ARTICLE II HHSC RIDERS

Medicaid

Rider 5. Cost Comparison Report. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, HHSC shall develop a report for the Legislature analyzing state and federally funded residential and nonresidential services in HCS, TxHmL, and ICFs/IID.
a. The report shall include the following:
1. the monthly average cost to the state per person for individuals residing in state-
operated and non-state operated ICF-IID/RC, HCS, and TxHmL program by Level of Need (LON), and facility size (private ICF-IID only)
2. a comparison of severity across settings; and,
3. the total number of persons, by LON, who transitioned from state-operated ICF-IID/RC to the HCS residential waiver program for the previous biennium, and their average monthly cost of service in the HCS waiver program
b. With respect to the cost to the state per person residing in a state operated ICF-IID/RC facility, the department shall include all costs, such as Statewide Indirect Cost Allocation Plan (SWICAP), Departmental Indirect Cost Allocation Plan (DICAP), maintenance and construction costs, employee benefit costs and other federally allowable administrative, medical and overhead costs. With respect to the cost to the state per person in state-operated ICF-IID/RC facilities, non-state operated ICF-IID/RC facilities, and the HCS and TxHmL waivers, HHSC shall include all Medicaid costs including acute care costs that are not included in the waiver rate for those programs and all costs to administer and license those programs. For state-operated ICF-IID/RC facilities, the average monthly administrative and overhead costs shall be reported separately from the average monthly client care costs. HHSC shall identify the types of costs included in each category.
c. Cost for waiver recipients will cover the time a person enrolled in the waiver through the time they are terminated from those services. The ICF-IID services costs will cover the time a person is admitted to the time of discharge unless the person is admitted to an ICF-IID or waiver within 60 days of discharge. In that case the Medicaid costs incurred during discharge will be counted toward the ICF-IID costs.
The report shall be submitted to the Legislature, Governor, LBB, and the public no later than August 31, 2018. (Former DADS Rider 21)

Rider 19. Network Access Improvement Program Report. HHSC shall submit a report each time a new round of Network Access Improvement Program (NAIP) proposals are approved. The report shall include a list of participating public health related institutions (HRI), public hospitals, and MCO partnerships, the anticipated amount paid to each MCO by HHSC and the anticipated amount paid to each HRI and public hospital by an MCO, and a summary of each partnership (including program methodology, targeted goals and performance metrics, and the payment structure). Each report shall be submitted to the Governor and the LBB 45 days prior to contract effective date.

Rider 23. 1115 Medicaid Transformation Waiver Distribution Public Reporting. Out of the funds appropriated above in Strategy L.1.1, HHS System Supports, HHSC shall report the recipients of all funds distributed by the commission for Uncompensated Care (UC) and Delivery System Reform Incentive Payments (DSRIP) under the 1115 Medicaid Transformation Waiver. HHSC shall submit the report to the Legislature, Governor, LBB, and the public within 45 days of distributing any funds or otherwise making payments under the 1115 Medicaid Transformation Waiver. The report shall include (1) the recipients of funds for UC and DSRIP, (2) the amount distributed to each recipient, (3) the amount of Intergovernmental Transfer (IGT) funds provided by each transferring entity within the region, and (4) the date such payments were made.

Rider 24. Report on the Vendor Drug Program. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, HHSC shall evaluate new delivery models for cost-effectiveness, increased competition, and improved health outcomes. HHSC shall report findings to the Governor, the LBB, and the appropriate standing committees of the Legislature by December 1, 2018 and include in the report a summary of previously submitted related reports and efforts undertaken to make the current models more effective.

Rider 27. Evaluation of Medicaid Data. Out of funds appropriated above, HHSC shall annually evaluate data submitted by MCOs to determine whether the data continues to be useful or if additional data, such as measurements of recipient services, is needed to oversee contracts or evaluate the effectiveness of Medicaid.

Rider 30. Monitor the Integration of Behavioral Health Services. Out of funds appropriated above, HHSC shall monitor the implementation of Government Code, Section 533.00255(b), which integrates behavioral health services into the Medicaid managed care program. **HHSC shall prioritize monitoring** MCOs that provide behavioral health services through a contract with a third party.

Rider 33. Interest List Reduction. Out of administrative funds appropriated above, and for HCS, CLASS, DBMD, MDCP, TxHmL& STAR+PLUS, HHSC is directed to consider factors such as length of time on the interest list, size of interest list, demographics, average cost, and crisis stabilization in providing services to interest list clients on a program- specific basis. (Former DADS Rider 27)

Rider 34. Medicaid Funding Reduction and Cost Containment.
a. HHSC shall develop and implement cost containment initiatives to achieve savings throughout the health and human services system. These initiatives shall include the following, if HHSC determines them to be cost-effective:

(1) Continue strengthening and expanding prior authorization and utilization reviews;
(2) Incentivize appropriate neonatal intensive care unit utilization and coding;
(3) Pursuant to Human Resources Code §§32.064 and 32.0641, maximize co-payments in Medicaid programs;
(4) Increase fraud, waste, and abuse prevention, detection, and collections;
(5) Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services;
(6) Increase efficiencies in the vendor drug program;
(7) Increase third party recoupments;
(8) Implement a pilot program on motor vehicle subrogation;
(9) Achieve efficiencies in the printing and distribution of Medicaid identification cards;
(10) Implement facility cost savings by reducing leased space or decommissioning buildings;
(11) Recoup administrative costs for programs HHSC administers for other entities, such as the School Health and Related Services Program (SHARS);
(12) Seek flexibility from the federal government to improve the efficiency of the Medicaid program;
(13) Improve prior authorization and utilization review for non-emergent air ambulance services;
(14) Evaluate reimbursement for dual eligibles;
(15) Review utilization and evaluate appropriateness of rates for durable medical equipment;
(16) Enforce the limitations on recipient disenrollment from managed care plans pursuant to Government Code, § 533.0076;
(17) Identify and execute savings by:
(i) Conducting an independent audit of Medicaid managed care premiums using a separate external actuarial firm every two years. The audit shall review HHSC's contracted actuarial services to ensure premiums are actuarially sound and are providing the greatest value for the state. Based on the audit findings, adjust Medicaid managed care premiums. This audit shall begin with the Medicaid managed care premiums for fiscal year 2018;
(ii) Ensuring collaboration between the Medicaid and CHIP data analytics unit and the HHSC actuarial staff to investigate and analyze any anomalies in the expenditure data used to set rates and to ensure the expenditure data being used to set rates is sound. Additionally, any anomalies identified related to service utilization, providers, payment methodologies, and compliance with the requirements in Medicaid and CHIP shall be reported to the Office of the Inspector General for further review;
(iii) Evaluating the methodology used to develop trend factors and other growth assumptions, including ensuring the methodology properly accounts for growth that could be considered one-time rather than ongoing;
(iv) Using a competitive procurement process with price as one component of the procurement evaluation;
(v) Ensuring all programs are meeting cost effectiveness requirements in the Texas Government Code, including the requirements established in Texas Government Code 533.0025; and
(vi) Conducting a cost-benefit analysis of contracted services for the provision of agency-related human resource functions. The analysis shall identify any additional operational efficiencies that could result in savings;
(18) Implement additional initiatives and programmatic efficiencies identified by HHSC.
b. HHSC shall provide a plan to the LBB to implement cost containment initiatives by December 1, 2017. For initiatives determined not to be cost effective, the agency shall submit the analysis underlying that determination with the plan. The plan shall be considered approved unless the LBB issues a written disapproval within 15 business days.
HHSC shall achieve savings of at least $350,000,000 in General Revenue Funds and $480,000,000 in Federal Funds for the 2018-19 biennium through the initiatives identified above.

Behavioral Health

Rider 40. Contingency for Behavioral Health Funds. Notwithstanding appropriation authority granted above, the Comptroller of Public Accounts shall not allow the expenditure of GR Related Funds at HHSC in Strategies I.2.1, Long-Term Care Intake &Access, F.1.3, Non-Medicaid IDD Community Services, D.1.7, Children with Special Needs, D.2.1, Community Mental Health Svcs - Adults, D.2.2, Community Mental Hlth Svcs -Children, D.2.3, Community Mental Health Crisis Svcs, D.2.4, Substance Abuse Prev/Inter/Treat, G.3.1, Other Facilities, G.2.1, Mental Health State Hospitals, G.2.2, Mental Health Community Hospitals, G.4.2, Facility Capital Repairs and Renov, M.1.1, Texas Civil Commitment Office, L.1.1, HHS System Supports, C.1.1, CHIP, F.3.2, Child Advocacy Programs, and F.3.3 Additional Advocacy Programs in fiscal year 2018 or fiscal year 2019, as identified in Art. IX, Sec 10.04, Statewide Behavioral Health Strategic Plan and Coordinated Expenditures, if the LBB provides notification to the Comptroller of Public Accounts that the agency's planned expenditure of those funds in FY 2018 or FY 2019 does not satisfy the requirements of Art. IX, Sec. 10.04, Statewide Behavioral Health Strategic Plan and Coordinated Expenditures. (Former DADS Rider 38, Former DSHS Rider 84, Former HHSC Rider 72.)

Rider 44. Mental Health Outcomes and Accountability. Out of funds appropriated above in Goal D, Additional Health-related Services, Strategies D.2.1, Community Mental Health Svcs - Adults, D.2.2, Community Mental Hlth Svcs - Children, and D.2.3, Community Mental Health Crisis Svcs, HHSC shall place ten percent (10%) of the General Revenue quarterly allocation from each Local Mental Health Authority (LMHA) at risk. Funds placed at risk shall be subject to recoupment for failure to achieve outcome targets set by HHSC. Funds that have been recouped for failure to achieve outcome targets will be used for technical assistance and redistributed as an incentive payment according to a methodology developed by the HHSC. Performance shall be assessed and payments made on a six-month interval. (Former DSHS Rider 58)

Rider 45. Mental Health Appropriations and the 1115 Medicaid Transformation Waiver. Out of funds appropriated above in Goal D, Additional Health-related Services, Strategies D.2.1, Community Mental Health Svcs - Adults, D.2.2, Community Mental Hlth Svcs - Children, and D.2.3, Community Mental Health Crisis Svcs, the Health and Human Services Commission (HHSC) by contract shall require that General Revenue funds be used to the extent possible to draw down additional federal funds through the 1115 transformation waiver or other federal matching opportunities. Nothing in this section shall relieve a Local Mental Health Authority from an obligation to provide mental health services under the terms of a performance contract with HHSC or to reduce the amount of such obligation specified in the contract. The HHSC shall report to the LBB and the Governor by December 1 of each fiscal year on efforts to leverage these funds. (Former DSHS Rider 59)

Rider 47. Mental Health Peer Support Re-entry Pilot. Out of funds appropriated above, HHSC through a Memorandum of Understanding shall allocate up to $1,000,000 in GR for the 2018-19 biennium from Strategy D.2.1, Community Mental Health Svcs-Adults, to implement a mental health peer support re-entry program. HHSC, in partnership with Local Mental Health Authorities and county sheriffs, shall establish a pilot program that uses certified peer support specialists to ensure inmates with a mental illness successfully transition from the county jail into clinically appropriate community-based care. HHSC shall submit a report to the Governor's Office and the LBB on the program that includes the total population to be served and client outcome measures by December 1, 2018. (Former DSHS Rider 73)

Rider 48. Quarterly Reporting of Waiting Lists for Mental Health Services. HHSC shall submit to the LBB and the Governor, no later than 60 days from the end of each fiscal quarter, the current waiting list and related expenditure data for the following:
a. Community mental health services for adults;
b. Community mental health services for children;
c. Forensic state hospital beds; and
d. Maximum security forensic state hospital beds.
The data shall be submitted in a format specified by the LBB and shall, at a minimum, include the number of clients waiting for all services, the number of underserved clients waiting for additional services, the number of individuals removed from the waiting list, and funds expended to remove individuals on the waiting list in the current fiscal quarter, and the average number of days spent on the waiting list. The information above shall be provided for each Local Mental Health Authority (LMHA), facility, or other contracted entity. HHSC shall distinguish between waiting lists at LMHAs, state facilities, or other contracted entities that are due to operational or other short-term factors and long-term waiting lists due to insufficient capacity.

Other Client Services

Rider 69. State Funding for Assistive Technologies and Devices. Included in the amounts appropriated above in Strategy F.2.1, Independent Living Services, is $1,000,000 in GR in FY 2018 and $1,000,000 in GR in FY 2019 for the purpose of providing assistive technologies, devices, and related training to Texans with the most significant disabilities. It is the intent of the legislature that these funds be expended to the greatest degree possible on disabled Texans who, without these technologies and devices, would be placed in nursing homes or otherwise removed from their communities. (Former DARS Rider 21)

Rider 70. Autism Program Provisions. a. Out of funds appropriated above for the 2018-19 biennium to HHSC in Strategy D.1.6, Autism Program, expenditures for Applied Behavioral Analysis (ABA) treatment services shall be only for children enrolled in the focused program.
b. Notwithstanding any other transfer provision in this Act, none of the funds appropriated above to HHSC shall be transferred to Strategy D.1.6, Autism Program.
c. Out of funds appropriated above in Strategy D.1.6, Autism Program, HHSC shall continue to provide support to the Texas Council on Autism and Pervasive Developmental Disorders and the Texas Autism Research and Resource Center during FYs 2018-19. (Former DARS Rider 28)

Rider 72. Medically Fragile Children. Out of funds appropriated above in Strategy D.1.7, Children with Special Needs, HHSC shall provide appropriate GR funding for programs specifically designed for medically fragile children, the most critical of the children with special health care needs. (Former DSHS Rider 33)

Revenue

Rider 93. Appropriation: Quality Assurance Fees. Informational Item. Appropriations from GR Dedicated - Quality Assurance Account No. 5080 in this Act total $80,500,000 in each FY in Strategy A.2.7, Intermediate Care Facilities-IID, for IDD services. Estimated amounts of $42,895 in fiscal year 2018 and $42,895 in FY 2019 are appropriated elsewhere in this Act for employee benefits of employees of community-based ICFs/IID also known as bond homes, that are operated by HHSC. Pursuant to Article IX, Sec. 6.08, Benefits Paid Proportional by Method of Finance, benefits for bond home employees reflect the proportion by fund type as used for salaries. (Former DADS Rider 22)

Rider 99. Fees for Community Services at SSLCs. Included in amounts appropriated above is an estimated $242,500 in GR in fiscal year 2018 and $242,500 in GR in fiscal year 2019 in Strategy G.1.1, SSLCs, for the purpose of providing medical, behavioral, and other SSLC services to community members who meet certain eligibility requirements, and contingent on HHSC generating sufficient collections from the provision of these services. In the event actual collections are less than these amounts identified above, the LBB may direct the Comptroller to reduce the appropriation authority provided above to be within the amount of revenue expected to be available. In the event actual collections are greater than these amounts, HHSC is authorized to expend the funds, subject to approval through Rider 87, SSLC Oversight. (Former DADS Rider 36) [*Rider 87 was approved and included as a directive in Article II.* **SB 547** *(Kolkhorst) related to a schedule of support services (and applicable fees) was also passed and made effective immediately.]*
Administration
Rider 139. Prevent Eligibility Determination Fraud. It is the intent of the Legislature that HHSC shall use technology to identify the risk for fraud associated with applications for benefits to prevent fraud. Within the parameters of state and federal law, HHSC 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 140. Improve Efficiencies in Benefit Applications. Out of funds appropriated above, HHSC shall promote submission of applications online for benefits administered by HHSC. HHSC shall develop standards and technical requirements to allow organizations to electronically submit applications. It is the intent of the Legislature that HHSC only expend resources to partner with entities whose role in submitting benefit applications has been statutorily established, or with entities that provide in-person assistance using the agency's website for clients.
Rider 142. Recruitment and Retention Strategies. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, HHSC shall develop recruitment and retention strategies for community attendants. HHSC shall submit an annual report by August 31 to the LBB and Governor reflecting actual expenditures, cost savings, and accomplishments implementing recruitment and retention strategies for community attendants.
Rider 146. Financial Monitoring of Community Centers. HHSC shall monitor the expenditure by community centers, as defined in the Texas Health and Safety Code Sec. 534.001, of funds appropriated by this Act. The agency shall require community centers to account for state funds separately from other sources of funds. (Former Special Provisions Sec. 8)
Rider 147. Efficiencies at Local Mental Health Authorities and Intellectual Disability Authorities. HHSC shall ensure that the local mental health authorities and local intellectual disability authorities that receive allocations from the funds appropriated above to HHSC 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. Funds appropriated above to HHSC in Strategies I.2.1, Long-Term Care Intake and Access, and F.1.3, Non-Medicaid IDD Community Services, may not be used to supplement the rate-based payments incurred by local intellectual disability authorities to provide waiver or ICF/IID services. (Former Special Provisions Sec. 34)
Rider 148. Community Centers. If HHSC determines that a community center, as defined in the Texas Health and Safety Code Sec. 534.001(b), is unable or unwilling to fulfill its contractual obligations to provide services or to exercise adequate control over expenditures and assets, the commission may take necessary steps, including the appointment of a management team as authorized by Health and Safety Code, §§534.038 through 534.040 and recoupment of funds, to protect the funds appropriated under this Act and ensure the continued provision of services. Any recouped funds shall be used to achieve equity. In conjunction with the reallocation of funds, the commission shall provide a report to the LBB and the Governor on the amount of funds, the reasons for the recoupment, the local authorities involved, any performance contract requirements that were not met, and the purposes of the reallocation. (Former Special Provisions Sec. 20)
Rider 157. Medicaid Provider Enrollment Portal. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall submit by June 1, 2018, a plan to allocate $3,157,241 in GR in FY 2019 from the appropriations above, consistent with the provisions of Rider 117, Transfer: Authority and Limitations, for the purpose of establishing a centralized Medicaid provider enrollment portal. Contingent upon written approval of the plan by the LBB and the Governor, $30,095,552 in All Funds in additional capital budget authority is provided to HHSC in FY 2019. HHSC must comply with the provisions of Article II, Special Provisions, §4, Federal Match Assumptions and Limitations on Use of Available General Revenue Funds, and Article IX, §13.02, Report of Additional Federal Funding, if HHSC will access additional federal funds or enhanced federal matching rates for the centralized Medicaid provider enrollment portal.
Rider 158. Managed Care Risk Margin. Included in appropriations above in Goal A, Medicaid Client Services, is a reduction of $37,568,472 in GR Funds and $52,308,256 in Federal Funds in FY 2018 and $38,742,976 in GR Funds and $53,943,566 in Federal Funds in FY 2019, a biennial total of $76,311,448 in GR Funds and $106,251,822 in Federal Funds as a result of reducing the risk margin in managed care premiums from 2.0 percent to 1.5 percent for STAR and STAR Health and from 2.0 percent to 1.75 percent for STAR+PLUS and STAR Kids. Included in appropriations above in Goal C, CHIP Client Services, is a reduction of $373,514 in GR Funds and $5,039,737 in Federal Funds in FY 2018 and $392,166 in GR Funds and $5,291,400 in Federal Funds in FY 2019, a biennial total of $765,680 in GR Funds and $10,331,137 in Federal Funds, as a result of reducing the risk margin in managed care premiums from 2.0 percent to 1.5 percent.

Rider 160. Lock-In for Controlled Substances. Out of funds appropriated above and consistent with Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter K, the Office of Inspector General shall collaborate with managed care organizations to expand appropriate use of a lock-in program related to controlled substances to maximize savings and prevent substance abuse.
Rider 165. Coordination of Medicaid Dental and Medicaid Services. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall review policies and procedures related to coordination of services between dental maintenance organizations (DMOs) and MCOs to ensure services are being delivered in the most appropriate and cost-effective setting; identify which services must be reimbursed by the DMO and the MCO when children require sedation in a dentist's office, ambulatory surgical center, or hospital; define the role of the DMO and MCO in approval of prior authorizations; and establish procedures for resolving any disputes in authorizations between DMOs and MCOs. To the extent allowed by state and federal law, HHSC may implement any recommendations developed as a result of the required review and provide a report with a summary of efforts to the LBB no later than December 1, 2018. [*Though SB 1927 (Kolkhorst) which did not pass included a provision to study Medicaid dental services for adults, the study called for was narrowly defined*.]
Rider 166. Coordination of Services. Out of funds appropriated above, HHSC shall study ways to improve coordination of therapy services that are billable to Medicaid provided by school districts that are also provided by other Medicaid providers. HHSC shall identify barriers to data collection and, in coordination with the Texas Education Agency (TEA) and participating school districts, evaluate the feasibility of participating school districts reporting to HHSC data to allow HHSC to determine: a. Data on the number of children identified, types of therapy services received, and cost of therapy services by fiscal year and provider type; and b. Recommendations to improve coordination of services for children who receive therapy services from both school districts and other Medicaid providers. HHSC shall submit a report identifying barriers to coordination and making recommendations to improve coordination of services and comparison of data to the LBB and Governor no later than December 1, 2018.
Rider 167. Office of Inspector General (OIG): Managed Care Organization Performance, Reporting Requirement. Out of funds appropriated above in Strategy K.1.1, Client and Provider Accountability, the OIG shall collaborate with Medicaid and Children's Health Insurance Program (CHIP) Managed Care Organizations (MCOs) to conduct a review of cost avoidance and waste prevention activities employed by MCOs throughout the state. The review shall include the strategies MCOs are implementing to prevent waste, including, but not limited to recovering overpayments, reducing Potentially Preventable Events (PPE), and conducting internal monitoring and audits. The review shall also consider the effectiveness of strategies employed by MCOs to prevent waste and the adequacy of current functions. The OIG shall submit a report to the LBB and the Governor by March 1, 2018, detailing its findings and recommendations for performance measures related to cost avoidance and waste prevention activities employed by MCOs. The recommended performance measures should be applicable to all MCOs throughout the state.
Rider 169. Therapy Services Accountability. HHSC shall work in cooperation with MCOs to create a more accountable and transparent system for therapy services by requiring all claims submitted to include rendering providers national provider identification number.
Rider 175. Managed Care Organization Services for Individuals with Serious Mental Illness. a. Out of funds appropriated above in Goal A, Medicaid Client Services, HHSC shall improve efforts to better serve individuals with serious mental illness, as defined by Section 1355.001, Texas Insurance Code. HHSC shall develop performance metrics to better hold managed care companies accountable for care of enrollees with serious mental illness. Performance metrics shall include those pursuant to Government Code, Chapter 536.003, as well as industry standard performance measures for integrated care, jail and emergency department diversion, post-release linkage to care, homelessness reduction, supportive housing, and medication adherence. HHSC's efforts should demonstrate improved outcomes, integration of care and enhanced cost control against an established baseline measurement for the target population of individuals with serious mental illness. HHSC shall submit a report to the LBB and Governor no later than November 1, 2018, detailing HHSC's performance metrics relating to providing services to individuals with serious mental illness as described above. b. Per the express authority granted in Government Code, Chapter 533.0025(b), HHSC may, if cost effective, develop and procure a managed care program for an alternative model of managed care in at least one service delivery area of the state to serve individuals with serious mental illness in Medicaid and CHIP managed care programs. c. If HHSC determines that the agency will not develop and procure a managed care program as described in (b) above, HHSC shall report to the LBB before any relevant procurements on why it did not. The report shall include a five year General Revenue and All Funds cost analysis, the specific consideration detailed in Government Code, Chapter 533.0025(c), and how HHSC and Managed Care Organizations will better serve those with severe mental illness in existing managed care service models.
Rider 187. Increase Consumer Directed Services. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, HHSC shall educate STAR+PLUS home and community-based services consumers about the Consumer Directed Services (CDS) option, and seek to increase the percentage of clients who choose CDS. HHSC shall collect information annually from each MCO on the percent of clients enrolled in CDS and shall establish incremental benchmarks for improvement. HHSC shall include this information on the agency website and provide it to the STAR Plus Quality Work Group. [*While this Rider is limited to educating individuals receiving services through STAR+PLUS, HB 3295 was amended with a provision in SB 1927 (Kolkhorst) that did not pass, requiring HHSC to identify and evaluate barriers preventing individuals from choosing the CDS option both in STAR+PLUS and HCS*.]
Rider 188. Review of Certain Medicaid Dental Services. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall conduct a review of the dental services provided to adults with disabilities through Medicaid. The review may focus on the following areas:

a. Preventive, emergency, periodontal, restorative, and prosthodontic dental care services available;
b. Limits or caps on services, or the cost of services;
c. The dental needs of adults with particular disabilities;
d. Availability of dentists participating in Medicaid who provide dental services to adults with disabilities; and
e. Utilization of emergency rooms for dental services and any effect on the cost of care.
HHSC shall submit a report to the LBB, Governor, Lieutenant Governor, Speaker of the House, and members of the Senate Committee of Finance, House Committee on Appropriations, Senate Committee on Health and Human Services, House Committee on Human Services, and House Committee on Public Health no later than December 1, 2018. The report shall detail the agency's findings related to the above items and provide recommendations for improving access to dental care. [*See also Rider 165*.]

Rider 190. Evaluation of Intermediate Care Facility Conversion. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, HHSC shall evaluate and report to the LBB on the cost effectiveness of permitting small ICFs/IID with four or fewer individuals living in the home, who are voluntarily relinquishing their ICF-IID bed, to convert to HCS. The report shall be submitted by March 1, 2018. [*This Rider generated controversy and inconsistency in LBB approval when efforts to add the same Rider to HB 1 were made by the HAC Article II subcommittee. The Rider in SB 1 (Senate Finance Committee) allowed for the conversion providing such was cost neutral and the conversion pertained to ICFs/IID with only 4 or fewer persons. The LBB would only approve the Rider if it called for an evaluation of the feasibility of allowing conversion when discussed in the HAC Article II subcommittee. Efforts were then made to amend the Rider on the House Floor on Thursday, April 6, 2017 (Rider Day) to parallel the Rider contained in the Senate's budget. The amended Rider, however, had to be withdrawn as HHSC reported cost of permitting the conversions would cost $1 billion.*]

Rider 194. Community Integration Performance Indicators. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, HHSC shall develop measurements of community integration outcomes, which may include measures of opportunity (objective and subjective), community participation, community presence, well-being, and recovery, for the STAR+PLUS and STAR Kids programs. HHSC shall work with clients, providers, and other relevant stakeholders to develop these measures and establish methods of data collection. Upon stakeholder agreement, HHSC may begin data collection for measures reporting, and shall publish final data on these measures on the HHSC website on an annual basis.

Rider 196. Ensure Network Adequacy. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, HHSC shall seek to ensure that contracted managed care organizations maintain an adequate network of providers, especially with respect to community attendants

Rider 200. Study Relating to Enhanced Criminal Background Check Standards for Certain Health and Human Services Commission Contractors. It is the intent of the Legislature that, out of GR funds appropriated above, HHSC conduct a study on the feasibility and necessity of developing enhanced criminal background check standards for individuals who provide services to or otherwise work with children and the elderly as an employee of an entity that contracts with HHSC. Not later than March 1, 2018, HHSC shall submit a report on the findings of the study together with the recommendations to the LBB, the Governor, members of the House Appropriations Committee, Senate Finance Committee, and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services.

Rider 201. Enhanced Eligibility Screening Tools. It is the intent of the Legislature that, using funds appropriated above, HHSC:
(1) cross match, on a quarterly basis beginning September 1, 2017, statistically significant samples of recipient enrollment records from the medical assistance, financial assistance, supplemental nutrition assistance, and children's health insurance programs against death records, employment and wage records, records of lottery winnings, residency checks, child support enforcement records, out-of-state electronic benefits transactions, the enrollment status of persons in other state administered public assistance programs, and any other data HHSC considers appropriate in order to strengthen program integrity, reduce fraud, waste, and abuse, and achieve cost savings in the programs;
(2) not later than September 1, 2018, prepare and submit a written report to the governor, lieutenant governor, speaker of the house of representatives, and any legislative committees with jurisdiction over the commission containing the findings from the cross matches conducted under Subdivision (1) of this rider, including findings of incidents of fraud, waste, or abuse in the programs listed in that subdivision; and
(3) based on findings from the samples of cross matches, conduct a cross match of all recipient enrollment records for the programs listed in Subdivision (1) of this rider not later than December 1, 2018.

203. Program of All-inclusive Care for the Elderly (PACE).
a. Expansion of PACE Sites. HHSC may use funds appropriated in Strategy A.3.5, Program of All-inclusive Care for the Elderly (PACE) to add up to three additional PACE sites, each serving up to 150 participants beginning in fiscal year 2018.
b. *Funding for Additional Sites and Participants*. Notwithstanding HHSC, Rider 117, Transfers: Authority and Limitations and Special Provisions Relating to All Health and Human Services Agencies, Section 6, Limitations on Transfer Authority, if funds appropriated in Strategy A.3.5, Program of All-inclusive Care for the Elderly (PACE) are not sufficient to pay for services described in subsection (a), HHSC shall transfer funds from Goal A, Medicaid, Strategy A.1.1, Aged and Medicare-related, or Strategy A.1.2, Disability-Related, in an amount not to exceed $1,784,785 in GR Funds in FY 2018 and $4,980,432 in GR Funds in FY 2019. The Executive Commissioner of HHSC must certify that funds appropriated in Strategy A.3.5, Program of All-

inclusive Care for the Elderly (PACE) were insufficient due to an increase in the number of participants served, not due to an increase in the average cost or rate. The Executive Commissioner of HHSC shall provide written notification to the LBB and the Governor of the certification and the transfer amounts within 30 business days of the date on which any transfer occurs.
c. Additional Funding for PACE Program. Should transfer authority provided in subsection (b) be insufficient to serve the increase in participants described by subsection (a), the Executive Commissioner of HHSC shall submit a written request to the LBB and the Governor for approval to transfer additional funds from Strategy A.1.1, Aged and Medicare-related, or Strategy A.1.2, Disability-Related to Strategy A.3.5, Program of All-inclusive Care for the Elderly (PACE). The request shall be considered to be approved unless the LBB or the Governor issues a written disapproval within 30 business days of the date on which the staff of the LBB concludes its review of the request and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. Any requests for additional information made by the LBB shall interrupt the counting of the 30 business days.
d. Average Cost for New PACE Recipients. Proposed rates related to new sites are subject to the requirements in Special Provisions Relating to All Health and Human Services Agencies, Section 17, Rate Limitations and Reporting Requirements. The fiscal impact of proposed rates shall be calculated relative to the average cost per recipient for existing PACE sites.

204. Clear Process for Including Prescription Drugs on the Texas Drug Code Index. HHSC shall make clear their process for the inclusion of prescription drugs in the Medicaid and Children's Health Insurance Programs. In implementing the prescription drug inclusion process, HHSC shall ensure that the timeline for review, including initiation of drug review, clinical evaluation, rate setting, LBB notification, and making the product available, does not extend past the 90th day of receipt of the completed application for coverage on the Texas Drug Code Index (TDCI). After the applicable DUR board meeting and approval by the HHSC Executive Commissioner, HHSC will complete the public posting of medical policies associated with the product. Prior to December 1, 2017, HHSC shall report to the LBB and the Governor the steps taken to streamline their process.

205. Operational and Administrative Efficiencies Related to Technology and Electronic Visit Verification. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall conduct a review of technology usage and Electronic Visit Verification (EVV). The review shall include the following:
a. programmatic and administrative areas where HHSC can maximize current investments in technology and automation to achieve operational efficiencies, generate cost savings and cost avoidance, and create opportunities to share services within the health and human services system;
b. strategies to improve the collection and maintenance of current and accurate contact information for individuals receiving health and human services benefits;
c. operational efficiencies and cost savings achieved by HHSC through improvements in collection and maintenance of current and accurate contact information for individuals receiving health and human services benefits; and
d. strategies to streamline the administrative requirements imposed on health care providers that are required to use EVV, including a review of:
(1) minimum state and federal statutory requirements relating to EVV;
(2) state program and policy requirements requiring health care providers to make unnecessary visits or incur unnecessary costs; and
(3) differences in compliance requirements between fee-for-service and managed care.
HHSC shall submit a report detailing the agency's findings to the LBB, Governor, Lieutenant Governor, Speaker of the House of Representatives, members of the House Appropriations Committee, Senate Finance Committee, and the permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services no later than March 31, 2018.

211. Contingency for HB 1486. Contingent on enactment of House Bill 1486, or similar legislation relating to the provision of peer specialists, peer services, and the provision of those services under the medical assistance program, by the Eighty-fifth Legislature, Regular Session, and included in amounts appropriated above is $360,366 in GR Match for Medicaid No. 758 and $474,234 in Federal Funds in FY 2018 and $1,013,257 in GR Match for Medicaid No. 758 and $1,361,843 in Federal Funds in FY 2019 in Strategy A.1.2, Disability-Related; and $79,500 in GR in each fiscal year of the biennium in Strategy B.1.1, Medicaid Contracts and Administration, to implement the provisions of the legislation. [HB 1486 (Price, Four) did pass.]

213. Informational Listing: Expansion of Community-based Services. Appropriations made above in Goal A, Medicaid Client Services, include $20,156,364 in GR Funds and $26,916,316 in Federal Funds for the 2018-19 biennium for the expansion of community-based services as follows:
a. For the Promoting Independence Initiative, the following additional waiver slots:
(1) **325 Home and Community-based Services (HCS) slots** for persons moving out of large and medium Intermediate Care Facilities for Individuals with Intellectual Disabilities;
(2) **110 HCS slots** for children aging out of foster care;
b. For the purpose of complying with federal Preadmission Screening and Resident Review requirements, the following additional waiver slots:
(1) **150 HCS slots** for persons with intellectual and developmental disabilities (IDD) moving from nursing facilities; and
(2) **150 HCS slots** for persons with IDD diverted from nursing facility admission.
All waiver slots identified in subsections (a) and (b) are end-of-year targets for fiscal year 2019. Appropriations assume equal rollout throughout the 2018-19 biennium. HHSC shall take any action necessary to ensure that persons are enrolled in waiver services as intended by appropriations and shall provide a plan for achieving this goal. The plan shall be submitted by September 1, 2017, and

progress reports related to achieving enrollment goals shall be submitted on March 1, 2018; September 1, 2018; and March 1, 2019. Each progress report shall identify the number of persons enrolled in each type of slot and for each purpose identified in subsections (a) and (b); planned enrollment for the remainder of the 2018-19 biennium; any issues with enrollment identified by the agency; and how the agency plans to address those issues to achieve the targets by the end of fiscal year 2019. The plan and subsequent progress reports shall be submitted to the LBB, the Governor, the Senate Finance Committee, and the House Appropriations Committee.

214. Exemption from Waiver Rate Reductions. Included in amounts appropriated above in Goal A, Medicaid Client Services, is $7,500,000 in GR Funds and $12,700,000 in Federal Funds for the 2018-19 biennium to exempt consumer directed services from rate reductions for Supported Home Living services in HCS and Community Support Services in TxHmL

215. Medicaid Therapy Services Reporting. Out of funds appropriated above in Strategy L.1.1, HHS System Support, HHSC shall submit, on a quarterly basis, the following information related to pediatric acute care therapy services (including physical, occupational, and speech therapies) and whether the items below negatively affect access to care:
a. Provider and member complaints by disposition received by the Office of the Ombudsman and HHSC Health Plan Management;
b. Provider and member complaints by disposition reported by Medicaid Managed Care Organizations;
c. The number of pediatric acute care therapy provider terminations and the reason for identified terminations;
d. The utilization of pediatric acute care therapy services;
e. The number of members on a waiting list, unable to access pediatric acute care therapy services due to insufficient network capacity; and
f. The number of pediatric acute care therapy providers no longer accepting new clients and the reason for identified panel closures.
HHSC shall submit the quarterly reports to the LBB and the Governor in a format specified by the LBB beginning December 1, 2018.

218. Adjustment of Therapy Rate Reductions. Funds appropriated above in the strategies in Goal A, Medicaid Client Services, include $11,850,000 in GR Funds and $15,593,261 in Federal Funds ($27,443,261 in All Funds) for FY 2018 and $12,555,500 in GR Funds and $16,834,045 in Federal Funds ($29,389,045 in All Funds) for FY 2019 to restore approximately 25 percent of the reductions made to reimbursement rates for acute care therapy services during the 2016-17 biennium. HHSC is directed to allocate the restorations among provider types and procedure codes to preserve access to care for clients served under Medicaid fee-for-service and managed care models. It is the intent of the Legislature that HHSC shall ensure any funds restored through this rider are fully reflected in reimbursement rates paid to providers of acute care therapy services in both fee-for-service and managed care models.

Additionally, funds appropriated above in Goal A, Medicaid Client Services, include $14,100,000 in GR Funds and $18,554,006 in Federal Funds ($32,654,006 in All Funds) for FY 2018 to phase-in and delay the reduction of rates for therapy assistants. Appropriated amounts assume the reductions will not begin until December 1, 2017 and that rates will remain at 85 percent of the rate paid to a licensed therapist from that date until September 1, 2018. Appropriated amounts assume rates for therapy assistants will be reduced to 70 percent of the rate paid to a licensed therapist beginning September 1, 2018.

220. Evaluation of Medicaid Managed Care.
a. Review of Managed Care System. From funds appropriated above and pursuant to its authority under general law, HHSC shall contract with an independent organization to conduct a comprehensive evaluation of managed care in the Texas Medicaid program. The evaluation must include a review of the current delivery system, an assessment of the performance of managed care including analysis of costs, cost savings, cost trends, the impact of caseload growth, cost containment initiatives, and contractual mandates. HHSC shall also include in the evaluation how cost trends for managed care programs in Texas compare to other states and recommendations on additional operational efficiencies, delivery system reforms, and cost containment initiatives.
b. Contract Review and Oversight. Out of funds appropriated above in L.1.1, HHS System Supports, HHSC shall conduct a review of the agency's contract management and oversight function for Medicaid and CHIP managed care contracts. The review should consider the effectiveness and frequency of audits, the data necessary to evaluate existing contract requirements and enforcement, including penalties, and the need for additional training and resources for effective contract management.
c. Managed Care Rate Setting. Out of funds appropriated above, HHSC shall conduct a study of Medicaid managed care rate setting processes and methodologies in other states.
d. Managed Care Administrative Expenditure Audit. Out of funds appropriated above, HHSC shall conduct an audit of administrative expenditures made by managed care organizations in Medicaid and the Children's Health Insurance Program. HHSC shall use the audit process to identify opportunities for savings.
HHSC shall develop and report on its findings from sections (a) through (d) to the Governor, the LBB and members of the House Appropriations Committee, Senate Finance Committee, and the permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services no later than September 1, 2018.