Rider Revisions

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Lisa Subia	Date: August 23, 2012	Request Level: Base

Current Rider Number	Page Number in GAA 2012-2013	Proposed Rider Language
HHSC 1	II-80	**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.

	2012	2013
~~**A. Goal:** HHS ENTERPRISE OVERSIGHT & POLICY~~		
~~**Outcome (Results/Impact):**~~		
~~Average Medicaid and CHIP Children Recipient Months Per Month~~	~~3,166,648~~	~~3,224,726~~
~~**A.1.2. Strategy:** INTEGRATED ELIGIBILITY & ENROLLMENT~~		
Output (Volume)		
~~Average Monthly Number of Eligibility Determinations~~	~~891,406~~	~~941,406~~
~~**Efficiencies:**~~		
~~Average Cost Per Eligibility Determination~~	~~47.64~~	~~45.7~~
~~**Explanatory:**~~		
~~Percent of Poverty Met by TANF, Food Stamps, and Medicaid Benefits~~	~~87.61%~~	~~87.59%~~
~~Total Value of Food Stamps Distributed~~	~~5,561,000,000~~	~~5,573,000,000~~
~~**B. Goal:** MEDICAID~~		
~~**Outcome (Results/Impact):**~~		
~~Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month~~	~~3,620,829~~	~~3,709,990~~
~~**B.1.4. Strategy:** CHILDREN & MEDICALLY NEEDY~~		
~~**Output (Volume):**~~		
~~Average Number of Legal Permanent Resident Recipient Months per Month~~	~~83,812~~	~~84,581~~
~~**B.1.5. Strategy:** MEDICARE PAYMENTS~~		
~~**Output (Volume):**~~		
~~Average Supplemental Medical Insurance Part B (SMIB) Recipient Months Per Month~~	~~558,424~~	~~573,056~~
~~**Efficiencies:**~~		
~~Average Supplemental Medical Insurance Benefits (SMIB) Premium Per Month~~	~~118.82~~	~~124.06~~
~~**B.1.6. Strategy:** STAR+PLUS (INTEGRATED MANAGED CARE)~~		
~~**Output (Volume):**~~		
~~Average Aged and Medicare-eligible Recipient Months Per Month: STAR+PLUS~~	~~132,224~~	~~135,725~~
~~Average Disabled and Blind Recipient Months Per Month: STAR+PLUS~~	~~131,072~~	~~138,711~~
~~**Efficiencies:**~~		
~~Average Cost Per Aged and Medicare-eligible Recipient Month: STAR+PLUS Acute Care~~	~~162.78~~	~~162.78~~
~~**B.2.1. Strategy:** COST REIMBURSED SERVICES~~		

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

~~Average Number of Non-citizens Recipient Months Per Month 10,051 10,126~~

~~**B.2.2. Strategy:** MEDICAID VENDOR DRUG PROGRAM~~

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

~~Total Medicaid Prescriptions Incurred 34,682,808 35,329,701~~

~~**B.3.3. Strategy:** EPSDT COMPREHENSIVE CARE PROG (FFS)~~

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

~~Average Number of Texas Health Steps (EPSDT) Comprehensive Care Program Recipient Month per Month (Fee-for-Service Only) 554,929 572,883~~

~~**B.4.1. Strategy:** STATE MEDICAID OFFICE~~

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

~~Medicaid Acute Care Recipient Months Per Month: Managed Care 2,705,372 2,768,083~~

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

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

~~Average CHIP Programs Recipient Months Per Month (Includes all CHIP Programs) 584,161 588,476~~

~~Average CHIP Programs Benefit Cost with Prescription Benefit Per Recipient Month (Includes all CHIP Programs) 122.61 122.84~~

~~**C.1.4. Strategy:** CHIP PERINATAL SERVICES~~

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

~~Average Perinate Recipient Months Per Month 36,981 36,981~~

~~**C.1.5. Strategy:** CHIP VENDOR DRUG PROGRAM~~

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

~~Total Number of CHIP Prescriptions (Includes all CHIP Programs) 2,490,354 2,509,993~~

~~**Efficiencies:**~~

~~Average Cost Per CHIP Prescription (Includes all CHIP Programs) 63.18 63.18~~

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

~~**D.1.1. Strategy:** TANF (CASH ASSISTANCE) GRANTS~~

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

~~Average Number of TANF Recipients Per Month 118,829 119,750~~

~~Average Number of State Two-Parent Cash Assistance Program Recipients Per Month 5,402 5,402~~

~~**Efficiencies:**~~

~~Average Monthly Grant: Temporary Assistance for Needy Families (TANF) 71.24 73.08~~

~~Average Monthly Grant: State Two-Parent Cash Assistance Program 68.49 70.01~~

~~**D.1.2. Strategy:** REFUGEE ASSISTANCE~~

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

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		~~Number of Refugees Receiving Contracted Social Services, Financial Assistance, or Medical Assistance~~	~~20,000~~	~~20,000~~
		~~**D.2.1. Strategy:** FAMILY VIOLENCE SERVICES~~		
		~~**Output (Volume):**~~		
		~~Number of Persons Served by Family Violence Programs/Shelters~~	~~80,940~~	~~80,940~~
		~~**Efficiencies:**~~		
		~~Health and Human Services Average Cost Per Person Receiving Emergency Shelter Services through the Family Violence Program~~	~~811.1~~	~~865.18~~
		~~**D.2.2. Strategy:** ALTERNATIVES TO ABORTION~~		
		~~**Output (Volume):**~~		
		~~Number of Persons Receiving Pregnancy Support Services as an Alternative to Abortion~~	~~16,000~~	~~16,000~~
			2014	2015
		A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY		
		Outcome (Results/Impact):		
		Average Medicaid and CHIP Children Recipient Months Per Month	3,484,497	3,707,092
		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	3,947,805	4,191,664
		Average Medicaid Acute Care (including Drug) Cost Per Recipient Month	316.99	308.17
		Medicaid Acute Care Recipient Months: Proportion in Managed Care	82.00%	82.23%
		Average Number of Members Receiving Waiver Services through STAR+PLUS	36,370	37,388
		B.1.1 Strategy: AGED AND MEDICARE-RELATED ELIGIBILITY GROUP		
		Output (Volume):		

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		Average Aged and Medicare-Related Recipient Months Per Month	378,523	387,350
		Avg Aged and Medicare-Related Recipient Months Per Month: STAR+PLUS	230,530	235,906
		Efficiencies:		
		Average Aged and Medicare-Related Acute Care Cost Per Recipient Month	85.84	85.82
		Avg Cost Per Aged & Medicare-Related Recipient Month: STAR+PLUS LTC	520.09	520.09
		B.1.2 Strategy: DISABILITY-RELATED ELIGIBILITY GROUP		
		Output (Volume):		
		Average Disability-Related Recipient Months Per Month	451,043	471,472
		Average Disability-Related Recipient Months Per Month: STAR+PLUS	193,099	201,621
		Efficiencies:		
		Average Disability-Related Acute Care Cost Per Recipient Month	734.36	736.56
		Avg Cost/Disability-Related Recipient Month: STAR+PLUS Long Term Care	235.74	235.79
		B.1.3 Strategy: PREGNANT WOMEN ELIGIBILITY GROUP		
		Output (Volume):		
		Average Pregnant Women Recipient Months Per Month	135,356	136,689
		Efficiencies:		
		Average Pregnant Women Cost Per Recipient Month	669.90	666.15
		B.1.4 Strategy: OTHER ADULTS ELIGIBILITY GROUP		
		Output (Volume):		
		Average TANF-Level Adult Recipient Months Per Month	139,469	142,252
		Efficiencies:		
		Average TANF-Level Adult Cost Per Recipient Month	372.06	368.28
		B.1.5 Strategy: CHILDREN ELIGIBILITY GROUP		
		Output (Volume):		
		Average Poverty-Related Children Recipient Months Per Month	2,811,713.07	3,021,744.06
		Average Number of Qualified Alien Recipient Months per Month	18,524	18,780
		Average STAR Health Foster Care Children Recipient Months Per Month	31,701	32,157
		Efficiencies:		
		Average Poverty-Related Children Cost Per Recipient Month	162.01	154.82
		Average STAR Health Foster Care Children Cost Per Recipient Month	790.18	786.23

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		B.2.1 Strategy: NON-FULL BENEFIT PAYMENTS		
		Output (Volume):		
		Average Number of Non-citizens Recipient Months Per Month	11,020	11,344
		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	82.12	81.68
		B.2.3 Strategy: MEDICAL TRANSPORTATION		
		Output (Volume):		
		Average Nonemergency Transportation (NEMT) Recipient Months Per Month	1,750,000	1,800,000
		Efficiencies:		
		Average Cost Per One-Way Medical Transportation Trip	24.43	24.60
		Average Nonemergency Transportation (NEMT) Cost Per Recipient Month	2.95	2.90
		B.2.4 Strategy: HEALTH STEPS (EPSDT) DENTAL		
		Efficiencies:		
		Average Cost Per THSteps (EPSDT) Dental Recipient Months Per Month	37.72	37.72
		B.2.5 Strategy: FOR CLIENTS DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID		
		Output (Volume):		
		Average SMIB Recipient Months Per Month	606,173	633,454
		Efficiencies:		
		Average SMIB Premium Per Month	103.93	103.93
		C. Goal: CHILDREN'S HEALTH INSURANCE PROGRAM SERVICES		
		Outcome (Results/Impact):		
		Average CHIP Programs Recipient Months Per Month	641,082	653,191
		Average CHIP Programs Benefit Cost with Prescription Benefit	156.49	156.52
		C.1.1 Strategy: Children's Health Insurance Program (CHIP)		
		Output (Volume):		

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		Average CHIP Children Recipient Months Per Month	603,243	614,590
		Efficiencies: Average CHIP Children Benefit Cost Per Recipient Month	110.95	110.95
		C.1.2 Strategy: CHIP PERINATAL SERVICES		
		Output (Volume): Average Perinatal Recipient Months Per Month	37,840	38,601
		C.1.3 Strategy: CHIP PRESCRIPTION DRUGS		
		Output (Volume): Total Number of CHIP Prescriptions	2,713,843	2,785,728
		Efficiencies: Average Cost Per CHIP Prescription	71.05	70.52
		D Goal: ENCOURAGE SELF SUFFICIENCY		
		D.1.1 Strategy: Temporary Assistance for Needy Families Grants		
		Output (Volume): Average Number of TANF Basic Cash Assistance Recipients Per Month Avg Number of State Two-Parent Cash Assist Recipients Per Month	93,816 3,692	95,114 3,743
		Efficiencies: Average Monthly Grant: TANF Basic Cash Assistance Average Monthly Grant: State Two-Parent Cash Assistance Program	73.26 70.20	74.72 71.80
		D.2.1 Strategy: FAMILY VIOLENCE SERVICES:		
		Output (Volume): Number of Persons Served by Family Violence Programs/Shelters	79,000	79,000
		Efficiencies: HHSC Avg Cost Per Person Receiving Family Violence Shelter Services	951.69	951.69
		D.2.2 Strategy: ALTERNATIVES TO ABORTION. NONTRANSFERABLE.		
		Output (Volume): Number of Persons Receiving Services as Alternative to Abortion	16,000	16,000
		Rider is revised to incorporate 2014-2015 base targets and projected performance. Performance associated with		

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		exceptional budget request is on page 43.
HHSC 2	II-82	**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 i 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.

	2012	2013
~~a. Acquisition of Information Resource Technologies~~		
~~(1) Data Center Consolidation[14]~~	~~$ 39,320,284~~	~~$ 22,848,544~~
~~(2) Seat Management Services (PCs, Laptops, & Servers)~~	~~11,698,298~~	~~11,718,756~~
~~(3) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations~~	~~4,635,366~~	~~0~~
~~(4) Enterprise Telecom Management Services~~	~~12,438,387~~	~~12,391,063~~
~~(5) Enterprise Info & Asset Mgt (Data Warehouse)~~	~~11,906,354~~	~~12,095,609~~
~~(6) Texas Integrated Eligibility Redesign System~~	~~68,426,440~~	~~53,294,645~~
~~(7) Medicaid Eligibility and Health Information~~	~~7,558,449~~	~~7,175,391~~
~~(8) Enterprise Resource Planning[15]~~	~~9,408,000~~	~~0~~
~~(9) Technology Support for State Hospital & State Living Centers~~	~~4,930,800~~	~~1,150,800~~
~~(10) Improve Security for IT Systems~~	~~$ 2,484,250~~	~~$ 3,040,461~~
~~Total, Acquisition of Information Resource Technologies~~	~~$ 172,806,628~~	~~$ 123,715.269~~
~~b. Other Lease Payments to the Master Lease Purchase Program (MLPP)~~		
~~(1) TIERS Lease Payments to Master Lease Program~~	~~$ 2,119,499~~	~~$ 2,102,175~~
~~Total, Capital Budget~~	~~$ 174,926,127~~	~~$ 125,817,444~~
~~Method of Financing (Capital Budget):~~		
~~General Revenue Fund~~		
~~General Revenue Fund~~	~~$ 3,540,308~~	~~$ 2,386,082~~
~~GR Match for Medicaid~~	~~27,318,978~~	~~20,319,925~~
~~GR Match for Title XXI (CHIP)~~	~~1,435,178~~	~~1,119,964~~
~~GR Match for Food Stamp Administration~~	~~26,220,771~~	~~17,288,433~~
~~Subtotal, General Revenue Fund~~	~~$ 58,515,235~~	~~$ 41,114,404~~

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~~Federal Funds 83,210,999 63,470,409~~

~~Interagency Contracts 33,200,793 21,232,631~~

~~Total, Method of Financing $ 174,926,127 $ 125,817,444~~

~~[14] Incorporates Article IX, §17.01 of this Act, relating to reductions in data center services, resulting in a reduction of $4,874,677 All Funds in fiscal year 2012 and $3,534,509 All Funds in fiscal year 2013.~~

~~[15] Incorporates $6,700,000 in General Revenue Funds in fiscal year 2012 previously included in "Supplemental Appropriations Made in Riders" relating to rider 75 in the agency's bill pattern. Amounts shown in rider have been included in Strategies A.2.1, Consolidated Systems Support, and B.1.4, Children and Medically Needy. There is a related increase of capital budget authority of $9,408,000 in All Funds in fiscal year 2012.~~

	2014	2015
a. Acquisition of Information Resource Technologies		
(1) Data Center Consolidation	$ 30,697,959	$ 23,385,243
(2) Seat Management Services (PCs, Laptops, & Servers)	11,763,050	11,718,754
(3) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations	4,635,366	0
(4) Enterprise Telecom Managed Services	12,438,387	12,391,056
(5) Enterprise Info & Asset Mgt (Data Warehouse)	11,489,624	11,489,624
(6) Integrated Eligibility Technologies (TIERS)	69,153,846	54,027,582
(7) Medicaid Eligibility and Health Information	6,006,129	2,782,337
Total, Acquisition of Information Resource Technologies	$ 146,184,361	$ 115,794,596
b. Other Lease Payments to the Master Lease Purchase Program (MLPP)		
(1) TIERS Lease Payments to Master Lease Program	$ 2,572,531	$ 1,937,913
Total, Capital Budget	$ 148,756,892	$ 117,732,509
Method of Financing (Capital Budget):		
General Revenue Fund		
General Revenue Fund	$ 9,511,368	$ 2,604,675
GR Match for Medicaid	22,771,329	19,739,621
GR Match for Title XXI (CHIP)	1,058,014	967,772
GR Match for Food Stamp Administration	22,762,354	19,343,105

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		Subtotal, General Revenue Fund $ 56,103,065 $ 42,655,173 Federal Funds 73,982,423 57,436,613 Interagency Contracts 18,671,404 17,640,723 Total, Method of Financing $ 148,756,892 $ 117,732,509 *Rider is revised to reflect requested 2014-2015 base capital projects. Additional capital associated with exceptional item requests are on page 49.*
HHSC 4	II-83	**Reimbursement of Advisory Committee Members.** [16] Pursuant to Government Code § 2110.004, reimbursement of expenses for advisory committee members, out of funds appropriated above not to exceed $100,000~~$63,200~~ 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, ~~and~~ Volunteer Advocate Program Advisory Committee and the Task Force on Health Information Technology.~~.~~ 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. ~~[16] In addition to the authority provided here for the reimbursement of expenses for advisory committee members, Article IX, §§18.69 and 18.93 of this Act also provide authority for the reimbursement of expenses incurred by the Interagency Council For Addressing Disproportionality and the Task Force on Health Information Technology.~~ *Rider is revised to reflect the addition of a new advisory committee whose members can be reimbursed for travel and expenses during the 2014-2015 biennium. This advisory committee was authorized for reimbursement in Article IX, Section 18.93, for the 2012-2013 biennium pursuant to the enactment of House Bill 300. Additionally, dollar amount increased to support costs of 10 advisory committees.*
HHSC 5	II-83	**Prescription ~~Vendor~~ Drug Rebates – Medicaid and CHIP.** All references in this rider to rebate revenue refer to vendor drug rebates as well as supplemental rebates earned via the preferred drug lists (methods of finance include Vendor Drug Rebates – Medicaid~~,~~ and Vendor Drug Rebates – CHIP~~, 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~~Vendor Drug Program~~, pursuant to the

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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~~5, CHIP Prescription Drugs ~~Vendor Drug Program~~.

c. **Rebates as a First Source of Funding.** Expenditures for the Medicaid and CHIP Vendor Drug Programs shall be made from rebates received in fiscal years 2014~~2012~~ and 2015~~2013~~. As rebates are generated, expenditures to support ~~the~~ Medicaid and CHIP Prescription Drugs ~~Vendor Drug Programs~~ shall be made from rebate revenues. In the event rebate revenues are not available for expenditure, General Revenue may be used to support both Medicaid and CHIP Prescription Drugs~~Vendor Drug Programs~~ until rebate revenues are available.

d. **Appropriation.** In addition to rebate revenues appropriated above in Strategy B.2.2, Medicaid Prescription Drugs ~~Vendor Drug Program~~, and Strategy C.1.~~3~~5, CHIP Prescription Drugs~~Vendor Drug Program~~, the Health and Human Services Commission is appropriated Medicaid and CHIP prescription drug ~~vendor drug~~ rebates generated in excess of those amounts, subject to the following requirements:

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

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

e. **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.

Rider is updated for biennial date changes and revised to update strategy names and references for the 2014-2015 biennium. The rider has also been revised to remove Medicaid Supplemental Drug Rebate Revenue as state law sunsets provisions allowing supplemental rebates at the end of fiscal year 2013.

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HHSC 6	II-84	**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 2014~~2012~~ and fiscal year 2015~~2013~~. 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-84	**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 services for eligible clients, the Health and Human Services Commission is authorized to transfer General Revenue from funds appropriated in Medicaid or CHIP strategies in fiscal year 2015~~2013~~ to fiscal year 2014~~2012~~ and such funds are appropriated to the commission for fiscal year 2014~~2012~~. Such transfers may only be made subject to the following: a. Transfers under this section may be made only: (1) if costs associated with providing Medicaid or CHIP services exceed the funds appropriated for these services for fiscal year 2014~~2012~~, 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

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		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.*
HHSC 11	II-85	**Disposition of Appropriation Transfers from State-owned Hospitals.** The Health and Human Services Commission shall use the sums transferred from state owned hospitals as provided elsewhere in the Act as necessary to apply for appropriate matching Federal Funds and to provide the state's share of disproportionate share payments, and uncompensated care payments allowed under the 1115 Healthcare Transformation and Quality Improvement Waiver excluding payments for physicians, pharmacies, and clinics ~~and upper payment limit payments~~ due to state-owned hospitals. Any amounts of such transferred funds not required for these payments shall be deposited by the Health and Human Services Commission to the General Revenue Fund as unappropriated revenue. By October 1 of each fiscal year, the Health and Human Services Commission shall present a schedule of projected transfers and payments to the Comptroller of Public Accounts, the Governor, and the Legislative Budget Board. The Comptroller of Public Accounts shall process all payments and transfers, unless disapproved or modified by the Legislative Budget Board or the Governor. *Rider is revised to remove upper payment limit payments since the Upper Payment Limit Program no longer exists and has been replaced with supplemental payments allowed under the 1115 Healthcare Transformation and Quality Improvement Waiver.*
HHSC 12	II-85	**Transfers: Authority and Limitations.** a. **Limitations on Transfers within/between Goals.** Notwithstanding the transfer provisions in the General Provisions (general transfer provisions) and other transfer provisions of this Act (including Article II Special Provisions, Sec. 10), funds appropriated by this Act to the Health and Human Services Commission (HHSC) for the following goals shall be governed by the specific limitations included in this provision. (1) **Goal B (Medicaid).** Transfers may be made between Medicaid appropriation items in Goal B. Transfers may not be made from appropriation items in Goal B to appropriation items in other goals without prior written approval from the Legislative Budget Board and the Governor. HHSC shall provide notification of all transfers pursuant to subsection (b) of this provision, and any transfer approval requests shall be submitted pursuant to subsection (c) of this provision. (2) **Goal C (CHIP Services).** Transfers may be made between CHIP appropriation items in Goal C. Transfers

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		may not be made from appropriation items in Goal C to appropriation items in other goals without prior written approval from the Legislative Budget Board and the Governor. HHSC shall provide notification of all transfers pursuant to subsection (b) of this provision, and any transfer approval requests shall be submitted pursuant to subsection (c) of this provision. (3) **Other Goals.** Funds appropriated by this Act to the Health and Human Services Commission (HHSC) in Goals A, D, E, F, and G may be transferred from one appropriation item to another appropriation item within or between Goals A, D, E, F and G in amounts not to exceed 25 percent of the originating appropriation item's All Funds amount for the fiscal year. HHSC shall provide notification of all transfers pursuant to subsection (b) of this provision. b. **Notification Regarding Transfers that do not Require Approval.** Authority granted by this provision to transfer funds is contingent upon a written notification from HHSC to the Legislative Budget Board and the Governor at least 30 days prior to the transfer, which includes the following information: (1) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing; (2) the names of the originating and receiving strategies and the method of financing and FTEs 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. c. **Requests for Transfers that Require Approval.** 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: (1) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing; (2) the names of the originating and receiving strategies and the method of financing and FTEs 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

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		the originating and the receiving strategies; and (4) the capital budget impact. A transfer request shall be considered to be ~~dis~~approved unless the Legislative Budget Board and the Governor issue written dis<u></u>approvals within 45 calendar days of receipt of the request. d. **Transfers into Items of Appropriation.** Transfers may be made from any appropriation item to the appropriation items in section (a), subject to the limitations established in section (a) for each appropriation item. ~~e. **Cost Pools.** Notwithstanding the above limitations, transfers may be made from Medicaid and CHIP appropriation items (Goals B and C) to separate accounts authorized by agency rider and established by the State Comptroller for payment of certain support costs not directly attributable to a single program.~~ ~~f.~~e. **Cash Management.** Notwithstanding the above limitations, HHSC may temporarily utilize funds appropriated to Medicaid and CHIP (Goals B and C) for cash flow purposes. All funding used in this manner shall be promptly returned to the originating strategy. This authorization is subject to limitations established by the Comptroller of Public Accounts. The Comptroller of Public Accounts shall not allow the transfer of funds 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. In the case of disaster or other emergency, this provision is superseded by the emergency-related transfer authority in Article IX of this Act. *The rider is revised in section c to provide approval of transfer letters within 45 days of submission unless either LBB or Governor issues a disapproval letter. Additionally, reference to cost pools in Medicaid and CHIP are removed to reflect new budget structure.*
HHSC 13	II-87	**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

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		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 ~~2012~~ 2014 and ~~2013~~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 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-87	**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, Immigrant Health Insurance, School Employee Health Insurance, and CHIP Perinatal programs. Expenditures shall be made from CHIP Experience Rebates generated in fiscal years 2014~~2012~~ and 2015~~2013~~. 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, 2013~~2011~~, and receipts earned in fiscal years 2014~~2012~~ and 2015~~2013~~. 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

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		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-88	**CHIP: Unexpended Balances and Allocation of Funds.** a. **Unexpended Balances between Biennia.** Unexpended balances in General Revenue Funds appropriated for Goal C (CHIP) strategies to the Health and Human Services Commission (HHSC) for the fiscal year ending August 31, 2013~~2011~~ (estimated to be $0) are appropriated to the agency and included above for the fiscal year beginning September 1, 2013~~2011~~, 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 2013~~2011~~. 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, 2014~~2012~~ (estimated to be $0) are appropriated to the agency for the fiscal year beginning September 1, 2014~~2012~~, 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

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		(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 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 $282.0~~$282.3~~million for fiscal year 2014~~2012~~ and $288.0~~$289.7~~ million for fiscal year 2014~~2013~~ 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 2014~~2012~~ and fiscal year 2015~~2013~~ 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 tobacco settlement appropriations for 2014-2015 biennium.*

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HHSC 22	II-90	**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 20142012, and $62,851,931 in General Revenue is appropriated for TANF maintenance of effort for fiscal year 20152013. 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; b. 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 c. 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-90	~~**Performance Reporting for the Prescription Drug Rebate Program.** The 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, 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 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 deleted to eliminate duplicative reporting requirements. The rebate billing and collection information is included in the quarterly CMS reporting and is also accounted for in HHSC budget forecasting and LAR projections. For the past 6 years, the Statewide Single Audit has included a review of the revenue reporting and processes and procedures that surround the invoicing and collections of drug rebates.*

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HHSC 26	II-91	**~~Texas Integrated Eligibility Redesign Systems (TIERS).~~** ~~To fund the debt related to TIERS, the commission may seek funding from the most cost-effective type of financing, including but not limited to cash acquisition, commercial financing, and financing provided by the Texas Public Finance Authority. From any funds appropriated to the Health and Human Services Commission for the purpose of implementing the project, an amount not to exceed $4,221,674 (amounts needed for Master Lease Purchase Program) for the biennium in All Funds may be transferred to the Texas Public Finance Authority for lease payments to the Texas Public Finance Authority to pay debt service on the obligations issued by the Texas Public Finance Authority on behalf of the commission for the above-mentioned project.~~ *Rider is deleted as authority to pay debt service is included in the HHSC Rider 2, Capital Budget.*
HHSC 35	II-92	**Unexpended Balance Authority for Eligibility Determination Services.** Unexpended balances in General Revenue Funds appropriated in Strategy A.1.2, Integrated Eligibility and Enrollment, for the fiscal year ending August 31, 2014~~2012~~, are appropriated to the agency for the following fiscal year 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. 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 the fiscal year with an unexpended balance: (1) an explanation of the causes of the unexpended balance(s); (2) the amount of the unexpended balance(s) by strategy; and (3) the associated incremental change in service levels compared to performance targets in this Act for that fiscal year. b. The following information shall be provided for the fiscal year receiving the funds: (1) an explanation of purpose 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) the incremental change in service levels compared to performance targets in this Act for that fiscal year; and

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		(4) 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 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. *Rider is updated for biennial date change.*
HHSC 36	II-93	**Continued Medicaid Coverage for Clients Unable to Access 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~~Vendor Drug Program~~, the Health and Human Services Commission shall ~~continue to provide 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 Vendor Drug Program, 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 certain clients and 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 Prescription Drugs~~Vendor Drug Program~~ (e.g., prescribed over-the-counter medications~~,~~ and barbiturates~~., and benzodiazepines).~~ *Rider is revised to delete section no longer relevant. These provisions were originally included to account for the implementation of Medicare Part D. Additionally, the rider is revised to add 'certain clients' and remove benzodiazepines account for the Affordable Care Acts expansion of Medicare Part D coverage effective January 1, 2013. Rider is also revised to update strategy names for the 2014-2015 biennium.*
HHSC 37	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

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		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. In pursuing this objective, the commission, in coordination with the Attorney General, and with advice from representatives from the hospital industry, will: a. review the current instruments for reporting uncompensated care by Texas hospitals to ensure that accounting for uncompensated care as well as its reporting is consistent across hospitals; b. coordinate the different instruments for reporting uncompensated care in Texas, e.g., Statement of Community Benefits, Annual Hospital Survey, and DSH Survey, so that there is consistency in reporting among these instruments while maintaining the integrity of each instrument's purpose; c. identify the sources of funding to hospitals that are intended to offset uncompensated care; d. develop a standard set of adjustments that apply the funding sources to reported uncompensated care in such a manner that a reliable determination of the actual cost to a hospital for uncompensated care can be made; and e. identify a standard ratio of cost to charges (RCC) to standardize the conversion of reported charges to costs. 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, 2012. 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 revised to delete the biennial report as report will be completed prior to 2014-2015 biennium.*
HHSC 38	II-94	**Hospital Reimbursement.** ~~Contingent upon federal approval, and to the extent allowed by law,~~ It is the intent of the Legislature ,that no funds appropriated under this Article for the payment of inpatient hospital fees and charges under the medical assistance program may be expended, except under a prospective payment methodology for all Medicaid inpatient claims, excluding state owned teaching hospital Medicaid inpatient claims, that employs sound cost reimbursement principles and: a. enhances the Health and Human Services Commission's ability to be a prudent purchaser of health care;

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		b. reflects costs that are allowable, reasonable and medically necessary to deliver health care services to the state's Medicaid population; c. reduces the variability in the Medicaid reimbursement rates paid to hospitals for treating patients with the same diagnoses; d. promotes and rewards increased efficiency in the operation of hospitals; e. emphasizes and rewards quality of outcomes and improves the treatment of Medicaid patients through pay-for-performance principles; f. recognizes, through add-on payments or other methods, the unique needs of rural hospitals and children's hospitals; and ~~g. reformulates the Disproportionate Share Hospital (DSH) supplemental payment methodology to increase its focus on paying hospitals for uncompensated care and reduces the existence of the inpatient Medicaid shortfall that prevents the State from achieving this objective.~~ *Rider is revised to add intent that state owned teaching hospitals be excluded from this reimbursement and adds add-on payments for children's hospitals.*
HHSC 40	II-94	**Payments to Hospital Providers.** ~~Until the Health and Human Services Commission (HHSC) implements a new inpatient reimbursement system for Fee-for-Service (FFS) and Primary Care Case Management (PCCM) or managed care, including but not limited to health maintenance organizations (HMO) inpatient services, h~~Hospitals that meet one of the following criteria: 1) located in a county with 50,000 or fewer persons according to the 2010 decennial U.S. Census, or 2) is a Medicare-designated Rural Referral Center (RRC) or Sole Community Hospital (SCH), that is not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or 3) is a Medicare-designated Critical Access Hospital (CAH), shall be reimbursed based on a statewide standard dollar amount (SDA) reimbursement methodology with add-ons. ~~the cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most recent data. Hospitals that meet the above criteria, based on the 2000 decennial census, will be eligible for TEFRA reimbursement without the imposition of the TEFRA cap for patients enrolled in FFS and PCCM. For patients enrolled in managed care other than PCCM, including but not limited to health maintenance organizations (HMO), inpatient services provided at hospitals meeting the above criteria will be reimbursed at the Medicaid reimbursement calculated using each hospital's most recent FFS rebased full cost Standard Dollar Amount for the biennium.~~ *Section 2702 of the Affordable Care Act (ACA) prohibits Medicaid from paying for certain health care acquired conditions (HCACs). The final rule released on this provision also further stipulates that hospitals that are exempt from this requirement under Medicare are not exempt under Medicaid (i.e. TEFRA, rural hospitals). The MMIS claims engine does*

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		not currently have a mechanism by which a claims reduction can be imposed for TEFRA reimbursed hospitals. Transitioning the rural hospitals to a statewide standard dollar amount (SDA) reimbursement methodology with add-ons will allow HHSC to use existing claims engine logic to impose the federally required reduction for HCACs.
HHSC 42	II-95	**Graduate Medical Education.** The Health and Human Services Commission is authorized to spend Appropriated Receipts - Match for Medicaid and matching Medicaid Federal Funds out of Strategy B.2.1, Non-Full Benefit Payments~~Cost Reimbursed Services~~, for Graduate Medical Education payments to state-owned teaching hospitals, contingent upon receipt of allowable funds from state-owned teaching hospitals to be used as the non-federal share for Medicaid Graduate Medical Education. Appropriated Receipts - Match for Medicaid shall be the only source of funds used for the non-federal share for Medicaid Graduate Medical Education, and the Health and Human Services Commission shall develop a payment methodology for Medicaid Graduate Medical Education payments to state-owned teaching hospitals. *Rider is revised to update strategy name for the 2014-2015 biennium.*
HHSC 43	II-95	**Enterprise Data Warehouse.**[~~17~~] Out of funds appropriated above in Strategy A.2.1, Consolidated System Support, the Health and Human Services Commission (HHSC) may expend $4,212,954~~$5,966,954~~ 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, 2013~~2011~~ and September 1, 2014~~2012~~ reflecting actual expenditures and accomplishments to date. The reports shall also reflect an estimate of planned expenditures and accomplishments for the remainder of the 2014-2015~~2012-13~~ biennium. ~~[17] *Rider amended for technical corrections*~~ *Rider is updated for biennial date changes and requested 2014-2015 base capital project amount. Rider revision associated with exceptional capital budget request is on page 51.*
HHSC 44	II-95	~~**SAVERR to TIERS.** Out of funds appropriated above in Strategy F.1.1, TIERS & Eligibility Supporting Technologies, the Health and Human Services Commission will convert all the remaining SAVERR cases into the TIERS system, contingent upon receipt of required approval by federal funding partners, no later than December 31, 2011~~. *Rider is deleted as the conversion of SAVERR cases into the TIERS system was completed during fiscal year 2012.*
HHSC 46	II-96	**Local Reporting on ~~UPL,~~ DSH, Uncompensated Care and Delivery System Reform Incentive Payment~~Indigent Care~~ Expenditures.** Out of funds appropriated above, and as the state Medicaid operating agency, the Health and

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		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 Upper Payment Limit (UPL) program~~, the Disproportionate Share Hospital (DSH) program, and Uncompensated Care (UC) Pool, and the Delivery System Reform Incentive Payment Pool (DSRIP) ~~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, ~~UPL~~ 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 revised to delete references to the Upper Payment Limit Program and add references to supplemental payments allowed under the 1115 Healthcare Transformation and Quality Improvement Waiver.*
HHSC 47	II-96	**~~Nurse Family Partnership Federal Funding.~~** ~~Contingent on receipt of additional Federal Funding specifically for nurse home visitations to families with young children, the Health and Human Services Commission shall budget these funds for the Nurse Family Partnership program in Strategy A.1.1, Enterprise Oversight and Policy.~~ *This rider was added in anticipation of additional federal funds available for the Visiting Nurse Program. Additional federal funding has been received and applied to the program. The rider is not needed for the 2014-2015 biennium and should be deleted as there is additional authority in Article IX for the receipt of federal funds by state agencies.*
HHSC 48	II-96	**Women's Health Program~~Services Demonstration Project: Savings and Performance Reporting~~.** Out of funds appropriated in strategy B.2.1 "Non-Full Benefit Payments", the Health and Human Services Commission (HHSC) shall provide Women's Health Program services to women. Only women whose income and family size puts them at or below 185% of the Federal Poverty Guidelines and who meet all other eligibility requirements are eligible for Texas Women's Health Program services. The commission is authorized to expend matching Medicaid federal funds in the event that they are available.

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		~~It is the intent of the Legislature that the Health and Human Services Commission~~ HHSC shall submit an annual report to the Legislative Budget Board and the Governor that includes the following information: a. enrollment levels of targeted low-income women, including service utilization by geographic region, delivery system, and age; b. savings or expenditures attributable to enrollment levels as reported in section (a) and; c. descriptions of all outreach activities undertaken for the reporting period. *Rider is revised to combine Riders 48 and 62 as the Women's Health Program will transition from a Medicaid program to a fully state funded program called the Texas Women's Health Program in November 2012. HHS has the authority under Chapter 31, Texas Health and Safety Code, to provide primary health care services, including family planning services.*
HHSC 49	II-96	**Medication Therapy Management.** ~~Out of funds appropriated above to the Health and Human Services Commission in strategy B.2.2, Medicaid Vendor Drug Program, the commission shall allocate up to $170,000 in General Revenue Funds for the 2012-13 biennium to establish a medication therapy management pilot program created to reduce adverse drug events and related medical costs for a subset of high-risk Texas Medicaid clients. 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, and submit a report to the Governor and the Legislative Budget Board by December 1, 2012.~~ *Rider is deleted as HHSC expects the legislature to act on the rider reporting requirements.*
HHSC 50	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 2012 and $50,000 in fiscal year 2013 to the Texas~~

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		~~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 claims for veterans receiving Medicaid or other state public benefits for which veterans are entitled from the Department of Veterans Affairs.~~ ~~c. Develop a method to calculate savings and costs avoided from information/data received from the PARIS which results in Medicaid beneficiaries or other state public assistance beneficiaries receiving benefits/compensation for which veterans are entitled from the U.S. Department of Veterans Affairs.~~ ~~d. Ten percent of the General Revenue savings during fiscal year 2012 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 2013.~~ *Rider is deleted as Subchapter B, Chapter 531.0998(e), Government Code, expires September 1, 2013. Mandated under HB 1784 (82nd Legislature, Regular Session), HHSC, Department of Aging and Disability Services (DADS), Texas Veterans Commission (TVC) and Texas Veterans Land Board (VLB) have entered into a Memorandum of Understanding to coordinate and collect information about the use and analysis of PARIS Veterans match system and develop ways to generate costs savings for the state and maximize access to benefits for veterans. As of July 31, 2012, 11 months into the fiscal year, TVC has not reported any benefit claims being adjudicated for veterans as a result of usage of the PARIS Veterans match information and HHSC has not received enough data from TVC to begin calculating potential cost savings. TVC indicated that it may take 12-18 months for the Department of Veterans Affairs to adjudicate a new claim for veterans' benefits after they have filed it on behalf of the veteran. As a result, HHSC has not realized any cost savings from usage of the PARIS Veterans match system. It is also problematic to accurately calculate cost savings, based on the assumption that HHSC would receive accurate information from the other agencies, in addition to the fact that calculations would be based on projected cost avoided of HHSC and DADS clients' future benefits being reduced or denied as a result of beginning to receive veterans' benefits. In the meantime, HHSC continues to incur the expense of processing the file of PARIS Veterans match data to include additional information from HHSC and DADS eligibility systems prior to sending it through a secured file transfer process (FTP) to TVC.*
HHSC 51	II-97	~~**Managed Care Expansion.**[18] Included in appropriations to the Health and Human Services Commission (HHSC) above in Goal B, Medicaid, is a net $60,556,875 in General Revenue ($149,537,984 All Funds) in fiscal year 2012 and $110,693,789 in General Revenue ($272,508,811 All Funds) in fiscal year 2013 to expand the managed care model for the provision of Medicaid and CHIP services. The appropriation also assumes a transfer of $184,163,492 in General~~

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		~~Revenue in fiscal year 2012 and $359,005,944 in General Revenue in fiscal year 2013 from the Department of Aging and Disability Services to the HHSC.~~ ~~The expansion assumes a savings to be realized in client services at HHSC of $123,606,617 in General Revenue ($291,466,116 All Funds) in fiscal year 2012 and $248,312,155 in General Revenue ($569,545,340 All Funds) in fiscal year 2013.~~ ~~The full appropriation and transfer amounts are contingent on the enactment of Senate Bill 23, or similar legislation authorizing the use of managed care in the south Texas counties of Cameron, Hidalgo and Maverick. If Senate Bill 23 is not enacted, the appropriation above in Goal B, Medicaid, is reduced by $57,370,186 General Revenue and $87,670,192 in Federal Funds in fiscal year 2012 and $121,680,697 in General Revenue and $185,809,691 in Federal Funds in fiscal year 2013. Also, if Senate Bill 23 or similar legislation is not enacted, the transfer from the Department of Aging and Disability Services is reduced by $143,139,236 in General Revenue in fiscal year 2012 and $297,625,734 in General Revenue in fiscal year 2013. The expansion of the managed care model is estimated to result in a net savings of $385,661,820 in General Revenue ($889,316,205 All Funds) in Article II in the biennium.~~ ~~The commission shall provide a report detailing the cost savings in General Revenue and All Funds realized by the expansion of managed care in the biennium. The report shall be submitted to the Legislative Budget Board and the Governor by July 1, 2012.~~ ~~*[18] Incorporates the enactment SB 2, §10, 82nd First Called Session, a contingency rider related to enabling legislation for the expansion of managed care model of Medicaid services in South Texas counties. The enabling legislation, SB 7, 82nd 1st Called Session, did pass, resulting in the level of funding for the managed care expansion included in the Conference Committee bill.*~~ *Rider is deleted as it relates to appropriations for fiscal years 2012-2013. Continuation of the Medicaid managed care expansion is reflected in the 2014-2015 base requests for caseload growth and as an exceptional item for cost and utilization growth.*
HHSC 52	II-97	**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 1 of each fiscal year of the 2014-2015~~2012-13~~ biennium the actual amount of federal Social Services Block Grant funds expended and the actual amount of unexpended and unobligated balances. The Health and Human Services Commission shall also report how the unexpended and unobligated balances in Social Services Block Grant funds of each fiscal year of the 2014-2015~~2012-13~~ biennium will be used prior to expending the balances. This provision does not apply to Social Services Block Grant supplemental or emergency funds.

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		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 54	II-98	**~~Capitated Managed Care Model of Dental Services Reporting.~~** ~~Out of funds appropriated above to the Health and Human Services Commission in strategy B.3.2, Health Steps (EPSDT) Dental, contingent on the Health and Human Service Commission changing the service delivery model for dental services from a fee-for-service model to a capitated managed care model, the Health and Human Services Commission shall evaluate the impact of providing dental services through a capitated managed care model on access, 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, 2013.~~ *Rider is deleted as the evaluation will be completed and submitted prior to the 2014-2015 biennium.*
HHSC 55	II-98	**~~Report on Telemonitoring in the Texas Medicaid Program.~~**[19] ~~Contingent on passage of Senate Bill 967, House Bill 1605 or similar legislation that would expand use of telemonitoring in the Texas Medicaid Program, by the Eighty-second Legislature, Regular Session, the Health and Human Services Commission shall provide a report to the Governor and Legislative Budget Board by September 1, 2012 that includes the following:~~ ~~a. Either:~~ ~~(1) a summary of the implementation of telemonitoring services for select diabetes patients within the Texas Health Management Program, if the results from the Medicaid Enhanced Care diabetes telemonitoring pilot program show that it was cost-neutral or cost-saving, or~~ ~~(2) an analysis of the estimated cost-effectiveness and feasibility of adding a telemonitoring pilot program to the Texas Health Management Program for select diabetes patients, if the results from the Medicaid Enhanced Care diabetes telemonitoring pilot program show that it was not cost-neutral or cost-saving;~~ ~~b. An analysis of the estimated cost-effectiveness and feasibility of adding telemonitoring pilot programs to the Texas Health Management Program for other conditions (e.g. high-risk pregnancy, congestive heart failure, or chronic obstructive pulmonary disease); and~~ ~~c. A summary of the telemonitoring activities and their cost-effectiveness used by health maintenance~~

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		~~organizations in STAR and STAR+PLUS; and a summary of the steps taken by the Health and Human Services Commission to disseminate that information.~~ ~~[19] *Neither SB 967 nor HB 1605, 82nd Regular Session, passed.*~~ *Rider is deleted as the legislation cited in the rider was not enacted so the reports to be submitted contingent upon the legislation are not required.*
HHSC 56	II-98	**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: 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. ~~The Department 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, 2012.~~ *Rider is revised to maintain intent and delete reporting requirement as the report will be completed and submitted prior to the 2014-2015 biennium.*
HHSC 57	II-99	~~**Finger Imaging Contract.**~~[20] ~~Included in appropriations above in Strategy B.1.4, Children and Medically Needy, is a reduction of $2,800,000 in General Revenue funding for the elimination of a finger imaging contract, contingent upon the enactment of House Bill 710 or similar legislation. It is not the intent of the Legislature to prohibit the use of biometrics in this or any health and human services program.~~

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		~~[20] HB 710, relating to verification of identity of applicants for benefits under and prevention of duplicate participation in the financial assistance and supplemental nutrition assistance programs, did pass. The funding reduction was included in the Conference Committee bill.~~ *Rider is deleted as the funding reduction was made in fiscal years 2012-2013 contingent upon the enactment of H.B. 710. The legislation was enacted and the reduction is continued in the base request funding for fiscal years 2014-2015.*
HHSC 58	II-99	~~**Contingency for Senate Bill 8.**[21] Contingent on the enactment of Senate Bill 8, or similar legislation relating to creation of an Institute of Health Care Quality and Efficiency and repeal of the Texas Health Care Policy Council, by the Eighty-second Legislature, Regular Session, 2011, appropriations in Strategy A.1.1, Enterprise Oversight and Policy, to the Health and Human Services Commission are increased by $228,800 in fiscal year 2012 and $228,800 in fiscal year 2013 in interagency contracts. The number of "Full-Time Equivalents (FTE)" is increased by 2.0 FTEs in fiscal year 2012 and 2.0 FTEs in fiscal year 2013.~~ ~~[21] SB 8, 82nd Regular Session did not pass. However, a contingency rider in SB 2, 82nd 1st Called Session, §11, and similar legislation, SB 7, 82nd 1st Called Session, did pass. $228,800 in Interagency Contracts in each fiscal year was included in the Conference Committee bill in Strategy A.1.1, Enterprise Oversight and Policy.~~ *Rider is deleted as the Institute of Health Care Quality and Efficiency was created at HHSC during fiscal year 2012 and funding is included in the base request funding for fiscal years 2014-2015.*
HHSC 59	II-99	~~**Federal Flexibility.** Included in appropriations above to the Health and Human Services Commission (HHSC) in Strategy B.1.4, Children and Medically Needy, is a reduction of $700,000,000 in General Revenue Funds and $1,666,666,667 in Federal Funds in fiscal year 2013 related to containing cost growth in the Texas Medicaid and Children's Health Insurance Program (CHIP) programs. It is the intent of the Legislature that, if necessary, HHSC seeks federal approval for waiver(s) that would permit the following:~~ ~~a. that the state of Texas have greater flexibility in standards and levels of eligibility in Medicaid and CHIP programs;~~ ~~b. that the state of Texas design and implement benefit packages that target the specific health needs and reflect the geographic and demographic needs of Texas;~~ ~~c. that the state of Texas Medicaid and CHIP programs foster a culture of individual responsibility through the appropriate use of co-payments;~~

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		~~d. that the state of Texas consolidate funding streams to increase accountability, transparency, and efficiency (consolidated funding streams should be considered for both hospital and long term care);~~ ~~e. that the federal government assume financial responsibility for 100 percent of the health care services provided to unauthorized immigrants; and~~ ~~f. that existing state and local expenditures be utilized to maximize federal matching funds.~~ *Rider is deleted as the rider reductions apply to funding in the 2012-2013 biennium and are reflected in the base funding for FY 2014-2015.*
HHSC 60	II-100	~~**Upper Payment Limit Reimbursement for Children's Hospitals.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission (HHSC) is authorized to provide the state match for a children's hospital participating in the Upper Payment Limit (UPL) reimbursement program based upon the following criteria:~~ ~~a. The children's hospital shall formally request that HHSC provide the state match. The request should include documentation of the efforts taken by the hospital to participate in the private hospital UPL program, a description of the financial impact to the hospital for the loss of this revenue source, and any impact to the local community.~~ ~~b. HHSC shall analyze the children's hospital request and determine if there is a critical need to provide state matching funds for UPL reimbursement to that children's hospital.~~ ~~c. Upon a determination of critical need, HHSC shall notify the Legislative Budget Board and the Governor of the amount of General Revenue Funds to be transferred out of another Medicaid strategy to strategy B.2.5, Upper Payment Limit, for the provision of the state match for the eligible children's hospital and the projected state expenditure for the UPL reimbursement for each fiscal year.~~ ~~HHSC shall not expend more than $5,000,000 in General Revenue Funds for the purpose of providing the state match for the children's hospital UPL program for the biennium beginning September 1, 2011.~~ *Rider is deleted as the rider has expired.*
HHSC 61	II-100	~~**Medicaid Funding Reduction.**~~ ~~a. Included in appropriations above in Strategy B.1.4, Children and Medically Needy, is a reduction of $225,000,000 in General Revenue Funds in fiscal year 2012 and $225,000,000 in General Revenue Funds in fiscal year 2013, a biennial total of $450,000,000 in General Revenue Funds. The Health and Human Services~~

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		~~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) Implementing payment reform and quality based payments in fee for service and managed care,~~ ~~(2) Increasing neonatal intensive care management,~~ ~~(3) Transitioning outpatient Medicaid payments to a fee schedule,~~ ~~(4) Developing more appropriate emergency department hospital rates for nonemergency related visits,~~ ~~(5) Maximizing co-payments in all Medicaid and non-Medicaid programs,~~ ~~(6) Maximizing federal matching funds through a combination of a Medicaid waiver, full risk transportation broker pilots, and/or inclusion of transportation services in managed care organizations,~~ ~~(7) Reducing costs for durable medical equipment and laboratory services through rate reductions, utilization management and consolidation,~~ ~~(8) Statewide monitoring of community care through telephony in Medicaid fee-for-service and managed care,~~ ~~(9) Expanding billing coordination to all non-Medicaid programs,~~ ~~(10) Increasing utilization of over-the-counter medicines,~~ ~~(11) Renegotiating more efficient contracts,~~ ~~(12) Equalizing the prescription drug benefit statewide,~~ ~~(13) Allowing group billing for up to three children at one time in a foster care or home setting who receive private duty nursing services,~~ ~~(14) Achieving more competitive drug ingredient pricing,~~ ~~(15) Increasing generic prescription drug utilization,~~ ~~(16) Improving birth outcomes by reducing birth trauma and elective inductions,~~ ~~(17) Increasing competition and incentivizing quality outcomes through a statewide Standard Dollar Amount and applying an administrative cap,~~

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		~~(18) Establishing a capitated rate to cover wrap-around services for individuals enrolled in a Medicare Advantage Plan,~~ ~~(19) Improving care coordination for Children with Disabilities in managed care,~~ ~~(20) Automatically enrolling clients into managed care plans,~~ ~~(21) Restricting payment of out-of-State Services to the Medicaid rate and only our border regions,~~ ~~(22) Increasing utilization management for provider-administered drugs,~~ ~~(23) Implementing the Medicare billing prohibition,~~ ~~(24) Increasing the assessment time line for private duty nursing,~~ ~~(25) Maximizing federal match for services currently paid for with 100 percent general revenue,~~ ~~(26) Adjusting amount, scope and duration for services,~~ ~~(27) Increasing fraud, waste and abuse detection and claims,~~ ~~(28) Strengthening prior authorization when efficient,~~ ~~(29) Paying more appropriately for outliers, and~~ ~~(30) 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, 2011 to the Legislative Budget Board, the Governor, and the Comptroller of Public Accounts. The plan must be submitted in a format specified by the Legislative Budget Board.~~ *Rider is deleted as the reductions apply to funding in the 2012-2013 biennium and are reflected in the base funding for FY 2014-2015.*
HHSC 62	II-101	~~**Contingency for Women's Health Program.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission, contingent on receiving a waiver under Section 1115 of the Social Security Act, shall provide Women's Health Program services under Medicaid to women. Only women whose income and family size puts them at or below 185% of the Federal Poverty Guidelines and who meet all other Medicaid eligibility requirements are eligible for Women's Health Program services.~~

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		Rider is deleted and combined with current rider #48.
HHSC 64	II-102	**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. 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~~2011~~ and December 1, 2014~~2012~~ 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 updated for biennial date changes.*
HHSC 65	II-102	**Office for the Prevention of Developmental Disabilities.** Out of funds appropriated in Strategy A.1.1, Enterprise Oversight and Policy, the ~~The~~ Health and Human Services Commission shall support the Office for the Prevention of Developmental Disabilities ~~expend,~~ from funds otherwise appropriated to the commission by this Act, in an amount not to exceed $111,806~~$111,805~~ each fiscal year ~~for salaries, benefits, travel expenses, and other support of the Office for Prevention of Developmental Disabilities~~. However, grants and donations received through the authority provided by Article IX Sec. 8.01, Acceptance of Gifts of Money, are not subject to this limit and may be expended by the Office.

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		Rider is revised to clarify funding is from funds appropriated above in base. Rider revision associated with exceptional budget request is on page 51.
HHSC 66	II-102	~~**Office of Acquired Brain Injury.** Out of Federal Funds appropriated above in strategy A.1.1, Enterprise Oversight and Policy, the Health and Human Services Commission shall use the federal CFDA 93.234 grant amount of $250,000 in each fiscal year of the biennium for the purpose of funding 1.0 FTE and the Office of Acquired Brain Injury in order to assess and serve youth in the Texas juvenile justice system with brain injury and other projects including brain injured veterans.~~ *Rider is deleted as it relates to federal funding available for the fiscal years 2012-2013. For the 2014-2015 biennium, there is an exceptional item request to continue the Office of Acquired Brain Injury with general revenue since there would no longer be federal funding.*
HHSC 67	II-102	**Statewide Hospital SDA.** 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 hospital rates using a methodology based on a statewide standard dollar amount (SDA) by using All Patient Refined Diagnosis Related Groups (APR-DRGs). ~~September 1, 2011.~~ The commission may consider high cost hospital functions and services, including regional differences, when developing the rate methodology. ~~Included in appropriations above in Goal B, Medicaid, is a reduction of $30,900,000 in General Revenue Funds for the implementation of a statewide SDA methodology for payments to hospitals. Until September 1, 2012, HHSC may use up to $20,000,000 in General Revenue Funds in Goal B, Medicaid, to mitigate disproportionate losses.~~ There may be a separate base SDA for each of the following three peer groups: children's hospitals, rural hospitals, and other acute care hospitals. This provision shall not apply to MD Anderson Cancer Center, The University of Texas Medical Branch at Galveston (UTMB), and The University of Texas Health Science Center at Tyler. These hospitals will continue to be reimbursed based on the cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most recent data. *Rider is revised to reflect the implementation of the rider and related rule changes.*
HHSC 68	II-102	~~**Medicaid Cost and Quality: Physician Payment for Quality.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission (HHSC) shall establish a committee of Texas physicians and HHSC representatives in order to determine the ten most overused services performed by physicians in Texas Medicaid, using national guidelines related to unnecessary medical procedures as the basis for this determination.~~ ~~Based on these determinations, HHSC shall decrease Medicaid payments for those services that should not be provided. Physicians will maintain the right to appeal the decision in individual cases.~~ *Rider is deleted as this determination and decrease process is in place.*

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HHSC 69	II-103	~~**Medicaid Cost and Quality: Use of Nurse Practitioner/Physician Extenders.** Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission (HHSC) shall expend General Revenue Funds, in an amount not to exceed $1,250,000, to establish a pilot "Grand Aides" program that uses nurse practitioner/physician extenders ("Grand Aides") to serve clients receiving Medicaid services. Grand Aides are senior members of the community, who, as part of a team under close supervision by a nurse practitioner or physician, shall use protocols by telephone and home visit with "portable telemedicine" for simple conditions such as colds, to reduce inappropriate Emergency Department visits by 25 percent. HHSC shall report the results of this pilot program, including cost and quality measures, to the Senate Finance Committee and the House Appropriations Committee by December 1, 2012.~~ *Rider is deleted as the report will be completed prior to 2014-2015 biennium. Additionally, because of some negotiations and a reported lack of preparedness of the individuals who have gone through the "grand aides" training, this contract and related services will not begin until end of October.*
HHSC 70	II-103	~~**Supplemental Payments.** It is the intent of the Legislature that when the Health and Human Services Commission calculates supplemental payments, data be collected to provide transparency regarding claims associated with the supplemental payment program. An independent audit of the program, including a review of regional affiliations, uncompensated care claims for both uninsured and insured individuals, and contractual agreements, and a report with findings should be completed and distributed annually on December 1 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.~~ *Rider is deleted as the audit requirements are duplicative of other supplemental payment program reviews that HHSC performs.*
HHSC 71	II-103	~~**Medicaid Cost and Quality: Comprehensive Follow-up Care for High-risk Infants.** Out of funds appropriated above, the Health and Human Services Commission (HHSC) shall support a comprehensive follow-up program for premature, high-risk infants if the commission determines that such a program is cost effective for the Texas Medicaid program. Similar programs have reduced emergency room visits, pediatric intensive care unit (ICU) admissions, life-threatening illnesses, and total estimated cost. This program should serve infants who were (1) born at or before 30 weeks gestation, or (2) at or below 1000 grams birth weight, or (3) had major complications (e.g., development of chronic lung disease) before discharge from a neonatal ICU. Comprehensive care shall be provided in special follow-up clinics staffed by a small team of pediatricians and nurse practitioners. Expectations are for improved quality of care and reduced cost.~~ ~~HHSC shall report cost and quality measures to the Senate Finance Committee and House Appropriations Committee by December 1, 2012.~~ *Rider is deleted as the report will be completed prior to 2014-2015 biennium. The contract will start service provision*

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HHSC 72	II-103	**~~Medicaid Vitamin Coverage.~~** ~~Contingent upon federal approval of a Texas Medicaid State Plan amendment providing vitamin and mineral supplements to Medicaid-eligible children, out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall assign prices to vitamins and minerals dispensed at Vendor Drug Program (VDP)-enrolled pharmacies.~~ *Rider is deleted as the authority has been enacted in rule.*
HHSC 73	II-103	**Prevent Eligibility Determination Fraud.** It is the intent of the Legislature that to prevent fraud and to maximize efficiencies, the Health and Human Services Commission shall use technology to identify the risk for fraud associated with applications for benefits~~, upon the completion of the rollout of the Texas Integrated Eligibility Redesign System (TIERS)~~. Within the parameters of state and federal law, the commission shall set appropriate verification and documentation requirements based on the application's risk to ensure agency resources are targeted to maximize fraud reduction and case accuracy. *Rider revised to reflect completion of TIERS rollout.*
HHSC 74	II-103	**Improve Efficiencies in Benefit Applications.** In order to improve efficiencies, the Health and Human Services Commission shall promote online submissions of applications for benefits administered by the agency. HHSC shall develop standards and technical requirements ~~within six months following the statewide implementation of the Texas Integrated Eligibility Redesign System (TIERS),~~ to allow organizations to electronically submit applications. *Rider revised to reflect completion of TIERS rollout.*
HHSC 75	II-104	~~**Unexpended Balance Authority for Human Resources Upgrade.**~~[22] ~~a. Unexpended Balance between Biennia. Unexpended balances in General Revenue Funds appropriated for the HHS HR/Payroll system upgrade in fiscal year 2011 (estimated to be $6,700,000) in strategy A.2.1, Consolidated Systems Support and B.1.4, Children & Medically Needy, are appropriated to the Health and Human Services Commission (HHSC) for the fiscal year beginning September 1, 2011, 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 2011. The amount of the appropriation is limited to the amount of the unexpended balance.~~ ~~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~~

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		~~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 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 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.~~ ~~c. HHSC shall also request the appropriate authority for transfers to other HHS agencies and increased assessments as directed by Article II, Special Provisions Section 10 and Section 46, respectively.~~ ~~[22] Incorporates $6,700,000 in General Revenue Funds in fiscal year 2012 previously included in "Supplemental Appropriations Made in Riders." Amounts shown have been included in Strategies A.2.1, Consolidated Systems Support, and B.1.4, Children and Medically Needy. There is a related increase of capital budget authority of $9,408,000 in All Funds in fiscal year 2012.~~ *Rider is deleted as it relates to unexpended balance authority for Human Resources Upgrade funding in fiscal years 2012-2013. The project should be completed during the biennium and this authority is not needed for the 2014-2015*

3.B. Rider Revisions and Additions Request

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		biennium.
HHSC 76	II-104	~~**STAR+PLUS.** It is the intent of the Legislature that if federal approval is not granted for protection of hospital Upper Payment Limit (UPL) payments, the Health and Human Services Commission (HHSC) shall implement the STAR+PLUS expansion while keeping hospitals carved out of the model. Further, to the extent allowable by law, HHSC shall achieve the projected savings to the state, estimated to be $28,900,000 in General Revenue Funds, which includes the anticipated increases in premium tax, through rate reductions to inpatient and outpatient hospital rates, selective contracting, or other initiatives proposed by the commission.~~ *Rider is deleted as HHSC has approval of a federal 1115 waiver that maintains the receipt of federal funding similar to payments to hospitals in the prior Upper Payment Limit program.*
HHSC 77	II-105	~~**STAR.** It is the intent of the Legislature that if federal approval is not granted for protection of hospital Upper Payment Limit (UPL) payments, the Health and Human Services Commission (HHSC) shall not implement the expansion of STAR. Further, to the extent allowable by law, HHSC shall achieve the projected savings to the state, estimated to be $242,700,000 in General Revenue Funds, which includes the anticipated increases in premium tax, through rate reductions to inpatient and outpatient hospital rates, selective contracting, or other initiatives proposed by the commission.~~ *Rider is deleted as HHSC has approval of a federal 1115 waiver that maintains the receipt of federal funding similar to payments to hospitals in the prior Upper Payment Limit program.*
HHSC 80	II-105	~~**Durable Medical Equipment Savings Initiatives.** Included in appropriation levels above in Goal B, Medicaid, are General Revenue Funds reductions of $88,300,000 for the following items:~~ ~~a. targeted rate reductions on durable medical equipment for a savings of $56,700,000 in General Revenue Funds;~~ ~~b. selective contracting for incontinence supplies for a savings of $12,800,000 in General Revenue Funds;~~ ~~c. savings from adding Diabetic supplies as a category on the pharmacy preferred drug list for a total of $1,800,000 in General Revenue Funds; and~~ ~~d.~~a. ~~additional cost containment initiatives related to durable medical equipment for a total of $17,000,000 in General Revenue Funds.~~ *Rider is deleted as the reductions apply to the funding in the 2012-2013 biennium.*

3.B. Rider Revisions and Additions Request

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HHSC 81	II-105	~~**Prescription Drug Carve in to Managed Care Organizations.** It is the intent of the Legislature that capitated managed care organizations in STAR, STARHealth, STAR+PLUS and CHIP:~~ ~~a. manage prior authorization for prescription drugs in a manner that is no more stringent than those prior authorization processes used by the Health and Human Services Commission (HHSC) in its administration of the Medicaid Vendor Drug Program;~~ ~~b. comply with the prescription drug claims payment requirements in effect September 1, 2011 in the Texas Insurance Code if prescription drugs are a covered benefit provided by managed care organizations in STAR, STARHealth, STAR+PLUS or CHIP;~~ ~~c. may not require members to obtain prescription drugs from a mail-order pharmacy; and~~ ~~d. adhere to the HHSC preferred drug list during fiscal years 2012 and 2013.~~ *Rider is deleted as prescription drugs have been carved into managed care during the 2012-13 biennium.*
HHSC 701	II	**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 financing item, 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, 2012, and receipts collected in fiscal years 2014 and 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, 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.

3.B. Rider Revisions and Additions Request

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		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. *This new rider would provide appropriation authority for the provider screening and enrollment fee to be collected by the State for those providers who have not already paid the fee directly to the federal government or another state's Medicaid program or Children's Health Insurance Program. The rider specifies the uses of the fee pursuant to federal law.*
HHSC 702	II	**Investing in HHSC Business Process Improvements**. a. Notwithstanding any other provisions in this Act, if the Executive Commissioner determines that the investment of appropriated funds into technology and communications promotes more efficient use of space, state staff or resources for business process improvements, the executive commissioner is authorized to do the following actions to the extent necessary to achieve efficiencies: (1) to expend out of funds appropriated to the Health and Human Services Commission; (2) to adjust the capital authority limitation; and (3) to transfer funds within the commission as allowed by this Act b. 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, 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; (4) the impact to general revenue and any other method of financing by strategy by fiscal year; and (5) any estimated increase in capital expenditures by method of financing by fiscal year. c. The Comptroller of Public Accounts shall not allow the transfer of funds or the adjustment of capital authority

3.B. Rider Revisions and Additions Request

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		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 request could allow HHSC to indentify existing funding and efficiencies to provide initial funding to install technology or communications changes necessary to improve business processes and modernize office infrastructure so that efficiencies or increased productivity can be attained.*

3.B. Rider Revisions and Additions Request

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HHSC 1	II-80	**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.

	2012	2013
A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY		
Outcome (Results/Impact):		
Average Medicaid and CHIP Children Recipient Months Per Month	3,166,648	3,224,726
A.1.2. Strategy: INTEGRATED ELIGIBILITY & ENROLLMENT		
Output (Volume):		
Average Monthly Number of Eligibility Determinations	891,406	941,406
Efficiencies:		
Average Cost Per Eligibility Determination	47.64	45.7
Explanatory:		
Percent of Poverty Met by TANF, Food Stamps, and Medicaid Benefits	87.61%	87.59%
Total Value of Food Stamps Distributed	5,561,000,000	5,573,000,000
B. Goal: MEDICAID		
Outcome (Results/Impact):		
Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month	3,620,829	3,709,990
B.1.4. Strategy: CHILDREN & MEDICALLY NEEDY		
Output (Volume):		
Average Number of Legal Permanent Resident Recipient Months per Month	83,812	84,581
B.1.5. Strategy: MEDICARE PAYMENTS		
Output (Volume):		
Average Supplemental Medical Insurance Part B (SMIB) Recipient Months Per Month	558,424	573,056
Efficiencies:		
Average Supplemental Medical Insurance Benefits (SMIB) Premium Per Month	118.82	124.06
B.1.6. Strategy: STAR+PLUS (INTEGRATED MANAGED CARE)		
Output (Volume):		
Average Aged and Medicare-eligible Recipient Months Per Month: STAR+PLUS	132,224	135,725
Average Disabled and Blind Recipient Months Per Month: STAR+PLUS	131,072	138,711
Efficiencies:		
Average Cost Per Aged and Medicare-eligible Recipient Month: STAR+PLUS Acute Care	162.78	162.78
B.2.1. Strategy: COST REIMBURSED SERVICES		

3.B. Rider Revisions and Additions Request

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~~**Output (Volume):**~~
~~Average Number of Non-citizens Recipient Months Per Month 10,051 10,126~~
~~**B.2.2. Strategy:** MEDICAID VENDOR DRUG PROGRAM~~
~~**Output (Volume):**~~
~~Total Medicaid Prescriptions Incurred 34,682,808 35,329,701~~
~~**B.3.3. Strategy:** EPSDT COMPREHENSIVE CARE PROG (FFS)~~
~~**Output (Volume):**~~
~~Average Number of Texas Health Steps (EPSDT) Comprehensive Care Program Recipient Month per Month (Fee-for-Service Only) 554,929 572,883~~
~~**B.4.1. Strategy:** STATE MEDICAID OFFICE~~
~~**Output (Volume):**~~
~~Medicaid Acute Care Recipient Months Per Month: Managed Care 2,705,372 2,768,083~~

~~**C. Goal:** CHIP SERVICES~~
~~**Outcome (Results/Impact):**~~
~~Average CHIP Programs Recipient Months Per Month (Includes all CHIP Programs) 584,161 588,476~~
~~Average CHIP Programs Benefit Cost with Prescription Benefit Per Recipient Month (Includes all CHIP Programs) 122.61 122.84~~
~~**C.1.4. Strategy:** CHIP PERINATAL SERVICES~~
~~**Output (Volume):**~~
~~Average Perinate Recipient Months Per Month 36,981 36,981~~
~~**C.1.5. Strategy:** CHIP VENDOR DRUG PROGRAM~~
~~**Output (Volume):**~~
~~Total Number of CHIP Prescriptions (Includes all CHIP Programs) 2,490,354 2,509,993~~
~~**Efficiencies:**~~
~~Average Cost Per CHIP Prescription (Includes all CHIP Programs) 63.18 63.18~~

~~**D. Goal:** ENCOURAGE SELF SUFFICIENCY~~
~~**D.1.1. Strategy:** TANF (CASH ASSISTANCE) GRANTS~~
~~**Output (Volume):**~~
~~Average Number of TANF Recipients Per Month 118,829 119,750~~
~~Average Number of State Two-Parent Cash Assistance Program Recipients Per Month 5,402 5,402~~
~~**Efficiencies:**~~
~~Average Monthly Grant: Temporary Assistance for Needy Families (TANF) 71.24 73.08~~
~~Average Monthly Grant: State Two-Parent Cash Assistance Program 68.49 70.01~~
~~**D.1.2. Strategy:** REFUGEE ASSISTANCE~~
~~**Output (Volume):**~~
~~Number of Refugees Receiving Contracted Social Services, Financial Assistance,~~

3.B. Rider Revisions and Additions Request

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		~~or Medical Assistance~~	~~20,000~~	~~20,000~~
		~~**D.2.1. Strategy:** FAMILY VIOLENCE SERVICES~~		
		~~**Output (Volume):**~~		
		~~Number of Persons Served by Family Violence Programs/Shelters~~	~~80,940~~	~~80,940~~
		~~**Efficiencies:**~~		
		~~Health and Human Services Average Cost Per Person Receiving Emergency Shelter Services through the Family Violence Program~~	~~811.1~~	~~865.18~~
		~~**D.2.2. Strategy:** ALTERNATIVES TO ABORTION~~		
		~~**Output (Volume):**~~		
		~~Number of Persons Receiving Pregnancy Support Services as an Alternative to Abortion~~	~~16,000~~	~~16,000~~
			2014	2015
		A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY		
		Outcome (Results/Impact):		
		Average Medicaid and CHIP Children Recipient Months Per Month	3,484,497	3,707,092
		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	48.57	48.09
		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	3,947,805	4,191,664
		Average Medicaid Acute Care (including Drug) Cost Per Recipient Month	353.03	403.81
		Medicaid Acute Care Recipient Months: Proportion in Managed Care	82.00%	82.23%
		Average Number of Members Receiving Waiver Services through STAR+PLUS	36,370	37,388
		B.1.1 Strategy: AGED AND MEDICARE-RELATED ELIGIBILITY GROUP		
		Output (Volume):		
		Average Aged and Medicare-Related Recipient Months Per Month	378,523	387,350

3.B. Rider Revisions and Additions Request

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		Avg Aged and Medicare-Related Recipient Months Per Month: STAR+PLUS	230,530	291,042
		Efficiencies:		
		Average Aged and Medicare-Related Acute Care Cost Per Recipient Month	93.99	113.97
		Avg Cost Per Aged & Medicare-Related Recipient Month: STAR+PLUS LTC	547.40	562.33
		B.1.2 Strategy: DISABILITY-RELATED ELIGIBILITY GROUP		
		Output (Volume):		
		Average Disability-Related Recipient Months Per Month	451,043	526,616
		Average Disability-Related Recipient Months Per Month: STAR+PLUS	193,099	201,621
		Efficiencies:		
		Average Disability-Related Acute Care Cost Per Recipient Month	808.88	769.59
		Avg Cost/Disability-Related Recipient Month: STAR+PLUS Long Term Care	248.12	240.15
		B.1.3 Strategy: PREGNANT WOMEN ELIGIBILITY GROUP		
		Output (Volume):		
		Average Pregnant Women Recipient Months Per Month	135,356	136,689
		Efficiencies:		
		Average Pregnant Women Cost Per Recipient Month	710.12	769.33
		B.1.4 Strategy: OTHER ADULTS ELIGIBILITY GROUP		
		Output (Volume):		
		Average TANF-Level Adult Recipient Months Per Month	139,469	142,252
		Efficiencies:		
		Average TANF-Level Adult Cost Per Recipient Month	419.62	501.86
		B.1.5 Strategy: CHILDREN ELIGIBILITY GROUP		
		Output (Volume):		
		Average Poverty-Related Children Recipient Months Per Month	2,811,713.07	3,021,744.06
		Average Number of Qualified Alien Recipient Months per Month	18,524	18,780
		Average STAR Health Foster Care Children Recipient Months Per Month	31,701	32,157
		Efficiencies:		
		Average Poverty-Related Children Cost Per Recipient Month	182.29	201.83
		Average STAR Health Foster Care Children Cost Per Recipient Month	888.87	1,050.08
		B.2.1 Strategy: NON-FULL BENEFIT PAYMENTS		

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		Output (Volume):		
		Average Number of Non-citizens Recipient Months Per Month	11,020	11,344
		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	86.69	91.04
		B.2.3 Strategy: MEDICAL TRANSPORTATION		
		Output (Volume):		
		Average Nonemergency Transportation (NEMT) Recipient Months Per Month	1,750,000	1,800,000
		Efficiencies:		
		Average Cost Per One-Way Medical Transportation Trip	24.43	24.60
		Average Nonemergency Transportation (NEMT) Cost Per Recipient Month	2.95	2.90
		B.2.4 Strategy: HEALTH STEPS (EPSDT) DENTAL		
		Efficiencies:		
		Average Cost Per THSteps (EPSDT) Dental Recipient Months Per Month	39.60	41.58
		B.2.5 Strategy: FOR CLIENTS DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID		
		Output (Volume):		
		Average SMIB Recipient Months Per Month	606,173	633,454
		Efficiencies:		
		Average SMIB Premium Per Month	110.20	116.80
		C. Goal: CHILDREN'S HEALTH INSURANCE PROGRAM SERVICES		
		Outcome (Results/Impact):		
		Average CHIP Programs Recipient Months Per Month	641,082	653,191
		Average CHIP Programs Benefit Cost with Prescription Benefit	177.69	189.71
		C.1.1 Strategy: Children's Health Insurance Program (CHIP)		
		Output (Volume):		
		Average CHIP Children Recipient Months Per Month	603,243	614,590

3.B. Rider Revisions and Additions Request

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		Efficiencies:		
		Average CHIP Children Benefit Cost Per Recipient Month	130.17	139.52
		C.1.2 Strategy: CHIP PERINATAL SERVICES		
		Output (Volume):		
		Average Perinatal Recipient Months Per Month	37,840	38,601
		C.1.3 Strategy: CHIP PRESCRIPTION DRUGS		
		Output (Volume):		
		Total Number of CHIP Prescriptions	2,713,843	2,785,728
		Efficiencies:		
		Average Cost Per CHIP Prescription	73.84	76.17
		D Goal: ENCOURAGE SELF SUFFICIENCY		
		D.1.1 Strategy: Temporary Assistance for Needy Families Grants		
		Output (Volume):		
		Average Number of TANF Basic Cash Assistance Recipients Per Month	93,816	95,114
		Avg Number of State Two-Parent Cash Assist Recipients Per Month	3,692	3,743
		Efficiencies:		
		Average Monthly Grant: TANF Basic Cash Assistance	73.26	74.72
		Average Monthly Grant: State Two-Parent Cash Assistance Program	70.20	71.80
		D.2.1 Strategy: FAMILY VIOLENCE SERVICES:		
		Output (Volume):		
		Number of Persons Served by Family Violence Programs/Shelters	80,686	80,686
		Efficiencies:		
		HHSC Avg Cost Per Person Receiving Family Violence Shelter Services	840.09	840.09
		D.2.2 Strategy: ALTERNATIVES TO ABORTION. NONTRANSFERABLE.		
		Output (Volume):		
		Number of Persons Receiving Services as Alternative to Abortion	16,000	16,000
		Rider is revised to incorporate 2014-2015 targets and projected performance for exceptional item requests.		

3.B. Rider Revisions and Additions Request

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HHSC 2	II-82	**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.

	2012	2013
~~a. Acquisition of Information Resource Technologies~~		
~~(1) Data Center Consolidation~~ [14]	~~$ 39,320,284~~	~~$ 22,848,544~~
~~(2) Seat Management Services (PCs, Laptops, & Servers)~~	~~11,698,298~~	~~11,718,756~~
~~(3) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations~~	~~4,635,366~~	~~0~~
~~(4) Enterprise Telecom Management Services~~	~~12,438,387~~	~~12,391,063~~
~~(5) Enterprise Info & Asset Mgt (Data Warehouse)~~	~~11,906,354~~	~~12,095,609~~
~~(6) Texas Integrated Eligibility Redesign System~~	~~68,426,440~~	~~53,294,645~~
~~(7) Medicaid Eligibility and Health Information~~	~~7,558,449~~	~~7,175,391~~
~~(8) Enterprise Resource Planning~~ [15]	~~9,408,000~~	~~0~~
~~(9) Technology Support for State Hospital & State Living Centers~~	~~4,930,800~~	~~1,150,800~~
~~(10) Improve Security for IT Systems~~	~~$ 2,484,250~~	~~$ 3,040,461~~
~~Total, Acquisition of Information Resource Technologies~~	~~$ 172,806,628~~	~~$ 123,715.269~~
~~b. Other Lease Payments to the Master Lease Purchase Program (MLPP)~~		
~~(1) TIERS Lease Payments to Master Lease Program~~	~~$ 2,119,499~~	~~$ 2,102,175~~
~~Total, Capital Budget~~	~~$ 174,926,127~~	~~$ 125,817,444~~
~~Method of Financing (Capital Budget):~~		
~~General Revenue Fund~~		
~~General Revenue Fund~~	~~$ 3,540,308~~	~~$ 2,386,082~~
~~GR Match for Medicaid~~	~~27,318,978~~	~~20,319,925~~
~~GR Match for Title XXI (CHIP)~~	~~1,435,178~~	~~1,119,964~~
~~GR Match for Food Stamp Administration~~	~~26,220,771~~	~~17,288,433~~
~~Subtotal, General Revenue Fund~~	~~$ 58,515,235~~	~~$ 41,114,404~~
~~Federal Funds~~	~~83,210,999~~	~~63,470,409~~

3.B. Rider Revisions and Additions Request

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~~Interagency Contracts 33,200,793 21,232,631~~

~~Total, Method of Financing $ 174,926,127 $ 125,817,444~~

~~[14] Incorporates Article IX, §17.01 of this Act, relating to reductions in data center services, resulting in a reduction of $4,874,677 All Funds in fiscal year 2012 and $3,534,509 All Funds in fiscal year 2013.~~

~~[15] Incorporates $6,700,000 in General Revenue Funds in fiscal year 2012 previously included in "Supplemental Appropriations Made in Riders" relating to rider 75 in the agency's bill pattern. Amounts shown in rider have been included in Strategies A.2.1, Consolidated Systems Support, and B.1.4, Children and Medically Needy. There is a related increase of capital budget authority of $9,408,000 in All Funds in fiscal year 2012.~~

	2014	2015
a. Acquisition of Information Resource Technologies		
(1) Data Center Consolidation	$ 44,998,327	$ 37,017,829
(2) Seat Management Services	11,808,393	11,747,399
(3) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations	5,483,769	1,474,761
(4) Enterprise Telecom Managed Services	12,563,794	12,470,156
(5) Enterprise Info & Asset Mgt (Data Warehouse)	28,503,702	28,128,317
(6) Integrated Eligibility Technologies (TIERS)	69,153,846	54,027,582
(7) Medicaid Eligibility and Health Information	6,006,129	2,782,337
(8) Improve Security Infrastructure for Regional HHS Client Delivery Facilities	1,527,000	0
(9) Implement Information Security Improvements & Application Provisioning Enhancements	5,221,691	3,160,191
(10) Upgrade HHSAS Financials – Hardware Remediation (HHS Agencies)	1,293,155	323,467
(11) Security Mobile Infrastructure & Enterprise Communications	25,350,000	0
(12) Upgrade Winters Data Center Facilities	4,000,000	0
(13) Maintain Support of State-Operated Facilities	3,691,498	0
(14) Improve OIG Staffing and Support	14,423,438	6,576,562
Total, Acquisition of Information Resource Technologies	$ 234,024,742	$ 157,708,601
b. Acquisition of Capital Equipment and Items		
(1) Replace and Maintain HHSC Vehicles	546,637	543,411
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

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Lisa Subia	Date: August 23, 2012	Request Level: Exceptional

Current Rider Number	Page Number in GAA 2012-2013	Proposed Rider Language
		Total, Capital Budget $ 237,143,910 $ 160,189,925 Method of Financing (Capital Budget): General Revenue Fund General Revenue Fund $ 30,926,520 $ 10,390,340 GR Match for Medicaid 41,610,850 28,706,524 GR Match for Title XXI (CHIP) 1,106,951 980,238 GR Match for Food Stamp Administration 30,048,823 21,126,658 Subtotal, General Revenue Fund $ 103,693,144 $ 61,203,760 Federal Funds 114,773,292 81,345,442 Interagency Contracts 18,677,474 17,640,723 Total, Method of Financing $ 237,143,910 $ 160,189,925 *Rider is revised to reflect capital projections in the 2014-2015 Exceptional Items.*
HHSC 43	II-95	**Enterprise Data Warehouse.**~~17~~ Out of funds appropriated above in Strategy A.2.1, Consolidated System Support, the Health and Human Services Commission (HHSC) may expend $10,560,729~~$5,966,954~~ 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, 2013~~2011~~ and September 1, 2014~~2012~~ reflecting actual expenditures and accomplishments to date. The reports shall also reflect an estimate of planned expenditures and accomplishments for the remainder of the 2014-15~~2012-13~~ biennium. ~~17 *Rider amended for technical corrections*~~ *Rider is updated for biennial date changes and requested 2014-2015 exceptional capital project amount. Funding is requested in Exceptional Item #19.*
HHSC 65	II-102	**Office for the Prevention of Developmental Disabilities.** Out of funds appropriated in Strategy A.1.1, Enterprise Oversight and Policy, the ~~The~~ Health and Human Services Commission shall support the Office for the Prevention of Developmental Disabilities ~~expend,~~ from funds otherwise appropriated to the commission by this Act, in an amount not to

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Lisa Subia	Date: August 23, 2012	Request Level: Exceptional

Current Rider Number	Page Number in GAA 2012-2013	Proposed Rider Language
		exceed $188,548~~$111,805~~ each fiscal year ~~for salaries, benefits, travel expenses, and other support of the Office for Prevention of Developmental Disabilities~~. However, grants and donations received through the authority provided by Article IX Sec. 8.01, Acceptance of Gifts of Money, are not subject to this limit and may be expended by the Office. *Rider is revised to require HHSC to support a sufficient staffing level of three employees for TOPDD associated with the additional general revenue funding in the requested exceptional item. Donated funding could support other initiatives and staffing as determined by the TOPDD Director. The provision was 76th Legislature) with a limit of $120,000. The current dollar limitation has not kept pace with Legislative salary increases and travel costs from the original Rider 48. Employee benefits for general revenue-supported salaries are not paid directly from state agency appropriations. Funding is requested in Exceptional Item #21.*

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Lisa Subia	Date: August 23, 2012	Request Level: Base

Special Provisions	Page Number in GAA	Proposed Rider Language
Sec. 7	II-109	**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)

	~~2012~~	~~2013~~	2014	2015
Federal Fiscal Year	~~58.22%~~	~~57.29%~~	59.80%	59.80%
State Fiscal Year	~~58.42%~~	~~57.37%~~	59.76%	59.80%

Enhanced Federal Medical Assistance Percentage (EFMAP)

	~~2012~~	~~2013~~	2014	2015
Federal Fiscal Year	~~70.75%~~	~~70.10%~~	71.86%	71.86%
State Fiscal Year	~~70.89%~~	~~70.15%~~	71.83%	71.86%

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;

(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.

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		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 and the FFIS estimated FMAP rates for FFYs 2014-2015 published May 2012.*
Sec. 10	II-110	**Limitations on Transfer Authority.** Notwithstanding the general transfer provisions of this Act, but in concert with agency-specific limitations on transfer authority in this Article, the Executive Commissioner of the Health and Human Services Commission is authorized to make transfers of funding, full-time equivalents (FTEs), and capital budget authority within and between health and human services agencies as listed in Chapter 531, Government Code~~, subject to the prior written approval of the Legislative Budget Board and the Governor~~. Transfers that exceed $1,000,000 in general revenue, capital authority in excess of $100,000 or FTE adjustments of more than 10 FTEs are subject to the prior written approval of the Legislative Budget Board and the Governor. Transfers below these thresholds require written notification to the Legislative Budget Board and Governor. No single transfer may exceed 12.5 percent of the originating strategy's appropriation for funding or FTEs for the fiscal year. To request a transfer, the Executive Commissioner of the Health and Human Services Commission 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, including the following: (1) a description of each initiative with funding and FTE information by fiscal year; and (2) an indication of whether the expenditure will be one-time or ongoing. b. the names of the originating and receiving agencies and/or strategies and the method of financing and FTEs 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 agencies and/or strategies; and

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		d. the capital budget 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 Comptroller of Public Accounts shall not allow the transfer of funds if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied. In the case of disaster or other emergency, this provision is superseded by the emergency-related transfer authority in Article IX of this Act. *Rider is amended to request flexibility with certain transfers and to reduce the number of requests submitted that require approval.*
Sec. 13	II-111	~~**Medicaid Informational Rider.**[1] 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:~~

~~Agency Name~~	~~FY 2012~~	~~FY 2013~~
~~Department of Aging and Disability Services~~	~~$5,847,091,843~~	~~$3,335,380,469~~
~~Department of Assistive and Rehabilitative Services~~	~~89,628,499~~	~~89,622,543~~
~~Department of Family and Protective Services~~	~~12,917,911~~	~~12,916,491~~
~~Department of State Health Services~~	~~132,052,179~~	~~158,719,628~~
~~Health and Human Services Commission~~	~~18,721,354,714~~	~~12,159,260,983~~
~~**Total, Medical Assistance Program**~~	~~**$24,803,045,146**~~	~~**$15,755,900,114**~~
~~**Method of Financing:**~~		
~~General Revenue for Medicaid~~	~~$10,167,665,968~~	~~$6,478,525,044~~
~~Tobacco Settlement Receipts for Medicaid~~	~~157,697,879~~	~~139,760,115~~
~~Subtotal, General Revenue Funds~~	~~10,325,363,847~~	~~6,618,285,159~~

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Special Provisions	Page Number in GAA	Proposed Rider Language
		~~General Revenue – Dedicated 59,821,479 59,321,479~~ ~~Federal Funds 14,293,550,365 8,953,842,388~~ ~~Interagency Contracts 2,183,083 2,183,083~~ ~~Medicaid Subrogation Receipts 59,349,552 59,349,552~~ ~~Appropriated Receipts – Match for Medicaid 42,381,151 42,381,151~~ ~~Foundation School Funds as Match for Medicaid 4,840,842 4,982,476~~ ~~MR Collections for Patient Support and Maintenance 15,554,827 15,554,826~~ ~~Subtotal, Other Funds 124,309,455 124,451,088~~ ~~**Total, All Funds $24,803,045,146 $15,755,900,114**~~ ~~*[1] Incorporates certain Article IX adjustments and contingency appropriations. Also incorporates SB 2, 82nd Legislature, 1st Called Session, 2011.*~~ *Information rider will need to be updated for Medicaid appropriations in the General Appropriations Act.*
Sec. 14	II-112	**Caseload and Expenditure Reporting Requirements.** a. **Quarterly Forecasts**. The Health and Human Services Commission, in cooperation with operating agencies, shall submit to the Legislative Budget Board and the Governor, at the end of each fiscal quarter, reports projecting anticipated caseload and prescription drug data and related expenditure amounts for the 36 month period beginning with the first month after the reports are due, for the following programs: (1) Medicaid (acute and long-term care); (2) Medicare; (3) Children's Health Insurance Program (CHIP) and related programs; (4) Temporary Assistance for Needy Families; ~~(5) Children with Special Health Care Needs;~~ ~~(6)~~(5) foster care, adoption assistance, and permanency care assistance; ~~(7)~~(6) Early Childhood Intervention services; and

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		~~(8)~~(7) other programs upon request of the Legislative Budget Board or the Governor. The reports shall be prepared in a format specified by the Legislative Budget Board. b. **Monthly Data.** The Health and Human Services Commission, in cooperation with operating agencies, shall submit to the Legislative Budget Board and the Governor, at the end of each month, caseload and prescription drug data and related expenditure amounts for the programs identified in subsection (a) for at least the preceding 36 months. The data shall be submitted in a format specified by the Legislative Budget Board. c. Each report submitted to the Legislative Budget Board and the Governor pursuant to this provision must be accompanied by supporting documentation detailing the sources and methodologies utilized to develop any caseload or cost projections contained the report and any other supporting material specified by the Legislative Budget Board and the Governor. d. 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. e. The Comptroller of Public Accounts shall not allow the expenditure of funds appropriated by this Act to the Health and Human Services Commission if the Legislative Budget Board and the Governor certify to the Comptroller of Public Accounts that the Health and Human Services Commission is not in compliance with this provision. In the event that the forecasting function is transferred to another health and human services agency listed in Chapter 531, Government Code, the requirement for the Health and Human Services Commission to provide quarterly forecasts under subsection (a), monthly data under subsection (b), or supporting documentation under subsection (c) shall apply to the other health and human services agency. *Rrider is revised to remove report (5), Children with Special Health Care Needs, as the Department of State Health Service (DSHS) requested reporting requirement be incorporated into DSHS rider 40.*
Sec. 15	II-112	**Sec. 15. 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 additional specific limitations included in the provisions of this Section 15. For purposes of the provisions of this Section 15, "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: 1) be based

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on the most current caseload forecast submitted by the Health and Human Services Commission (HHSC) pursuant to other provisions in this Act, 2) include the impact on all affected programs, and 3) specify General Revenue Funds, TANF Federal Funds, and All Funds.

~~a. **Rate Increases in this Act**. Included in appropriations made elsewhere in this Act are General Revenue Funds and Federal Funds for the following specific rate increases and new rates:~~

~~(1) New premium rates for managed care organizations (MCO) contracting with HHSC for the expansion of the managed care model for the provision of Medicaid services assumed in this Act, such as geographical expansion and inclusion of services to be 'carved in' including, but not limited to, prescription drugs, inpatient hospital services, dental services and transportation. HHSC shall submit a written request pursuant to section (b) below, which should also include information on the rate basis for the MCO reimbursements to providers.~~

~~(2) New rates, bundled payments, or increased or reduced rates related to cost-containment initiatives included in HHSC Riders 61, Medicaid Funding Reduction, and 80, Durable Medical Equipment Savings Initiatives, and Article II Special Provisions Section 17, Additional Cost Containment Initiatives. At least 30 calendar days prior to the payment of the proposed new rate, bundled payment, or increased rate related to cost containment initiatives, HHSC shall submit a written notification to the Legislative Budget Board, the Governor, and the State Auditor with the following information:~~

~~(i) a description of the cost-containment initiative;~~

~~(ii) a list of each rate for which an increase is proposed or for each new rate;~~

~~(iii) an estimate of the fiscal impacts of each rate increase or new rate, by agency and by fiscal year; including the amount of General Revenue Funds, TANF Federal Funds, and All Funds, by fiscal year; and~~

~~(iv) the estimated savings to be achieved from the cost containment initiative that is assumed in the appropriation levels included above.~~

~~b.~~a. **Limitation on Rate Increases Not Authorized in this Act.** Without the prior written approval of the Legislative Budget Board and the Governor, no agency listed in Chapter 531, Government Code, may pay an increased rate or establish a new rate that is not specifically authorized under ~~Subsection (a)(2) above or~~ Subsection (b)~~(c)~~ below.

To request authorization for such a rate increase or to establish a new rate, the Executive Commissioner of the Health and Human Services Commission shall submit a written request to the Legislative Budget Board and the

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Governor at least 45 calendar days prior to implementation. At the same time, the Executive Commissioner 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 rate for which an increase is proposed or for each new rate; and

(2) an estimate of the fiscal impacts of each rate increase or new rate, by agency and by fiscal year, including the amount of General Revenue Funds, TANF Federal Funds, and All Funds, by 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.

Multiple risk groups may be reported at an aggregate level, and acute care services may be reported by rate category.

~~c.~~b. HHSC shall provide notification in a quarterly report that includes a list of each rate change, including the initial rate and the proposed new rate and the estimated biennial fiscal impact of the change by agency, fiscal year, and each method of finance to the Legislative Budget Board, the Governor, and the Comptroller of Public Accounts for the following rate changes:

(1) any rate change that is estimated to have an annual impact of less than $1,000,000~~$500,000~~ in General Revenue-Related Funds or TANF Federal Funds;

(2) new rates for new procedure codes required to conform to the federal Healthcare Common Procedure Coding System (HCPCS); and

(3) revised rates occurring as a result of a biennial rate review (Biennial Calendar Fee Review).

The rate changes included in the quarterly report shall be identified under the categories listed above. The report shall include a total for the estimated biennial net impact of all of the changed rates for each agency by method of finance. The rate changes under categories (2) and (3) may be reported at the aggregate level.

~~d.~~c. 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.

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		~~e.~~d. The Office of the State Auditor may review the fiscal impact information provided 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.~~e. 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. *Rrider is revised to deletes obsolete language related to cost containment provisions and increase the threshold of fiscal impact of rate changes to $1 million.*
Sec. 16	II-114	~~**Provider Rates.** Appropriations made elsewhere in this Act reflect reductions to provider rates for the 2012-13 biennium as identified below. All identified reductions for fiscal years 2012 and 2013 are intended to be calculated based on the rates in effect on August 31, 2010 and are in addition to cumulative rate reductions made during fiscal year 2011, also identified below. Reductions are intended to be applied to all delivery models, including managed care, and are a net overall reduction to the specified provider class. No additional reductions shall be made unless requested and approved according to the process required by Article II Special Provisions, Section 15 (b) for rate increases.~~ ~~**012-13**~~ ~~**FY 2011 Biennium** ~~**a. Department of Aging and Disability Services**~~ ~~(1) Community Care Entitlement 0% 0%~~ ~~(2) Home and Community-based Services (HCS) -2% -1%~~ ~~(3) Other Community Care Waivers 0% 0%~~ ~~(4) PACE 0% 0%~~ ~~(5) Nursing Facilities -3% 0%~~ ~~(6) Medicare Copay Skilled Nursing Facility 0% 0%~~ ~~(7) Nursing Facility-related Hospice -1% -2%~~ ~~(8) Intermediate Care Facilities - MR, excluding state supported living centers -3% -2%~~ ~~**b. Health and Human Services Commission**~~ ~~(1) CHIP Physicians -2% 0%~~ ~~(2) CHIP Dental Providers -2% 0%~~ ~~(3) Other CHIP Providers -2% -8%~~ ~~(4) Medicaid Physician Services -2% 0%~~ ~~(5) Medicaid Hospital Services, excluding those reimbursed under TEFRA -2% -8%~~ ~~(6) Medicaid Dental and Orthodontic Services -2% 0%~~

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~~(7) Medicaid Durable Medical Equipment -2% -10.5%~~
~~(8) Medicaid Laboratory Services, excluding reimbursements to the Department of State Health Services -2% -10.5%~~
~~(9) Medicaid Pediatric Private Duty Nursing and Home Health -2% 0%~~
~~(10)Other Medicaid Providers -2% -5%~~

Rider is deleted for the 2014-2015 as it is not needed. The provider rate reductions apply to the funding in the 2012-2013 biennium.

Sec. 17 — II-115

~~**Additional Cost Containment Initiatives.** Included in appropriations above to the health and human services agencies in Article II of this Act are reductions for anticipated savings for the following cost containment initiatives:~~

	~~General Revenue Funds~~	~~All Funds~~
~~**a. Department of Aging and Disability Services**~~		
~~(1) Nursing Facility Cost Change~~	~~$58,000,000~~	~~$138,095,238~~
~~(2) Wrap Around Services~~	~~$15,000,000~~	~~$35,732,856~~
~~(3) Equalizing Rates across Waivers~~	~~$12,500,000~~	~~$29,761,905~~
~~(4) Adjust Amount, Scope, and Duration for All Community Services~~	~~$31,000,000~~	~~$73,809,524~~
~~(5) Administrative Reductions Related to Requisition~~	~~$1,800,000~~	~~$4,285,714~~
~~**b. Department of State Health Services**~~		
~~(1) Residential Units~~	~~$6,000,000~~	~~$6,000,000~~
~~(2) North STAR Billing Change~~	~~$6,000,000~~	~~$6,000,000~~
~~(3) Medicines at Discharge for One Week~~	~~$1,900,000~~	~~$1,900,000~~
~~(4) Management Changes~~	~~$1,000,000~~	~~$1,000,000~~
~~**c. Health and Human Services Commission**~~		
~~(1) Fee Reductions for Vendor Drug Dispensing Fee and Primary Care Case Management Fee~~	~~$34,736,640~~	~~$82,991,338~~
~~(2) Optional Benefit Reduction through Changes in Amount, Scope, and Duration of Services~~	~~$45,000,000~~	~~$106,985,014~~
~~(3) Medicare Equalization*~~	~~$295,750,000~~	~~$704,166,667~~
~~(4) Reduce Managed Care Administrative Portion of Premiums~~	~~$27,000,000~~	~~$64,186,378~~
~~(5) More Efficient Managed Care Premium~~		

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		~~Methodology~~ ~~$169,300,000~~ ~~$402,472,364~~ ~~**Total, All Agencies**~~ ~~**$704,986,640**~~ ~~**$1,657,386,998**~~ ~~*includes provisional allowance for HHSC to phase in the policy in an effort to maintain access to dialysis services.~~ *Rider is deleted for the 2014-2015 as it is not needed. The identified cost containment reductions apply to the funding in the 2012-2013 biennium and are reflected in the base funding for FY 2014-2015.*
Sec. 23	II-121	**Mental Health (MH) and Mental Retardation (MR) Medicare Receipts.** a. For the purposes of this section and appropriation authority, MH and MR Medicare Receipts are classified as deposits in Revenue Object Code 3634 that are collected by the Department of State Health Services and the Department of Aging and Disability Services as payment for: (1) hospital, physician and other services rendered to Medicare-eligible individuals in state mental health and mental retardation facilities operated by the departments; (2) cost settlements for services rendered in state mental health and mental retardation facilities operated by the department as authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); and (3) prescription drugs reimbursed through the Medicare, Part D, prescription drug program. b. **Accounting and Reporting.** Amounts defined as MH and MR Medicare Receipts shall be deposited into the General Revenue Fund according to the identified Comptroller Revenue Object Code above. The departments shall report monthly to the Legislative Budget Board, Comptroller of Public Accounts and Governor on MH and MR Medicare Receipts collections by Comptroller Revenue Object Code, expenditures and anticipated revenues and balances. c. **Mental Health Medicare Receipts.** Included in the General Revenue Funds appropriated above to the Department of State Health Services in Strategy C.1.3, Mental Health State Hospitals, is $25,760,748 per year for the 2012-13 biennium, contingent upon generation of funds from MH Medicare Receipts collections. These funds shall be expended as collected and only within Strategy C.1.3, Mental Health State Hospitals. Appropriations made elsewhere in this Act for employee benefits include approximately $2,970,612 per year from MH Medicare Receipts. MH Medicare Receipts collections above $28,731,360 per year (excluding any amounts needed to comply with Article IX, Sec. 6.08, Benefits Paid Proportional by Fund) are hereby appropriated as Method of Financing Code 8034 - MH Medicare Receipts (General Revenue Funds) to the department for expenditures in Strategy C.1.3, Mental Health State Hospitals, pursuant to the limitations of this provision.

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		d. **Mental Retardation Medicare Receipts.** Included in the GR Match for Medicaid Funds appropriated above to the Department of Aging and Disability Services in Strategy A.8.1, State Supported Living Centers, is $15,660,934 ~~$18,316,760~~ per year for the 2014-2015 ~~2012-13~~ biennium, contingent upon generation of funds from MR Medicare Receipts collections. These funds shall be expended as collected and only within Strategy A.8.1, State Supported Living Centers. Appropriations made elsewhere in this Act for employee benefits include approximately $553,831 ~~$625,619~~ per year from MR Medicare Receipts. MR Medicare Receipts collections above $16,214,765 ~~$18,942,379~~ per year (excluding any amounts needed to comply with Article IX, Sec. 6.08, Benefits Paid Proportional by Fund) are hereby appropriated as Method of Financing Code 8097 - MR Medicare Receipts (General Revenue Funds) to the department for expenditures in Strategy A.8.1, State Supported Living Centers, pursuant to the limitations of this provision. *Rider is updated for biennial date changes and revised amounts for DADS.*
Sec. 32	II-123	**Sec. 32. Language Interpreter Services.** In order to compensate employees of health and human services agencies ~~state mental health and mental retardation facilities~~ for assuming the duty of providing interpreter services to consumers whose primary language is not English~~, facilities of the Department of State Health Services and the Department of Aging and Disability Services,~~ upon written authorization of the appropriate agency commissioner or his/her designee, may, from funds appropriated above, increase the salary of classified employees by an amount up to 6.8~~equal to a one step increase, or 3.25~~ percent, so long as the resulting salary rate does not exceed the rate designated as the maximum rate for the applicable salary group. This increase shall be granted only for the regular provision of interpreter services above and beyond the regular duties of the position, and shall be removed when these services are, for whatever reason, no longer provided by the employee or when they are no longer needed by the facility. Salary increases provided for this purpose are not merit increases and shall not affect an employee's eligibility to receive a merit increase. This authorization also includes employees who provide interpreter services in American Sign Language. *Rider is revised to allow all HHS agencies to increase salaries of employees that provide interpreter services up to 6.8 percent. As the Texas population is changing, we expect an increased demand for interpreter and translation services. Using state employees to provide these services saves appropriated monies and reduces current contract costs. Expanding this rider to include all HHS agencies and increasing the amount to 6.8 percent of base salary should provide the flexibility needed to meet this service demand. No additional funds are requested for this initiative.*
Sec. 36	II-124	**Sec. 36. 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

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		Living Centers. b. Notwithstanding the limitation described above, the department shall allow a local mental health or mental retardation 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~~state-approved~~ 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 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 revised as DSHS does not approve local purchasing arrangements; however, through review, DSHS can verify the cost effectiveness of local purchasing arrangements. DSHS also determines through contract oversight whether local authorities are achieving cost efficiencies to allow authorities to expend up to 15% of funds on direct services.*
Sec. 39	II-125	~~**Contracted Medical Services.** Out of funds appropriated above, the Department of State Health Services (DSHS) and the Department of Aging and Disability Services (DADS) shall not pay more than the approved reimbursement rate set by the Health and Human Services Commission for hospital services provided to an indigent DSHS or DADS consumer in a private or public hospital.~~ *Rider is deleted as DSHS has been unsuccessful in securing the approved reimbursement rates and has been consistently unable to acquire contracted medical services. DSHS uses the most cost effective means available in order to keep costs down.*
Sec. 40	II-125	**Efficiencies at Local ~~Mental Health and Mental Retardation~~ Authorities.** It is the intent of the Legislature that the local ~~mental health and mental retardation~~ authorities that receive allocations from the funds appropriated above to the Department of Aging and Disability Services and the Department of State Health Services shall maximize the dollars available to provide services by minimizing overhead and administrative costs and achieving purchasing efficiencies. Among the strategies that should be considered in achieving this objective are consolidations among local authorities and partnering among local authorities on administrative, purchasing, or service delivery functions where such partnering may eliminate redundancies or promote economies of scale. The Legislature also intends that each state agency which enters into a contract with or makes a grant to local authorities does so in a manner that promotes the maximization of third party billing opportunities, including to Medicare and Medicaid.

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		It is the Legislature's intent that local authorities not expend funds appropriated to the Department of Aging and Disability Services in Strategy A.4.2, Mental Retardation Community Services~~, or Strategy A.4.5, Mental Retardation In-Home Services,~~ to supplement the rate-based payments they receive to fund their costs as providers of waiver or ICF-~~MR~~ IID services. *Rider is revised to be more respectful to referenced authorities and services.*
Sec. 42	II-125	**Sec. 42. 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~~2012~~ are appropriated for the same purposes to the respective agencies for fiscal year 2015~~2013~~ 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~~2012~~. 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~~2012~~: (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~~2013~~: (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~~2012~~ if the amount of the estimated unexpended balance(s) varies by more than five percent from the amount estimated in the original request.

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		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 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. 43	II-126	**Appropriation of Receipts: Civil Monetary Damages and Penalties.** Included in the amounts appropriated above for the 2014-2015 ~~2012-13~~ biennium are the following: a. $2,660,000 in General Revenue Match for Medicaid for the Department of Aging and Disability Services; b. $1,414,870 in General Revenue Match for Medicaid for the Health and Human Services Commission; and c. $780,000~~$520,000~~ 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. *Rider is updated for biennial date change and revised amounts.*
Sec. 44	II-126	**Sec. 44. Financial Monitoring of Local Authorities ~~Community MHMR Centers~~.** The Department of Aging and Disability Services, the Department of State Health Services, and the Health and Human Services Commission shall enter into a written agreement that defines each agency's responsibilities for monitoring the expenditure by Local Authorities ~~community mental health and mental retardation centers~~ of funds appropriated by this Act. The written agreement shall include provisions for monitoring that require community mental health and mental retardation centers to account for state funds separately from other sources of funds.

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		Rider is revised to be more respectful to referenced centers and authorities.
Sec. 45	II-126	**Sec. 45. Appropriation of Unexpended Balances: Funds Recouped from Local Authorities.** Notwithstanding other provisions of this Act, any state funds appropriated for fiscal year 20142~~2012~~ recouped by the Department of Aging and Disability Services or the Department of State Health Services from a local mental health or mental retardation 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 or mental retardation authorities in fiscal year 20152~~2013~~. Each agency shall provide a report to the Legislative Budget Board and the Governor by June 1, 20142~~2012~~ that 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 updated for biennial date change.*
Sec. 47	II-127	**Sec. 47. Reporting Requirements for Confirmed Acts of Abuse Committed by Licensed Professionals Employed by the State.** The Department of Aging and Disability Services, the Department of State Health Services, and the Department of Family and Protective Services shall each submit a report to the Legislative Budget Board and the Governor by May 15, 20142~~2012~~, that identifies gaps in their processes and policies, corrective actions, and efforts taken to ensure interagency coordination for reporting all licensed professionals who have committed confirmed acts of abuse, neglect, or exploitation while employed as a state employee. The report should include the following information: a. documentation of any peer review processes for reporting licensed professionals; b. identification of corrective steps taken to comply with statutory requirements for reporting any licensed professionals who have committed confirmed acts of abuse, neglect, or exploitation to their respective professional licensing boards; and c. identification of the number of persons reported to each licensing board, by fiscal year, beginning in fiscal year 20142~~2012~~. *Rider is updated for biennial date change.*
Sec. 48	II-127	~~**Evaluate and Report on Case Management Services.** The Health and Human Services Commission shall coordinate an evaluation of targeted case management services delivered in the Medicaid program and other programs that provide case management services across all health and human service agencies. The commission shall identify the number of programs with case management and evaluate the method of delivery through state employees or contractors and the impact of case management services to clients. The evaluation may recommend improvements or changes in services and programs to streamline case management services. The Health and Human Services Commission shall submit findings to the Governor and the Legislative Budget Board by December 1, 2012.~~

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		Rider is deleted as it relates to an evaluation that will be completed and submitted prior to the 2014-2015 biennium.
Sec. 50	II-128	~~**Sec. 50. Health and Safety Cost Savings Initiatives at the Department of State Health Services.** Funding appropriated elsewhere in this Act for the 2012-13 biennium reflect a reduction of $8,724,682 in General Match for Medicaid ($20,773,052 in All Funds) to the Health and Human Services Commission in Goal B, Medicaid, and an increase of $8,724,682 in General Revenue Funds to the Department of State Health Services (DSHS) in the following strategies:~~ ~~a. $1,795,713 in Strategy A.1.2, Registries, Info, and Vital Records, for preventable adverse events data reporting;~~ ~~b. $264,893 in Strategy A.1.2, Registries, Info, and Vital Records, for targeted interventions for Health Care Associated Infections (HAIs);~~ ~~c. $564,076 in Strategy A1.2, Registries, Info, and Vital Records, for quality assurance teams for reducing HAIs;~~ ~~d. $4,100,000 in B.1.2, Women and Children's Health, for healthy baby initiatives; and~~ ~~e. $2,000,000 in Strategy A.3.1, Chronic Disease Prevention, for preventative hospitalization projects.~~ *Rider is deleted as this rider was implemented and is included in the 2014-2015 base request.*
Sec. 54	II-129	~~**Sec. 54. Attendant Wages and Benefits.** Out of funds appropriated elsewhere in this Act to the Health and Human Services Commission (HHSC), HHSC shall track how much of the funding appropriated for community long term services and support programs is used for attendant wages and employment benefits.~~ *Rider is deleted as HHSC Rate Analysis already tracks attendant wages and benefits through cost reports.*
Sec. 55	II-129	~~**Sec. 55. Funding for HIV Medications.** Upon a determination that funding in Strategy A.2.2, HIV/STD Prevention, at the Department of State Health Services (DSHS) is insufficient to cover the costs associated with the purchase of HIV medications, the executive commissioner may request to transfer up to $19,200,000 from General Revenue appropriations made in Goal B, Medicaid, at the Health and Human Services Commission to Strategy A.2.2, HIV/STD Prevention, the amounts necessary to maintain funding for HIV medications in the 2012-13 biennium. To request a transfer, the executive commissioner 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 be considered to be disapproved unless the Legislative Budget Board and the Governor issue written approvals within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to transfer 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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		~~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.~~ *Rider is deleted as this obsolete language relates to a 2012-2013 issue.*
Sec. 56	II-130	**Sec. 56. Waiver Program Cost Limits.** a. **Individual Cost Limits for Waiver Programs.** It is the intent of the Legislature that the Department of Aging and Disability Services and Health and Human Services Commission comply with the cost-effectiveness requirements of the Centers for Medicare and Medicaid Services and set the individual cost limit for each waiver program as follows: (1) Community-Based Alternatives Program: 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility; (2) Medically Dependent Children Program: 50 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility; ~~(3) Consolidated Waiver Program: 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility, or 200 percent of the estimated annualized per capita cost of providing services in an Intermediate Care Facility/Mental Retardation (ICF/MR), as applicable;~~ ~~(4)~~(3) Community Living Assistance and Support Services Program: 200 percent of the FY 2006 estimated annualized per capita cost of providing services in an ICF/IID to an individual qualifying for an ICF/IID Level of Care VIII;~~200 percent of the estimated annualized per capita cost of providing services in an ICF/MR to an individual qualifying for an ICF/MR Level of Care VIII;~~ ~~(5)~~(4) Deaf-Blind with Multiple Disabilities Program: 200 percent of the FY 2006 estimated annualized per capita cost of providing services in an ICF/~~MR~~IID to an individual qualifying for an ICF/~~MR~~IID Level of Care VIII;~~ 200 percent of the estimated annualized per capita cost of providing services in an ICF/MR to an individual qualifying for an ICF/MR Level of Care VIII;~~ ~~(6)~~(5) Home and Community-based Services Program: 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in an ICF/~~MR~~IID or 200 percent of the estimated annualized per capita cost for ICF/~~MR~~IID services, whichever is greater; and

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		~~(7)~~(6) STAR+PLUS Community-Based Alternatives: 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility. b. **Use of General Revenue Funds for Services.** (1) Out of funds appropriated for the waiver programs identified above, and subject to the terms of subsection (c) below, the department and commission are authorized to use general revenue funds to pay for services if: (i) the cost of such services exceeds the individual cost limit specified in a medical assistance waiver program listed above; (ii) federal financial participation is not available to pay for such services; and (iii) the department or commission determines that: (a) the person's health and safety cannot be protected by the services provided within the individual cost limit established for the program; and (b) there is no other available living arrangement in which the person's health and safety can be protected at that time, as evidenced by: (i) an assessment conducted by clinical staff of the department or commission; and (ii) supporting documentation, including the person's medical and service records. (2) Out of funds appropriated under this Article for the waiver programs identified above, and subject to the terms of subsection (c) below, the department and commission are authorized to use general revenue funds to continue to provide services to a person who was receiving medical assistance waiver program services on September 1, 2005, at a cost that exceeded the individual cost limit specified in the medical assistance waiver program, if: (i) federal financial participation is not available to pay for such services; and (ii) continuation of those services is necessary for the person to live in the most integrated setting appropriate to the needs of the person. (3) Authority provided in (b) above is contingent upon the agency submitting a report in writing to the Legislative Budget Board and Governor on October 1 of each year of the biennium. The report shall include the number

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		of clients by program which exceeds cost limits and the unmatched General Revenue associated with each by fiscal year. c. **Use of Utilization Management and Utilization Review Practices.** The department and commission shall employ utilization management and utilization review practices as necessary to ensure that the appropriate scope and level of services are provided to individuals receiving services in Medicaid 1915(c) waivers and STAR+PLUS administered by the agency and to ensure compliance with the cost-effectiveness requirements of the Centers for Medicare and Medicaid Services. *Rider is revised to ensure an accurate understanding of how the current service limits for these two waivers is calculated. The CWP waiver was terminated effective December 31, 2012.*
Sec. 57	II-131	~~**March 2013 and April 2013 Medicaid Payments.** To the extent allowable by law, the Health and Human Services Commission is authorized to defer the March 2013 payments for Medicaid managed care until April 2013 and the April 2013 payments for Medicaid managed care until May 2013. To the extent allowable by law, the Department of Aging and Disability Services is authorized to defer March 2013 payments for Medicaid until April 2013 and April 2013 Medicaid payments until May 2013.~~ *Rider is deleted as this obsolete language relates to a 2012-2013 issue.*
HHSC 703	II	**Appropriation of Costs.** Out of funds appropriated elsewhere in this Act as Appropriated Receipts relating to recovery by the Office of the Attorney General of overpayments and penalties relating to Medicaid fraud, abuse, and waste, and following any deduction or offset for attorney's fees, court costs and other authorized expenses, the appropriate Health and Human Services agency from which the Medicaid expenditures were originally incurred is hereby appropriated an amount sufficient to reimburse 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. At least semiannually, beginning within 60 days after the close of each fiscal year or more often upon request of the Legislative Budget Board, the Health and Human Services Commission must submit to the Legislative Budget Board, the Senate Finance Committee, the House Appropriations Committee, and the Governor a report that corresponds to the report required of the Office of the Attorney pursuant to Article I, section 8 (Appropriation of Receipts, Court Costs) and lists the amount of costs reimbursed pursuant to this section and the strategy or strategies to which the receipts were allocated, in addition to any other information that may be requested by the Legislative Budget Board. Notwithstanding any other provision of this Act, the remainder of such recoveries shall be credited to the appropriate Medicaid strategies to the HHS agency listed in Article II of this Act. *This new rider would provide authority to credit the Medicaid program with the proceeds of any fraud recoveries by the*

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		OAG after deduction of OAG attorney's fees and expenses.
HHSC 704	II	**Investing for HHS Business Process Improvements**. a. Notwithstanding any other provisions in this Act, if the Executive Commissioner determines that the investment of appropriated funds into technology and communications promotes more efficient use of space, state staff, or resources for business process improvements, the Executive Commissioner is authorized to do the following actions to the extent necessary to achieve efficiencies for office modernization for the health and human services agencies listed in Chapter 531, Government Code: (1) to expend funds appropriated to HHS agencies elsewhere in this Act; (2) to adjust the agnecy's capital authority limitation; and (3) to transfer funds within and between HHS agencies as allowed by this Act. b. 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. 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 provison would allow all 5 HHS agencies to implement office modernization with existing funding.*

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HHSC 705	II	**Contingency for B . Performance-based incentive payments for health and human services agencies' employees.** Contingent on enactment of B or similar legislation, by the Eighty-third Legislature, Regular Session, 2013, relating to performance-based incentive payments for health and human services agencies' employees, the Health and Human Services agencies may, from funds appropriated elsewhere in this Act, provide employees with performance incentive compensation payments. *New rider request to allow agencies to provide employees with performance incentive compensation payments to assist with retaining staff. This rider would be contingent on legislation providing statutory authority.*