ARTICLE II HHSC RIDERS
SAME in both SEANTE CSSB 1 & HOUSE CS for SB 1
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 20. 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 24. 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 25. 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 28. Evaluation of Medicaid Data. Out of funds appropriated above, HHSC shall annually evaluate data submitted by managed care organizations 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 35. 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 71 CSSB 1/ Rider 75 House CS for SB 1: 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 72 CSSB 1/ Rider 76 House CS for SB 1: 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 105 CSSB 1/ Rider 109 House CS for HB 1: Appropriation: Quality Assurance Fees. Informational Item. Appropriations from GR Dedicated - Quality Assurance Account No. 5080 in this Act total $70,000,000 in each fiscal year 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 fiscal year 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 111 CSSB 1 / Rider 115 House CS for SB 1: 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 89, SSLC Oversight. (Former DADS Rider 36)
Rider 156 CSSB 1 / Rider 160 House CS for SB 1: 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 157 CSSB 1 / Rider 161 House CS for SB 1: Contract Management and Oversight. Out of funds appropriated above in L.1.1, HHS System Supports, HHSC shall conduct a thorough review of its contract management and oversight function for Medicaid and CHIP managed care and fee-for-service contracts to make recommendations to identify anomalies in service utilization, identify the anomaly's underlying causes, create contingency plans for when qualified vendors cannot be found, and conduct an assessment of current contractual deficiencies. The review may be conducted by HHSC personnel or by an independent contractor (including under contract with the State Auditor's Office), but may not be reviewed by agency contract administration staff or the OIG. The review should consider the effectiveness and frequency of audits, the appropriateness of existing contract requirements including penalties, the availability of necessary data, the need for additional training and resources, the effectiveness of the planning process, how contract deliverables and milestones are tied with payment schedules, and adequacy of current prior authorization and utilization review functions. HHSC shall report its findings and recommendations to the Legislature no later than Sept. 1, 2018.
Rider 159 CSSB 1 / Rider 164 House CS for SB 1: 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 166 CSSB 1 / Rider 171 House CS for SB 1: 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 the Health and Human Services Commission 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 167 CSSB 1 / Rider 172 House CS for SB 1: 167. 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 194 CSSB 1 / Rider 210 House CS for SB 1: Therapy Services Accountability. HHSC shall work in cooperation with managed care organizations to create a more accountable and transparent system for therapy services by requiring all claims submitted to include rendering providers national provider identification number.

ARTICLE II HHSC RIDERS: SAME TOPIC, DIFFERENT DIRECTIVE/INTENT	
SEANATE CSSB 1	**HOUSE CS for SB 1**
Rider 36. Health and Human Services Cost Containment. 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) Increasing fraud, waste, and abuse prevention and detection; (2) Evaluating reimbursement for dual eligibles; (3) Improving prior authorization and utilization review for non-emergent air ambulance services; (4) Reviewing utilization and evaluating appropriateness of rates for durable medical equipment; (5) Increasing third party recoupments; (6) Implementing a pilot program on motor vehicle subrogation; (7) Achieving efficiencies in the printing and distribution of Medicaid identification cards; (8) Enforcing the limitations on recipient disenrollment from managed care plans pursuant to Government Code, §533.0076; and (9) Achieving other programmatic efficiencies. HHSC shall provide a plan to the Legislative Budget Board 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. HHSC shall **achieve savings of at least $410.0 million GR and $590.0 million in Federal Funds** for the 2018-19 biennium through the initiatives identified above and initiatives identified in Rider 178, Managed Care Risk Margin, Rider 182, Managed Care Contract Procurement, Rider 196, Contingency for Senate Bill 1787, and Rider 192, Prescription Drug Savings.	**Rider 36. Medicaid Funding Reduction and Cost Containment**. a. Included in appropriations above in Goal A, Medicaid Client Services, is a reduction of $55,400,000 in GR and $65,794,349 in Federal Funds in FY 2018 and $55,400,000 in GR and $67,205,813 in Federal Funds in FY 2019, a **biennial total of $110,800,000 GR** and $133,000,162 in Federal Funds. HHSC is authorized to transfer these reductions between fiscal years and to allocate these reductions among health and human services agencies as listed in Article II of this Act, pursuant to the requirement to submit a plan 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) 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) Explore changes to premium structure for managed care organizations and contracting tools to reduce costs and increase efficiency, (6) Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services, (7) Increase efficiencies in the vendor drug program, (8) Increase third party recoupments, (9) Implement a pilot program on motor vehicle subrogation, (10) Continue to pursue efficiencies in eligibility determination and processing by using self-service options to submit applications, (11) Implement facility cost savings by reducing leased space or decommissioning buildings, (12) Recoup administrative costs for programs HHSC administers for other entities, such as the School Health and Related Services Program (SHARS), (13) Seek flexibility from federal government to improve efficiency of Medicaid program, (14) Implement actions necessary to effect an increase in experience rebates, (15) Provide incentives for the completion of health risk screenings and engagement in healthy behaviors that address identified high-cost risk factors, and (16) Implement additional initiatives identified by HHSC. 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 Article II of this Act. The plan shall include reduction amounts by strategy and fiscal year and shall be submitted in writing before December 1, 2017 to the LBB, the Governor, and the Comptroller.

Rider 177. Federal Flexibility. HHSC shall evaluate and pursue all available flexibility from the federal government to waive, receive exemptions from, or delay federal requirements that impose a significant financial burden on the state. HHSC shall determine the cost savings associated with any flexibility achieved and notify the LBB of any changes implemented in Medicaid or the Children's Health Insurance Program.	**Rider 186. Federal Flexibility.** Included in amounts appropriated above in Goal A, Medicaid Client Services, is a reduction of $1,000,000,000 in GR and $1,368,000,000 in Federal Funds for the 2018-19 biennium. HHSC shall pursue flexibility from the federal government to reduce the cost of providing Medicaid client services to achieve the assumed level of savings. HHSC shall determine the cost savings associated with any flexibility achieved and notify the LBB of any changes implemented in the Medicaid or Children's Health Insurance Programs.
Rider 188. 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	**Rider 194. 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 Gov., 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.
Rider 195. Cost Neutral ICF to HCS Conversions. Contingent upon a determination of cost-neutrality on an annualized basis of each conversion, and upon approval pursuant to HHSC Rider 130, Transfers: Authority and Limitations, out of funds appropriated above in Strategy A.2.7, Intermediate Care Facilities-IID, HHSC may permit small ICFs/IID with four or fewer individuals living in the home, who are voluntarily relinquishing their ICF bed, to convert to HCS waiver placements. The number of waiver placements thus approved shall be considered an increase in the total number of HCS placements, and affected ICF-IID beds shall be decertified.	**Rider 211. 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. [*An amendment to strike this Rider and replace with the same text as Rider 195 (CSSB 1) was to be offered on the House Floor Thursday, April 6, 2017*, but was withdrawn. HHSC reported cost of permitting the conversions would cost $1 billion.]
ARTICLE II HHSC RIDERS (Riders ONLY in either Senate CSSB 1 or in House CS for SB 1)	
SENATE CSSB 1 ONLY	
Rider 176. 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 fiscal year 2019 from the appropriations above, consistent with the provisions of Rider 130, 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 fiscal year 2019. HHSC must comply with the provisions of Article II, Special Provisions, §4, Federal Match Assumptions and Limitations on Use of Available GHR, 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 178. Managed Care Risk Margin. Included in appropriations above in Goal A, Medicaid Client Services, is a reduction of $51,955,499 GR and $72,339,953 Federal Funds in FY 2018, and $53,349,661 GR and $74,281,107 Federal Funds in FY 2019, a biennial total of $105,305,160 GR and $146,621,060 Federal Funds as a result of reducing the risk margin in managed care premiums from 2.0 percent to 1.5 percent. Included in appropriations in Goal C, CHIP Client Services, is a reduction of $380,423 in GR and $4,888,589 in Federal Funds in FY 2018 and $382,226 in GR and $5,189,575 in Federal Funds in FY 2019, a biennial total of $762,649 in GR and $10,078,164 in Federal Funds, as a result of reducing the risk margin in managed care premiums from 2.0 percent to 1.5 percent.
Rider 179. Data Analysis Unit Reporting. Out of funds appropriated above, HHSC shall report to the LBB on a quarterly basis the activities and findings of the Data Analysis Unit established pursuant to Government Code, §531.0082. Additionally, any anomalies identified related to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and the Children's Health Insurance Program shall be reported to the Office of the Inspector General for further review.
Rider 180. Managed Care Administrative Expenditure Audit. Out of funds appropriated above, HHSC shall conduct an audit of administrative expenditures made by MCOs in Medicaid and the Children's Health Insurance Program. HHSC shall use the audit process to identify opportunities for savings and report the results of the audit to the LBB no later than September 1, 2018.
Rider 181. Evaluation of 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 and report the results of the study to the LBB no later than September 1, 2018.
Rider 182. Managed Care Contract Procurement. Out of funds appropriated above and consistent with applicable statutes and other laws, HHSC shall evaluate and strengthen its current managed care procurement process to achieve greater administrative efficiency and attain the greatest value for the state. As required by Government Code, §533.013, HHSC shall pursue a competitive bidding process for managed care contracts. Additionally, HHSC shall simultaneously procure for multiple managed care programs and enhance its methodology for scoring managed care organization responses to requests for proposal. If necessary, HHSC may extend existing managed care contracts to establish a uniform expiration date, provided it does so in a manner consistent with Government Code, §2155.144(c).
Rider 189. Coordination of Services. Out of funds appropriated above, HHSC shall determine the extent to which children who receive therapy services that are billable to Medicaid by school districts receive the same type of therapy service(s) from other Medicaid providers. The study shall cover FYS 2014 through 2016. HHSC shall report its findings to the LBB not later than December 1, 2018. The report shall include: a. A description of the methodology used to identify the universe of children who receive therapy services from both school districts and other Medicaid providers. b. Data on the number of children identified, types of therapy services received, and cost of therapy services by fiscal year and provider type; c. An analysis of the requirements to coordinate such care in federal and state statutes, rules, and regulations as well as in MCO contracts and HHSC's Memorandum of Understanding with the Texas Education Agency; and d. Recommendations to improve coordination of services for children who receive therapy services from both school districts and other Medicaid providers.
Rider 190. Office of Inspector General: Managed Care Organization Performance, Reporting Requirement. Out of funds appropriated above in Strategy K.1.1, Client and Provider Accountability, the Office of Inspector General shall collaborate with Medicaid and Children's Health Insurance Program (CHIP) 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 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 191. Office of Inspector General: Special Investigation Unit Guidance, Reporting Requirement. Out of funds appropriated above in Strategy K.1.1, Client and Provider Accountability, the Office of Inspector General shall develop recommendations for the composition and activities of Special Investigation Units (SIUs) required pursuant to Government Code, §531.113. The recommendations shall be developed in collaboration with HHSC and Medicaid and CHIP MCOs to ensure effective SIU functions. The OIG shall submit a report to the LBB and Governor by March 31, 2018, detailing effective SIU functions and the recommendations for the composition and activities of SIUs. The OIG shall post the report on the agency's webpage to ensure the recommendations are available to SIUs throughout the state.
Rider 192. Prescription Drug Savings. Included in appropriations above in Strategy A.1.6, Medicaid Prescription Drugs, is a reduction of $35,500,000 GR and $85,300,000 Federal Funds in fiscal year 2019 related to assumed changes in the provision of pharmacy benefits pursuant to Government Code §533.005(a)(26)(a-1). Contingent on enactment of SB 1922 - 85th Legislature, Regular Session, HHSC shall ensure MCOs contracted with the state maintain patient protections related to step therapy protocol, continuity of care, and prior authorization.
Rider 202. MCO Services for Individuals with Serious Mental Illness. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall improve efforts to better serve individuals with serious mental illness, as defined by Section 1355.001, Texas Insurance Code. In furtherance of these efforts, HHSC shall develop performance metrics to better hold manage care

companies accountable for care of enrollees with serious mental illness and may develop and procure a separate managed care program in at least one service area of the state aimed at serving individuals with serious mental illness.

Performance metrics shall include those pursuant to Government Code §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 LBB and Governor no later than November 1, 2018, detailing the agency's performance metrics relating to providing services to individuals with serious mental illness as described above.

HOUSE CS for SB 1 ONLY

Rider 181. Medicaid Medical Transportation. a. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall determine unmet transportation need based on information available from Medicaid client surveys to estimate the percentage of clients who did not use the Medical Transportation Program and experienced either a difficult or very difficult time obtaining transportation to medical appointments. HHSC shall notify the LBB and the relevant standing committees of the Legislature within 90 days of completing survey data collection if unmet transportation needs exceed 16 percent of total Medicaid clients. The notification must include a corrective action plan outlining how the agency and/or vendor(s) will remediate unmet transportation needs. b. To track the cost efficiency of the program, HHSC shall report the average cost per trip provided through the program for each FY in the biennium in a manner prescribed by the LBB. This report shall be provided to the LBB and shall be posted on the Commission's website not later than 60 days after the end of each FY.

Rider 183. Medicaid Care Coordination. To maximize the efficient coordination of health care services and improve health outcomes, out of funds appropriated in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall implement strategies to increase utilization of existing care coordination benefits among eligible Medicaid members with severe and persistent mental illness, depression, heart failure, or coronary heart disease. Care coordination benefits include, but are not limited to, targeted case management, health homes, and case management services provided by Medicaid MCOs. HHSC shall submit a report on the effectiveness of the strategies implemented to increase utilization of Medicaid care coordination benefits to the Governor, the LBB, and the appropriate Legislative standing committees by November 1, 2018. The report should include trend analysis of the utilization of care coordination benefits for the targeted population groups, any impacts on premiums paid to MCOs, as well as the impact on client health outcomes and costs incurred by MCOs associated with increased utilization of care coordination. The evaluation of health outcomes should be based on the highest quality research design that HHSC can feasibly utilize. If the evaluation of health outcomes is incomplete on November 1, 2018, a status report may be provided.

Rider 184. Federal Flexibility for Medicaid. Out of funds appropriated above to HSC in Strategy B.1.1, Medicaid Contracts & Administration, HHSC shall seek flexibility from the federal government to create a more efficient Medicaid program**.**

Rider 187. Program of All-inclusive Care for the Elderly (PACE).

a. Expansion of PACE Sites. HHSC may use funds appropriated in Strategy A.3.5, 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 134, 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, 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 General Revenue Funds in fiscal year 2018 and $4,980,432 in GR in FY 2019. The HHSC Executive Commissioner must certify that funds appropriated in Strategy A.3.5, 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 HHSC Executive Commissioner 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 HHSC Executive Commissioner 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, 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 Gov. 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.

Rider 192. Increase Consumer Directed Services (CDS). 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 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.
Rider 199. Clear Process for Including Prescription Drugs on the Texas Drug Code Index (TDCI). HHSC shall make clear their process for 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, public posting of medical policies and making the product available, does not extend past the 60th day of receipt of an application for coverage on the TDCI. Prior to December 1, 2017, HHSC shall report to the LBB and the Governor the steps taken to streamline their process.
Rider 203. Community Integration Performance Indicators. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (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 205. Ensure Network Adequacy. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, HHSC shall seek to ensure that contracted MCOs maintain an adequate network of providers, especially with respect to community attendants.
Rider 212. Adjustment of Therapy Rate Reductions. Funds appropriated in the strategies in Goal A, Medicaid Client Services, include $1,800,000 GR; $4,900,000 in Federal Funds ($6,700,000 in All Funds) for FY 2018 and $2,000,000 GR and $5,300,000 in Federal Funds ($7,300,000 in All Funds) for FY 2019. These amounts are in addition to $21,900,000 GR and $28,800,000 in Federal Funds ($50,700,000 in All Funds) for fiscal year 2018 and $23,100,000 GR and $31,000,000 in Federal Funds ($54,100,000 in All Funds) for FY 2019 included in appropriations to HHSC. In total $118,900,000 in All Funds for 2018-19 biennium is provided to restore approximately half 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 Legislature's intent 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.
Rider 213. Nonemergency Medical Transportation Program Efficiencies. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, HHSC shall work with contracted medical transportation organizations (MTOs) to improve administrative efficiencies and enhance program outcomes. In achieving these goals, HHSC shall consider recommendations from MTOs and other interested stakeholders. Areas of consideration may include reduction in requirements for individual transportation provider driver credentialing, standardization of reimbursement forms, and transition to a vendor administered phone system and complaint resolution process
ARTICLE II – SPECIAL PROVISIONS (SAME in both CSSB 1 & House CS for SB 1)
Sec. 9. Audit of Medicaid Funds. All transactions involving the payment, transfer, or investment of any funds of the Title XIX Medicaid program for the state by any non-governmental entity shall be subject to audit by the State Auditor's Office.
Sec. 15. Transfer Authority Related to TxHmL Waiver. Notwithstanding the limitations on transfer authority in Special Provisions Relating to All Health and Human Services Agencies, Sec. 6, Limitations on Transfer Authority, and Article IX, Sec. 14.01, Appropriation Transfers, and contingent on the transition of Medicaid program benefits for persons enrolled in TxHmL to the STAR+PLUS program, or other capitated managed care program, the HHSC Executive Commissioner may transfer GR and Federal Funds appropriated in FY 2019 in Strategy A.3.4, TxHmL to Strategy A.1.1, Aged and Medicare-Related and Strategy A.1.2, Disability Related. Transfer is limited to amounts necessary to provide services previously available from TxHmL through a capitated managed care program. Should HHSC decide to continue operation of TxHmL for purposes of providing services not available under managed care, amounts sufficient to provide those services should be retained in Strategy A.3.4,TxHmL. HHSC shall notify the LBB and Governor's Office of the actual transfer amounts and estimated impact on performance measures at least 60 days prior to transferring funds. Transfers are contingent upon HHSC submitting documentation describing any analyses conducted to determine the cost-effectiveness of the managed care delivery model chosen for the persons transitioning from TxHmL pursuant to Government Code §534.201(b). This information shall be submitted at the same time as the notification of transfer amounts. **Note: If passed, HB 3295 (Klick) will push back the carve-in date of TxHmL into STAR+PLUS from 9-1-2018 to 9-1-2020.**
Sec. 20. Health Insurance Providers Fee. Included in amounts appropriated elsewhere in this Act for fiscal year 2019 is $204,333,351 in General Revenue Funds ($492,298,001 in All Funds) to reimburse managed care organizations for payment of the Health Insurance Providers Fee pursuant to Section 9010 of the Affordable Care Act and associated federal income tax. Contingent upon a judgment of the Supreme Court of the United States declaring Section 9010 unconstitutional, enactment of federal law repealing Section 9010, or judgment of the Supreme Court of the United States or enactment of federal law amending Section 9010 to make reimbursement of the fee optional for states, HHSC shall cease any reimbursements to MCOs for payment of the fee and tax. Unless the

Commission obtains prior written approval from the LBB and the Governor to use these funds for an alternate purpose, any amounts identified in this section that remain unexpended shall lapse to the treasury at the end of the fiscal year.

ARTICLE II – SPECIAL PROVISIONS (ONLY in HOUSE CS for SB 1)

Sec. 23. Waiver Program Cost Limits.

a. Individual Cost Limits for Waiver Programs. It is the intent of the Legislature that HHSC comply with the cost-effectiveness requirements of the CMS and set the individual cost limit for each waiver program as follows:

(1) MDCP: 50 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility on August 31, 2010;

(2) CLASS: The fixed amount of $114,736.07 based on historical annualized per capita cost of providing services in an ICF/IID to an individual qualifying for an ICF/IID Level of Care VIII;

(3) DBMD: The fixed amount of $114,736.07 based on historical annualized per capita cost of providing services in an ICF/IID to an individual qualifying for an ICF/IID Level of Care VIII;

(4) HCS: 200 percent of the reimbursement rate that would have been paid for that same individual to receive services in an ICF/IID on August 31, 2010; and

(5) STAR+PLUS CBA: 202 percent of the reimbursement rate that would have been paid for that same individual to receive services in a nursing facility.

b. Use of GR for Services.

(1) Out of funds appropriated for the waiver programs identified above, and subject to the terms of subsection (c) below, the commission is authorized to use GR 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 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 commission; and

(ii) supporting documentation, including the person's medical and service records.

(2) Out of funds appropriated for the waiver programs identified above, and subject to the terms of subsection (c) below, HHSC is authorized to use GR 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 LBB and Governor on October 1 of each year of the biennium. The report shall include the number of clients by program which exceeds cost limits and the unmatched GR associated with each by fiscal year.

[This Rider has been in previous Appropriations bills for many years and was removed from both budget bills as introduced. The House budget restores the Rider. The Senate budget did not.]

Sec. 24. Nurse Home Visiting Programs. In an effort to leverage federal matching funds to support nurse home visiting services, including Nurse Family Partnership services, DFPS and HHSC may explore the feasibility and cost-effectiveness of including nurse home visiting services as a Medicaid benefit. HHSC may consider all potential options, including existing coverage categories and delivery system models. DFPS may transfer GR Funds appropriated to the Nurse Family Partnership and Texas Home Visiting Programs in the 2018-19 biennium to HHSC, contingent on prior written approval from the LBB, to support the inclusion of these services in Medicaid.

Sec. 25. Review and Report: Health and Human Services System and Managed Care. Out of funds appropriated elsewhere in Article II of the Act in Strategy L.1.1, HHS System Support, in HHSC bill pattern, HHSC shall conduct a review of health and human services in the state to evaluate opportunities to streamline case management services. The review shall be done in collaboration with DFPS, DSHS, and Medicaid and Children's Health Insurance Program (CHIP) Managed Care Organizations (MCOs) and shall:

a. Evaluate whether adjustments to capitation rates are necessary for Medicaid members receiving case management services independent of care coordination provided by managed care staff, such as the provision of targeted case management services by local providers;

b. Evaluate administrative efficiencies and potential reductions in duplication from streamlining related benefits such as MCO home health services and MCO provided care coordination;

c. Identify opportunities to clarify the division of responsibilities for case management services provided to children in STAR Health MCOs, DFPS contracted entities, and other providers of case management services; and

d. If feasible, identify opportunities for ensuring that a single entity is designated as the primary case manager for Medicaid clients. HHSC shall submit report to LBB and Governor by May 1, 2018, detailing its findings concerning the costs associated with duplicative effort, inefficiencies, and ineffective care in health and human services in the state.
Sec. 26. Administrative Savings in the Health and Human Services System. Out of funds appropriated elsewhere in Article II of the Act in Strategy L.1.1, HHS System Support, HHSC bill pattern, HHSC shall collaborate with DFPS and DSHS to conduct a review of the administrative functions of the health and human services agencies listed in Article II of this Act. The review shall include the identification of potential GR savings related to increased administrative efficiencies and the elimination of duplicative administrative functions. The review shall also consider the effectiveness of staffing levels dedicated to administrative functions. HHSC, DFPS, and DSHS shall develop a plan to achieve the potential GR savings identified above and submit a report to the Transition Legislative Oversight Committee, established pursuant Government Code, §531.0203, LBB and the Governor no later than September 1, 2018. The report shall include information regarding the consolidation of administrative functions pursuant to Senate Bill 200, Eighty-fourth Legislature, 2015, and the savings identified above by strategy, fiscal year, full-time equivalents, and method of finance. HHSC, DFPS, and DSHS may submit the above information in an individual report prepared in a format specified by the LBB or include the information in the report required pursuant to Government Code, §531.02031.
Sec. 27. Contract Cost Containment. Pursuant to Article IX Section 17.10, Contract Cost Containment, appropriations made above to the agencies in Article II are reduced by $227,446,650 in GR in 2018 and $227,446,650 in GR in 2019 and $1,646,475 in GR- Dedicated in 2018 and $1,646,475 in GR- Dedicated in 2019.
ARTICLE IX: SAME in both CSSB 1 & HOUSE CS for SB 1
Sec. 10.05. Funding for Autism Services. Appropriated elsewhere in this Act for autism services is $22,255,310 in GR for the 2018-19 biennium, which is allocated to the following agencies for the following purposes: (a) HHSC: GR Funds totaling $14,155,310 for the biennium for focused Applied Behavior Analysis (ABA) treatment services. (b) Texas Higher Education Coordinating Board (THECB): GR Funds totaling $8,100,000 for the 2018-19 biennium to distribute to autism research centers at institutions of higher education that currently provide evidence-based behavioral services and training, in the amounts and for the purposes as follows: (1) Parent-directed Treatment: $2,250,000 per fiscal year to serve 750 children per year; (2) Board-certified Behavioral Analyst (BCBA) Training for Teachers/Paraprofessionals: $950,000 per fiscal year to serve 2,547 children per year. The research centers may contract with educational service centers to provide this training; (3) Research, development and evaluation of innovative autism treatment models: $700,000 per fiscal year; (4) Administrative support of the programs in subsections (b)(1) through (b)(3): $150,000 per fiscal year may be expended by the Higher Education Coordinating Board; (5) If funds appropriated under Subsections (b)(1), (2), or (3) exceed the funds that can be expended in accordance with the requirements of that subsection, the Higher Education Coordinating Board may expend the excess funds on any purpose described in Subsections (b)(1), (2) or (3); and (6) Any unexpended balances on hand at the end of fiscal year 2018 are hereby appropriated for the same purpose for fiscal year 2019. (c) THECB shall gather data on the above programs from each institution's autism research center and submit an annual report on the effectiveness of each program, including the number of children served, the number of parents and/or teachers/paraprofessionals trained, and the results of the research on innovative treatment models. The report shall be submitted no later than September 1 of each year to the LBB, Office of the Governor, the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.
Sec. 13.08. Funding Reductions. In the event that federal programs that authorize federal funds included in this Act are eliminated, consolidated, or replaced with new federal programs and funding authorization or block grants, or the federal funds appropriated to agencies are reduced, any reduction or reallocation of federal funds will be distributed across affected agencies and programs to pattern the strategies and programs included in this Act to the extent possible without restricting the state's ability to receive federal funds, in accordance with a plan adopted by the designated single state agency or otherwise by each affected agency. An agency shall provide a copy of the plan to the LBB and the Governor.
ARTICLE IX: HOUSE CS for SB 1 ONLY
Sec. 17.10. Contract Cost Containment (only provisions relevant to HHSC are noted). It is the intent of the Legislature that all agencies and institutions of higher education find savings in contracted goods and services to ensure the cost-effective use of state appropriations regardless of method of finance or source of funds. Appropriations of GR and GR-Dedicated Funds made elsewhere in this Act are reduced by the amounts listed below. Affected agencies shall identify and execute savings and efficiencies in their use of contracted goods and services.

a. In addition to canceling contracts for which the agency does not have sufficient appropriations, agencies and institutions should implement the following strategies to the extent allowable by state statute and the Contract Management Guide:
1) Modify contract statements of work to remove non-essential services or requirements;
2) Provide services previously outsourced; any increase in full-time equivalents needed to provide such services must receive prior approval.
3) Reduce staff augmentation contracts for non-essential functions;
4) Ensure provisions related to service level and pricing mechanisms in existing contracts are correctly enforced;
5) Enforce damage provisions for vendor non-performance and collect monetary refunds for improper payments to vendors;
6) Ensure dollar values of performance bonds and insurance are consistent with risk of nonperformance and reduce requirements if it is prudent to do so;
7) Use TxSmartBuy, term contracts, and cooperative contracts whenever possible;
8) Modify supplier terms and discounts.
9) Consolidate purchasing requests and delivery intervals;
10) While ensuring the maximum use of competitive sourcing, consolidate contracts for similar services into the fewest vendors possible to reduce duplication of effort;
11) Reduce on-hand quantities of inventoried items and centralize warehouses; and
12) Encourage vendors to identify potential cost savings.
b. In addition, an agency or institution of higher education may not use funds appropriated elsewhere in this Act to pay for contracted goods or services unless it:
1) Seeks competitive bids before renewing or extending any contract valued at $50,000 or more.
2) Conducts a cost-benefit analysis to compare canceling or continuing any contract.
c. In addition to the provisions listed above, HHSC shall identify and execute savings in Medicaid contracts by:
1) Reducing reliance, to the extent permissible under federal guidelines, on contracted actuarial services;
2) 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;
3) Evaluating methodology used to develop trend factors and other growth assumptions and ensuring it properly accounts for growth that could be considered one-time rather than ongoing;
4) Using competitive bidding as required in the Texas Government Code and federal laws;
5) Ensuring all programs are meeting cost effectiveness requirements in the Texas Government Code, including the requirements established in Texas Government Code 533.0025; and
6) Conducting a cost-benefit analysis of contracted services for the provision of agency-related human resource functions.
d. Each agency and institution of higher education that receives appropriations in this Act, shall provide a report to the LBB and the Governor that details strategies implemented, savings realized, and any other information required by the LBB from contract cost containment efforts. The first report is due not later than September 30, 2018; 2nd report by August 31, 2019.
e.The reductions for each agency in 2018-19 GR and GR-Dedicated funds call for a **total savings of $496.3 million**.

Sec. 17.13. Appropriations for Selected State Agencies and Programs. In addition to funds appropriated elsewhere, the following are appropriated from Economic Stabilization Fund for FYs 2018-19:
Health and Human Services Commission
Critical Life and Safety Needs at State Hospitals and State Supported Living Centers $188,609,263
Forensic Bed Capacity at State Hospitals and Mental Health Community Hospitals $50,000,000
Deferred Maintenance – Commission Facilities $4,542,843
Department of Family and Protective Services
Relative Caregiver Payments – House Bill 4 Contingency $32,543,356
Information Management Protecting Adults and Children in Texas (IMPACT) Upgrades and Modernization $3,446,400
Department of State Health Services
X-ALD Newborn Screening $1,200,000
Deferred Maintenance – State Laboratories $400,000
Deferred Maintenance – Department Facilities $1,043,488

ARTICLE XI (WISH LIST/NOT BUDGETED ELSEWHERE): SAME TOPIC, DIFFERENT DIRECTIVES/INTENT

CSSB 1	House CS for SB 1
Sec. 1. The following items represent additional HHSC programs and strategies not budgeted elsewhere in this Act. The descriptions and sums represented do not represent items of appropriation, but reflect Legislature's intent that funding of these programs and strategies be given consideration at such time as additional resources become available, through other legislation, updated revenue estimates, budget execution actions pursuant to Chapter 317, Government Code, or other approvals by 85th Legislature. ○ Centralized Background Check Unit /Compliance Federal Child Care & Development Fund Regulations (97.5 FTEs) $11,898,500 / $12,093,843 ○ Additional Staff to Maintain Child Care Licensing Daily Caseload for investigations & inspections (90.5 FTEs) $11,206,370 / $11,296,777 ○ Expansion of Family Violence Services Focused on Survivor Needs $3,000,000 / $3,000,000 ○ Compliance with New CMS HCBS Rules for Community DH Programs $29,872,474 / $70,024,554 ○ Critical Incident Reporting System (1915 (c) waivers) $1,264,000 / $2,528,000 ○ Quality Improvement Enhancements - LTC Online Portal for PASRR Compliance a. Change of Ownership Workflow Improvements $608,750 / $2,435,000 b. Local Authority Specialized Services Verification $1,217,500 / $4,870,000 c. Portal PASRR Form Enhancements $2,310,000 / $9,240,000 ○ Social Security Number Removal Initiative (17.0 FTEs) $724,580 / $7,146,845 ○ Expansion of the Mortality Review Process and Quality Improvement to Community IDD Programs $1,737,500 / $3,475,000 ○ Maintain Medicaid Long-term Care Waiver programs at fiscal year 2017 service level $76,894,526 / $181,004,012 ○ Restore FTEs for SSLCs (676.0 FTEs in FY 2018 only) ○ Annualize Loss of Federal Funding to support the HHS System cost allocation plan prior to implementation of SB 208 $5,031,368 / $5,031,368 ○ Community Waiver Slots for Diversion &Transition from Institutionalized Settings (23.6 FTEs) $20,690,18 / $48,148,694 ○ Regional Laundry Equipment Maintenance and Replacement for the State Hospitals & SSLCs $2,843,650 / $2,843,650 ○ Fleet Operations - Vehicle Replacement, Maintenance, and Repair $7,888,488 / $7,888,488 ○ Guardianship Services Legal Support (4 FTEs) $770,062/ $770,062 ○ Case Management System $2,710,264 / $3,702,168 ○ eDiscovery Refresh $3,404,000 / $4,600,000 ○ Replacement of ReHabWorks Case Management System $3,269,280 / $3,269,280 ○ Electronic Life Record System at Rio Grande State Center $2,000,000 / $2,000,000 ○ Seat Management: DSHS $1,809,893 / $2,015,541; DFPS $4,353,090 / $4,783,616 ○ Medicaid Provider Enrollment Portal $3,157,241 / $30,095,552	**Sec. 1.** The following items represent additional HHSC programs and strategies not budgeted elsewhere. Descriptions and sums do not represent items of appropriation, but Legislature's intent that funding be given consideration at such time as additional resources become available through other legislation, updated revenue estimates, budget execution actions pursuant to Chapter 317, Government Code, or other approvals by the 85th Legislature**.** Court Appointed Special Advocates (CASA)/Child Advocacy Centers (CAC) $4,000,000 CASA and CAC -Rider Revision $ - Federal Child Care and Development Fund Requirements $12,093,843 Child Care Licensing Daily Caseloads $11,296,777 Family Violence Services $2,000,000 Early Childhood Intervention Services (ECI) $19,755,178 Community Day Habilitation Programs $70,024,554 Social Security Number Removal Initiative $7,146,845 State Supported Living Centers $16,763,227 DARS Legacy Programs $9,169,077 Community Care Waiver Slots $114,507,479 New Construction and/or Maintenance and Repairs $2 Regional Laundry Equipment Maintenance and Replacement $2,843,650 Fleet Operations $7,888,488 Texas Civil Commitment Office $5,277,289 Electronic Visit Verification Administrative Simplification –Rider $- Alternatives to Abortion –Rider $16,700,000 Intensive Behavior Intervention –Rider $32,762,628 CFC Services –Rider $64,000,000 [Restore HCS/TxHmL CFC 21% Rate Cut] HCS 3 and 4 Person Homes Rates - Rider $21,881,316 [2.2% rate increase] In-Home Family Support Program –Rider $9,979,814 Office of the Ombudsman –Rider $500,000 Medicaid Reimbursement Physicians Pediatric Rates –Rider $57,000,000 Umbilical Cord Blood Bank –Rider $2,000,000 UT Health Harris County Psychiatric Center Competency Restoration Unit Rider $10,671,536 UT Health Harris County Psychiatric Center –Rider $4,608,044 UT Health Harris County Psychiatric Center Swing Unit –Rider $8,199,090 Appropriation Quality Assurance Fees -Rider Revision $- Contingency for HB -IT Interface LoneStar Cards $- Contingency for HB -Texas Health Steps Program Mental Health Screening $- Contingency for HB -Pediatric Tele-Connectivity Resource Program $- Contingency for HB -Nursing Facility Quality -Based Payment Incentives $100,000,000

○ Office of the Inspector General (IG) - Additional Investigations Staff (9.0 FTEs) $903,030 $1,806,060 ○ IG - New Medicaid Fraud & Detection System (MFADS) $1,250,000 $5,000,000 ○ IG - New Case Management System $1,250,000 $2,500,000 ○ Texas Civil Commitment Office (TCCO) - Offsite Healthcare for Civilly Committed Sexually Violent Predators $834,937 $834,937 ○ TCCO - Supported Living Unit $1,612,900 / $1,612,900 ○ Youth Substance Abuse Prevention $2,210,786 / $2,210,786 ○ Supported decision-making at the state hospitals $691,992 / $691,992 ○ Cost increase for purchased psychiatric hospital beds $9,462,368 / $9,462,368 ○ Cost increase for the state hospitals $28,300,000 / $28,300,000 ○ Salary increases for direct delivery staffing at the state hospitals $47,211,970 / $47,211,970 ○ Increase maximum security bed capacity at North Texas State Hospital - Vernon Campus by 72 beds (364 FTEs) $30,840,426 / $30,840,426 ○ Purchase an additional 100 contracted community hospital beds (5.0 FTEs) $59,580,388 / $59,580,388	Contingency for HB -Medicaid Medical Transportation Program Pilot $500,000 Contingency for HB -Mental Health Jail Diversion and Crisis Stabilization Program $10,000,000 ICF Determination of IDD/Related Condition Assessments-Rider $- Medicaid Waiver Programs –Rider $- Collin County -Substance Abuse Treatment Services –Rider $1,430,000 Vendor Drug Program Reforms –Rider $- Study on Preferred Generic Prescription Drugs –Rider $- Improving Provider Information Management –Rider $- Statewide Behavioral Health Workforce Shortage Coordinator –Rider $ - Hospital Add-on Payment for Medical Education –Rider $- Study of the Effectiveness of Post-Partum Intervention Programs –Rider $- Texas Lifespan Respite Program –Rider $1,000,000 Hypertension Control Activities –Rider $2,000,000 In-Home Family Support Program –Rider $- North Texas Behavioral Health Authority –Rider $16,800,000 Healthy Community Collaboratives -Rider Revision $- Enhanced Nutrition and Wellness Education Program –Rider $250,000 Telephonic Signature Pilot –Rider $- Texas Integrated Eligibility Redesign System -Rider Revision $- Montgomery County Mental Health Treatment Facility –Rider $34,600,000 Access of Services –Rider $ - Medicaid Dual Eligible Rates –Rider $- Federally Qualified Health Center Reimbursement in Managed Care –Rider $ - Revision Statewide Suicide Prevention Coordinator –Rider $ - Third Party Liability Recovery –Rider $ - Medically Fragile Children –Rider $ - Interest List Notification –Rider $ - **Article II Subtotal $1,269,292,200**