Subtotal, General Revenue Fund $ 83,386,756 $ 57,206,204~~

~~Federal Funds 114,583,376 83,939,009~~

~~Interagency Contracts 30,531,354 21,142,399~~

~~Total, Method of Financing $ 228,501,486 $ 162,287,612~~

3.B. Rider Revisions and Additions Request

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	2016	2017
a. Acquisition of Information Resource Technologies		
(1) Seat Management Services (PCs, Laptops, & Servers)	$ 11,782,797	$ 11,738,055
(2) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations	2,162,794	0
(3) Enterprise Telecommunications Enhancements	6,453,828	0
(4) Enterprise Info & Asset Mgmt (Data Warehouse)	35,511,443	42,521,282
(5) Texas Integrated Eligibility Redesign System	53,391,893	61,049,622
(6) Secure Mobility Infrastructure & Enterprise Communications	2,075,000	2,075,000
(7) Case Management System for OIG	18,920,000	9,145,000
(8) Network Performance and Capacity	5,067,388	989,670
(9) HHSAS to CAPPS Upgrade and Enhancements	5,164,416	7,848,881
(10) Improve Employee Technical Support	4,925,204	3,590,340
(11) Cybersecurity Advancement for HHS Enterprise	7,204,204	7,064,204
(12) Workforce Management Tool	1,300,000	40,000
Total, Acquisition of Information Resource Technologies	$ 153,958,967	$ 146,062,054
b. Acquisition of Capital Equipment and Items		
(1) Facility Support Services – Fleet Operations	$ 637,457	$ 289,523
(2) Regional Laundry - Replacement of Equipment and Trailer	2,290,436	0
(2) Improve Security Infrastructure for Regional HHS Client Delivery Facilities	2,987,236	0
Total, Acquisition of Capital Equipment and Items	$ 5,915,129	$ 289,523
c. Other Lease Payments to the Master Lease Purchase Program (MLPP)		
(1) TIERS Lease Payments to Master Lease Program	$ 556,181	$ 0
d. Data Center Consolidation		
(1) Data Center Consolidation	$ 42,041,413	$ 46,878,700
e. CAPPS / Enterprise Resource Planning / ProjectONE		
(1) CAPPS - Enterprise Resource Planning	$ 9,717,048	$ 9,672,659
(2) CAPPS - PeopleSoft Licenses	1,268,244	1,312,632
Total, CAPPS / Enterprise Resource Planning / ProjectONE	$ 10,985,292	$ 10,985,291
Total, Capital Budget	$ 213,456,982	$ 204,215,568

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Dorothy Sinclair	Date: August 18, 2014	Request Level: Exceptional

Current Rider Number	Page Number in GAA 2014-2015	Proposed Rider Language

Method of Financing (Capital Budget):

General Revenue Fund		
General Revenue Fund	$ 28,938,173	$ 22,480,299
GR Match for Medicaid	32,427,182	33,459,576
GR Match for Title XXI (CHIP)	1,836,222	1,948,720
GR Match for Food Stamp Administration	24,348,016	23,752,083
Subtotal, General Revenue Fund	$ 87,549,593	$ 81,640,679
Federal Funds	103,402,283	103,197,237
Interagency Contracts	22,505,106	19,377,653
Total, Method of Financing	$ 213,456,982	$ 204,215,568

Rider is revised to reflect capital projections in the 2016-2017 Exceptional Items.