

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Base																																																																																					
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language																																																																																							
HHSC 1	II-82	<p>Performance Measure Targets. The following is a listing of the key performance target levels for the Health and Human Services Commission. It is the intent of the Legislature that appropriations made by this Act be utilized in the most efficient and effective manner possible to achieve the intended mission of the Health and Human Services Commission. In order to achieve the objectives and service standards established by this Act, the Health and Human Services Commission shall make every effort to attain the following designated key performance target levels associated with each item of appropriation.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="text-align: center;"><u>2010</u></th> <th style="text-align: center;"><u>2011</u></th> <th style="text-align: center;"><u>2012</u></th> <th style="text-align: center;"><u>2013</u></th> </tr> </thead> <tbody> <tr> <td colspan="5">A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY</td> </tr> <tr> <td colspan="5">Outcome (Results/Impact):</td> </tr> <tr> <td>Average Medicaid and CHIP Children Recipient Months Per Month</td> <td style="text-align: right;">2,677,484</td> <td style="text-align: right;">2,720,740</td> <td style="text-align: right;">3,681,419</td> <td style="text-align: right;">3,778,234</td> </tr> <tr> <td colspan="5">A.1.2. Strategy: INTEGRATED ELIGIBILITY & ENROLLMENT</td> </tr> <tr> <td colspan="5">Output (Volume):</td> </tr> <tr> <td>Average Monthly Number of Eligibility Determinations:</td> <td style="text-align: right;">513,226</td> <td style="text-align: right;">522,397</td> <td style="text-align: right;">890,000</td> <td style="text-align: right;">940,000</td> </tr> <tr> <td colspan="5">Efficiencies:</td> </tr> <tr> <td>Average Cost Per Eligibility Determination</td> <td style="text-align: right;">56.93</td> <td style="text-align: right;">57.24</td> <td style="text-align: right;">46.42</td> <td style="text-align: right;">44.49</td> </tr> <tr> <td colspan="5">Explanatory:</td> </tr> <tr> <td>Percent of Poverty Met by TANF, Food Stamps, and Medicaid Benefits</td> <td style="text-align: right;">76.9%</td> <td style="text-align: right;">76.62%</td> <td style="text-align: right;">87.61%</td> <td style="text-align: right;">87.59%</td> </tr> <tr> <td>Total Value of Food Stamps Distributed</td> <td style="text-align: right;">2,710,000,000</td> <td style="text-align: right;">2,716,000,000</td> <td style="text-align: right;">5,561.00</td> <td style="text-align: right;">5,573.00</td> </tr> <tr> <td colspan="5">B. Goal: MEDICAID</td> </tr> <tr> <td colspan="5">Outcome (Results/Impact):</td> </tr> <tr> <td>Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month</td> <td style="text-align: right;">3,105,445</td> <td style="text-align: right;">3,168,320</td> <td style="text-align: right;">3,884,015</td> <td style="text-align: right;">3,986,452</td> </tr> <tr> <td colspan="5">B.1.4. Strategy: CHILDREN & MEDICALLY NEEDY</td> </tr> <tr> <td colspan="5">Output (Volume):</td> </tr> </tbody> </table>				<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY					Outcome (Results/Impact):					Average Medicaid and CHIP Children Recipient Months Per Month	2,677,484	2,720,740	3,681,419	3,778,234	A.1.2. Strategy: INTEGRATED ELIGIBILITY & ENROLLMENT					Output (Volume):					Average Monthly Number of Eligibility Determinations:	513,226	522,397	890,000	940,000	Efficiencies:					Average Cost Per Eligibility Determination	56.93	57.24	46.42	44.49	Explanatory:					Percent of Poverty Met by TANF, Food Stamps, and Medicaid Benefits	76.9%	76.62%	87.61%	87.59%	Total Value of Food Stamps Distributed	2,710,000,000	2,716,000,000	5,561.00	5,573.00	B. Goal: MEDICAID					Outcome (Results/Impact):					Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month	3,105,445	3,168,320	3,884,015	3,986,452	B.1.4. Strategy: CHILDREN & MEDICALLY NEEDY					Output (Volume):				
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		Average Number of Legal Permanent Resident Recipient Months per Month	29,323	47,166	<u>83,812</u>	<u>84,581</u>
		B.1.5. Strategy: MEDICARE PAYMENTS				
		Output (Volume):				
		Average Supplemental Medical Insurance Part-B (SMIB) Recipient Months Per Month	536,425	551,479	<u>567,180</u>	<u>593,232</u>
		Efficiencies:				
		Average Supplemental Medical Insurance Benefits (SMIB) Premium Per Month	100.33	106.03	<u>117.22</u>	<u>117.22</u>
		B.1.6. Strategy: STAR+PLUS (INTEGRATED MANAGED CARE)				
		Output (Volume):				
		Average Aged and Medicare-eligible Recipient Months Per Month: STAR+PLUS	86,982	88,595	<u>132,329</u>	<u>135,377</u>
		Average Disabled and Blind Recipient Months Per Month: STAR+PLUS	78,250	81,594	<u>130,579</u>	<u>137,252</u>
		B.2.1. Strategy: COST REIMBURSED SERVICES				
		Output (Volume):				
		Average Number of Non-citizens Recipient Months Per Month	9,529	9,756	<u>10,951</u>	<u>11,463</u>
		B.2.2. Strategy: MEDICAID VENDOR DRUG PROGRAM				
		Output (Volume):				
		Total Medicaid Prescriptions Incurred	28,738,441	29,365,160	<u>36,942,856</u>	<u>37,786,590</u>
		B.3.3. Strategy: EPSDT COMPREHENSIVE CARE PROGRAM				
		Output (Volume):				
		Average Number of Texas Health Steps (EPSDT) Comprehensive Care Program Recipient Month per Month (Fee-for-Service Only)	508,835	517,292	<u>682,613</u>	<u>702,893</u>

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		<p>B.4.1. Strategy: STATE MEDICAID OFFICE</p> <p>Output (Volume): Medicaid Acute Care Recipient Months Per Month: Managed Care</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 10%; text-align: right;">2,178,617</td> <td style="width: 10%; text-align: right;">2,207,410</td> <td style="width: 10%; text-align: right;"><u>2,830,229</u></td> <td style="width: 10%; text-align: right;"><u>2,903,138</u></td> </tr> </table> <p>C. Goal: CHIP SERVICES</p> <p>Outcome (Results/Impact): Average CHIP Programs Recipient Months Per Month (Includes all CHIP Programs)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 10%; text-align: right;">530,504</td> <td style="width: 10%; text-align: right;">537,742</td> <td style="width: 10%; text-align: right;"><u>593,836</u></td> <td style="width: 10%; text-align: right;"><u>611,418</u></td> </tr> </table> <p>Average CHIP Programs Benefit Cost with Prescription Benefit Per Recipient Month (Includes all CHIP Programs)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 10%; text-align: right;">152.53</td> <td style="width: 10%; text-align: right;">153.34</td> <td style="width: 10%; text-align: right;"><u>157.86</u></td> <td style="width: 10%; text-align: right;"><u>157.74</u></td> </tr> </table> <p>C.1.4. Strategy: CHIP PERINATAL SERVICES</p> <p>Output (Volume): Average Perinate Recipient Months Per Month</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 10%; text-align: right;">70,017</td> <td style="width: 10%; text-align: right;">73,399</td> <td style="width: 10%; text-align: right;"><u>38,869</u></td> <td style="width: 10%; text-align: right;"><u>39,802</u></td> </tr> </table> <p>C.1.5. Strategy: CHIP VENDOR DRUG PROGRAM</p> <p>Output (Volume): Total Number of CHIP Prescriptions (Includes all CHIP Programs)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 10%; text-align: right;">1,966,138</td> <td style="width: 10%; text-align: right;">1,982,616</td> <td style="width: 10%; text-align: right;"><u>2,419,528</u></td> <td style="width: 10%; text-align: right;"><u>2,521,949</u></td> </tr> </table> <p>Efficiencies: Average Cost Per CHIP Prescription (Includes all CHIP Programs)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 10%; text-align: right;">62.98</td> <td style="width: 10%; text-align: right;">62.98</td> <td style="width: 10%; text-align: right;"><u>65.41</u></td> <td style="width: 10%; text-align: right;"><u>64.63</u></td> </tr> </table> <p>D. Goal: ENCOURAGE SELF SUFFICIENCY</p> <p>D.1.1. Strategy: TANF (CASH ASSISTANCE) GRANTS</p> <p>Output (Volume): Average Number of TANF Recipients Per Month</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"></td> <td style="width: 10%; text-align: right;">105,273</td> <td style="width: 10%; text-align: right;">105,273</td> <td style="width: 10%; text-align: right;"><u>126,491</u></td> <td style="width: 10%; text-align: right;"><u>129,621</u></td> </tr> </table> <p>Average Number of State Two-Parent Cash Assistance</p>				2,178,617	2,207,410	<u>2,830,229</u>	<u>2,903,138</u>		530,504	537,742	<u>593,836</u>	<u>611,418</u>		152.53	153.34	<u>157.86</u>	<u>157.74</u>		70,017	73,399	<u>38,869</u>	<u>39,802</u>		1,966,138	1,982,616	<u>2,419,528</u>	<u>2,521,949</u>		62.98	62.98	<u>65.41</u>	<u>64.63</u>		105,273	105,273	<u>126,491</u>	<u>129,621</u>
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		Program Recipients Per Month	4,424	4,589	<u>6,719</u>	<u>6,886</u>
		Efficiencies:				
		Average Monthly Grant: Temporary Assistance for Needy Families (TANF)	68.45	69.42	<u>58.69</u>	<u>60.67</u>
		Average Monthly Grant: State Two-Parent Cash Assistance Program	66.54	67.45	<u>34.77</u>	<u>34.49</u>
		D.1.2. Strategy: REFUGEE ASSISTANCE				
		Output (Volume):				
		Number of Refugees Receiving Contracted Social Services, Financial Assistance, or Medical Assistance	7,800	7,800	<u>15,000</u>	<u>15,000</u>
		D.2.1. Strategy: FAMILY VIOLENCE SERVICES				
		Output (Volume):				
		Number of Persons Women and Children Served by Family Violence Programs/Shelters	80,942	80,942	<u>81,000</u>	<u>81,000</u>
		Efficiencies:				
		Health and Human Services Average Cost Per Person Receiving Emergency Shelter and/or Nonresident Services through the Family Violence Program	284.36	284.36	<u>811.10</u>	<u>865.18</u>
		D.2.2. Strategy: ALTERNATIVES TO ABORTION				
		Output (Volume):				
		Number of Persons Receiving Pregnancy Support Services as an Alternative to Abortion	16,000	16,000	<u>14,400</u>	<u>14,400</u>
		<i>Rider performance measures have been updated for base request performance for FY 2012-13. Performance associated with exceptional budget request is on page 30.</i>				
HHSC 2	II-83	Capital Budget. None of the funds appropriated above may be expended for capital budget items except as listed below. The amounts shown below shall be expended only for the purposes shown and are not available for expenditure for other purposes. Amounts appropriated above and identified in the provision as appropriations either for "Lease Payments to the				

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		<p>Master Equipment Purchase Program" or for items with an "(MLPP)" notation shall be expended only for the purpose of making lease-purchase payments to the Texas Public Finance Authority pursuant to the provisions of Government Code § 1232.103.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="text-align: right; width: 10%;"><u>2010</u></th> <th style="text-align: right; width: 10%;"><u>2011</u></th> <th style="text-align: right; width: 10%;"><u>2012</u></th> <th style="text-align: right; width: 10%;"><u>2013</u></th> </tr> </thead> <tbody> <tr> <td>a. 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Other Lease Payments to the Master Lease Purchase Program (MLPP)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>(1) TIERS Lease Payments to Master Lease Program</td> <td style="text-align: right;">\$ <u>3,164,354</u></td> <td style="text-align: right;">\$ <u>2,966,676</u></td> <td style="text-align: right;"><u>2,846,905</u></td> <td style="text-align: right;"><u>2,835,113</u></td> </tr> <tr> <td style="padding-left: 20px;">Total, Capital Budget</td> <td style="text-align: right;">\$ <u>159,765,776</u></td> <td style="text-align: right;">\$ <u>122,492,571</u></td> <td style="text-align: right;">\$ <u>163,907,455</u></td> <td style="text-align: right;">\$ <u>126,059,133</u></td> </tr> </tbody> </table> <p>Method of Financing (Capital Budget):</p>				<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	a. Acquisition of Information Resource Technologies					(1) Data Center Consolidation	\$ 51,574,463	\$ 39,307,855	\$ <u>44,194,961</u>	\$ <u>26,383,053</u>	(2) Seat Management Services (PCs, Laptops, & Servers)	9,325,574	9,321,168	<u>11,698,298</u>	<u>11,718,756</u>	(3) Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations	4,036,000	2,535,430	<u>4,635,366</u>	_____	(4) Enterprise Messaging and Collaboration	406,575	406,575	_____	_____	(4) Enterprise Telecom Managed Services			<u>12,438,387</u>	<u>12,391,063</u>	(5) Enterprise Telecommunications Enhancements	3,163,705	0	_____	_____	(5) Enterprise Info & Asset Mgt (Data Warehouse)	12,228,522	12,228,522	<u>11,906,354</u>	<u>12,095,609</u>	(6) Integrated Eligibility Technologies (TIERS)	56,499,724	45,806,946	<u>68,426,440</u>	<u>53,294,645</u>	(7) Medicaid Eligibility and Health Information	12,838,075	6,366,442	<u>7,558,449</u>	<u>7,175,391</u>	(9) Information Technology Accessibility	17,540	2,957	_____	_____	(10) Enterprise Resource Planning	\$ 5,926,000	\$ 3,550,000	_____	_____	Total, Acquisition of Information Resource Technologies	\$ <u>156,016,175</u>	\$ <u>119,525,895</u>	\$ <u>160,858,255</u>	\$ <u>123,058,517</u>	b. 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(4) Enterprise Messaging and Collaboration	406,575	406,575	_____	_____																																																																																															
(4) Enterprise Telecom Managed Services			<u>12,438,387</u>	<u>12,391,063</u>																																																																																															
(5) Enterprise Telecommunications Enhancements	3,163,705	0	_____	_____																																																																																															
(5) Enterprise Info & Asset Mgt (Data Warehouse)	12,228,522	12,228,522	<u>11,906,354</u>	<u>12,095,609</u>																																																																																															
(6) Integrated Eligibility Technologies (TIERS)	56,499,724	45,806,946	<u>68,426,440</u>	<u>53,294,645</u>																																																																																															
(7) Medicaid Eligibility and Health Information	12,838,075	6,366,442	<u>7,558,449</u>	<u>7,175,391</u>																																																																																															
(9) Information Technology Accessibility	17,540	2,957	_____	_____																																																																																															
(10) Enterprise Resource Planning	\$ 5,926,000	\$ 3,550,000	_____	_____																																																																																															
Total, Acquisition of Information Resource Technologies	\$ <u>156,016,175</u>	\$ <u>119,525,895</u>	\$ <u>160,858,255</u>	\$ <u>123,058,517</u>																																																																																															
b. Acquisition of Capital Equipment and Items																																																																																																			
(1) Facility Support Services – Fleet Operations	\$ <u>585,250</u>	\$ <u>0</u>	<u>202,295</u>	<u>165,503</u>																																																																																															
c. Other Lease Payments to the Master Lease Purchase Program (MLPP)																																																																																																			
(1) TIERS Lease Payments to Master Lease Program	\$ <u>3,164,354</u>	\$ <u>2,966,676</u>	<u>2,846,905</u>	<u>2,835,113</u>																																																																																															
Total, Capital Budget	\$ <u>159,765,776</u>	\$ <u>122,492,571</u>	\$ <u>163,907,455</u>	\$ <u>126,059,133</u>																																																																																															

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Base																																																		
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language																																																				
		<p><u>General Revenue Fund</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%;">GR Match for Medicaid</td> <td style="width: 10%; text-align: right;">-\$ 31,464,624</td> <td style="width: 10%; text-align: right;">\$ 24,486,817</td> <td style="width: 10%; text-align: right;">\$ 30,356,099</td> <td style="width: 15%; text-align: right;">\$ 25,178,192</td> </tr> <tr> <td>GR Match for Title XXI (CHIP)</td> <td style="text-align: right;">4,483,753</td> <td style="text-align: right;">4,297,982</td> <td style="text-align: right;">1,435,425</td> <td style="text-align: right;">1,122,706</td> </tr> <tr> <td>GR Match for Food Stamp Administration</td> <td style="text-align: right;">19,422,184</td> <td style="text-align: right;">16,998,334</td> <td style="text-align: right;">26,577,263</td> <td style="text-align: right;">17,815,135</td> </tr> <tr> <td>General Revenue Fund</td> <td style="text-align: right;">18,016,270</td> <td style="text-align: right;">14,954,016</td> <td style="text-align: right;">3,382,430</td> <td style="text-align: right;">3,285,825</td> </tr> <tr> <td style="padding-left: 20px;">Subtotal, General Revenue Fund</td> <td style="text-align: right;"><u>\$ 70,386,831</u></td> <td style="text-align: right;"><u>\$ 57,737,146</u></td> <td style="text-align: right;"><u>\$ 61,751,217</u></td> <td style="text-align: right;"><u>\$ 47,401,858</u></td> </tr> <tr> <td>Federal Funds</td> <td style="text-align: right;">70,120,942</td> <td style="text-align: right;">58,155,650</td> <td style="text-align: right;">81,229,066</td> <td style="text-align: right;">60,068,739</td> </tr> <tr> <td>Interagency Contracts</td> <td style="text-align: right;">6,599,775</td> <td style="text-align: right;">6,599,775</td> <td style="text-align: right;">20,927,172</td> <td style="text-align: right;">18,588,536</td> </tr> <tr> <td>Bond Proceeds - Revenue Bonds</td> <td style="text-align: right;">12,658,228</td> <td style="text-align: right;">0</td> <td></td> <td></td> </tr> <tr> <td>Subtotal, Other Funds</td> <td style="text-align: right;">\$ 19,258,003</td> <td style="text-align: right;">\$ 6,599,775</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;">Total, Method of Financing</td> <td style="text-align: right;"><u>\$ 159,765,776</u></td> <td style="text-align: right;"><u>\$ 122,492,571</u></td> <td style="text-align: right;"><u>\$ 163,907,455</u></td> <td style="text-align: right;"><u>\$ 126,059,133</u></td> </tr> </table> <p><i>Capital Budget Rider is updated to reflect capital projects in the FY 2012-123 Base Request. Additional capital associated with exceptional item requests are on page30.</i></p>			GR Match for Medicaid	-\$ 31,464,624	\$ 24,486,817	\$ 30,356,099	\$ 25,178,192	GR Match for Title XXI (CHIP)	4,483,753	4,297,982	1,435,425	1,122,706	GR Match for Food Stamp Administration	19,422,184	16,998,334	26,577,263	17,815,135	General Revenue Fund	18,016,270	14,954,016	3,382,430	3,285,825	Subtotal, General Revenue Fund	<u>\$ 70,386,831</u>	<u>\$ 57,737,146</u>	<u>\$ 61,751,217</u>	<u>\$ 47,401,858</u>	Federal Funds	70,120,942	58,155,650	81,229,066	60,068,739	Interagency Contracts	6,599,775	6,599,775	20,927,172	18,588,536	Bond Proceeds - Revenue Bonds	12,658,228	0			Subtotal, Other Funds	\$ 19,258,003	\$ 6,599,775			Total, Method of Financing	<u>\$ 159,765,776</u>	<u>\$ 122,492,571</u>	<u>\$ 163,907,455</u>	<u>\$ 126,059,133</u>
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HHSC 4	II-84	<p>Reimbursement of Advisory Committee Members. Pursuant to Government Code § 2110.004, reimbursement of expenses for advisory committee members, out of funds appropriated above – not to exceed \$83,000 \$63,200 per year, is limited to the following advisory committees: Hospital Payment Advisory Committee, Medical Care Advisory Committee, Physician Payment Advisory Committee, Drug Use Review Board, Pharmaceutical and Therapeutics Committee, Public Assistance Health Benefits Review and Design Committee, <u>Children's Policy Council</u>, <u>Volunteer Advocate Program Advisory Committee</u> and Guardianship Advisory Board.</p> <p>To the maximum extent possible, the Commission shall encourage the use of videoconferencing and teleconferencing and shall schedule meetings and locations to facilitate the travel of participants so that they may return the same day and reduce the need to reimburse members for overnight stays.</p> <p><i>Rider revisions include the addition of the Children's Policy Council which was previously supported by the Texas Council for Developmental Disabilities (TCDD). TCDD has reimbursed travel reimbursement for several HHSC advisory committees for many years. Also the Volunteer Advocate Program Advisory Committee is added pursuant to the enactment of H.B. 4154 by the 81st Legislature.</i></p>																																																				

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Base
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HHSC 5	II-84	<p>Vendor Drug Rebates – Medicaid and CHIP. All references in this rider to rebate revenue refer to vendor drug rebates as well as supplemental rebates earned via the preferred drug lists (methods of finance include Vendor Drug Rebates-Medicaid, Vendor Drug Rebates –CHIP, and Vendor Drug Rebates –Supplemental Rebates).</p> <ul style="list-style-type: none"> a. Medicaid. The Health and Human Services Commission is authorized to expend Medicaid rebate revenues appropriated above in Strategy B.2.2, Medicaid Vendor Drug Program, pursuant to the federal requirements of the Omnibus Budget and Reconciliation Act of 1990 as well as rebates collected in excess of federal requirements pursuant to state law. b. CHIP. The Health and Human Services Commission is authorized to expend CHIP rebate revenues and related interest earnings appropriated above in Strategy C.1.5, CHIP Vendor Drug Program. c. Rebates as a First Source of Funding. Expenditures for Medicaid and CHIP Vendor Drug Programs shall be made from rebates received in fiscal years 2010-2012 and 2013-2014. As rebates are generated, expenditures to support the Medicaid and CHIP Vendor Drug Programs shall be made from rebate revenues. In the event rebate revenues are not available for expenditure, General Revenue may be used to support both Vendor Drug Programs until rebate revenues are available. d. Appropriation. In addition to rebate revenues appropriated above in strategy B.2.2, Medicaid Vendor Drug Program, and Strategy C.1.5, CHIP Vendor Drug Program, the Health and Human Services Commission is appropriated Medicaid and CHIP vendor drug rebates generated in excess of those amounts, subject to the following requirements: <ul style="list-style-type: none"> (1) Vendor drug rebates shall be expended prior to utilization of any General revenue available for the purpose of the CHIP or Medicaid Vendor Drug Programs. (2) In the event General Revenue has been expended prior to the receipt of vendor drug rebates, the commission shall reimburse General Revenue. The Commission shall reimburse the General Revenue Fund with vendor drug rebates on a monthly basis in order to prevent accumulation of vendor drug rebates. (3) <u>Program Benefit Agreement revenues collected in lieu of state supplemental rebates will be expended prior to utilization of any General revenue available for the purpose of the Medicaid program specified in the Agreement.</u> 		

3.B. Rider Revisions and Additions Request

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		<p style="text-align: center;">e. Limited Use of Rebates. Rebates generated by the Medicaid program shall only be used for the Medicaid program. Rebates generated by the CHIP program shall only be used for the CHIP program.</p> <p style="text-align: center;"><i>Rider is updated for biennial dates and amended to add authority for pharmacy benefit agreements which are authorized in Government Code Section 531.070.</i></p>		
HHSC 6	II-85	<p>Medicaid Subrogation Receipts (State Share). For the purpose of this provision, Medicaid Subrogation Receipts are defined as tort settlements related to the Medicaid program. Amounts defined as Medicaid Subrogation Receipts are to be deposited into the General Revenue Fund, Object No. 3802. The Commission is authorized to receive and expend Medicaid Subrogation Receipts. Expenditures shall be made from recoupments and interest earnings received in fiscal year 2010 <u>2012</u> and fiscal year 2011 <u>2013</u>. The use of the state's share of Medicaid Subrogation Receipts is limited to funding services for Medicaid clients, Medicaid Subrogation Receipts shall be expended as they are received as a first source, and General Revenue shall be used as a second source, to support the Medicaid program. In the event that these revenues should be greater than the amounts identified in the method of finance above as Medicaid Subrogation Receipts (State Share), the Commission is hereby appropriated and authorized to expend these Other Funds thereby made available, subject to the following requirements:</p> <ul style="list-style-type: none"> a. Amounts available shall be expended prior to utilization of any General Revenue available for the same purposes. b. In the event General Revenue has been expended prior to the receipt of the state's share of Medicaid Subrogation Receipts, the Commission shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent accumulation of Medicaid Subrogation Receipts balances. <p>The preceding paragraph shall be the exclusive appropriation authority for receipts from the above identified sources, and none of these receipts shall be appropriated by a provision of Article IX of this Act.</p> <p><i>Rider is updated for biennial dates.</i></p>		
HHSC 7	II-85	<p>Appropriation Transfers Between Fiscal Years. In addition to the transfer authority provided elsewhere in this Act and in order to provide for unanticipated events that increase costs associated with providing Medicaid or CHIP services for eligible clients, the Health and Human Services Commission is authorized to transfer General Revenue from funds appropriated in Medicaid or CHIP strategies in fiscal year 2013 <u>2014</u> to fiscal year 2012 <u>2010</u> and such funds are appropriated to the Commission for fiscal year 2012 <u>2010</u>. Such transfers may only be made subject to the following:</p>		

3.B. Rider Revisions and Additions Request

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		<p>a. Transfers under this section may be made only;</p> <p style="padding-left: 20px;">(1) If costs associated with providing Medicaid or CHIP services exceed the funds appropriated for these services for fiscal year 2012 2010, or</p> <p style="padding-left: 20px;">(2) For any other emergency expenditure requirements, including expenditures necessitated by public calamity.</p> <p>b. A transfer authority by this section must receive the prior written approval of the Governor and the Legislative Budget Board.</p> <p>c. The Comptroller of Public Accounts shall cooperate as necessary to assist the completion of a transfer and spending made under this section.</p> <p><i>Rider is updated for biennial dates.</i></p>		
HHSC 13	II-88	<p>Use of Additional Medicaid Program Income. For the purposes of this provision, Medicaid program income is defined as: 1) refunds/rebates of previously paid premiums and interest earnings generated in relationship to accounts listed below; 2) refunds/rebates received from the Medicaid claims payment contractor or other sources; and 3) managed care rebates as described below. Amounts defined as program income are to be deposited into the General Revenue Fund, Object No. 3639. The Health and Human Services Commission is authorized to receive and spend program income and interest earnings generated from fund balances with the Disbursement Account, and the STAR (Managed Care) Account, as defined in the contractual agreement with the fiscal agent and/or insurance carrier for purchased health services except for those interest earnings related to the Cash Management Improvement Act (CMIA). The Commission is also authorized to receive and spend experience rebates generated in accordance with its contractual agreements with health maintenance organizations who participate in Medicaid managed care.</p> <p>Expenditures shall be made from credits, managed care rebates, and interest earnings received in fiscal years 2012 2010 and 2013 2014. The use of the credits, managed care rebates, and interest earnings is limited to funding services for Medicaid clients. Medicaid program income shall be expended as they are received as a first source, and General Revenue shall be used as a second source, to support the Medicaid program. In the event that these revenues should be greater than the amounts identified in the method of finance above as Medicaid Program income, the commission is hereby appropriated and authorized to expend these General Revenue Funds thereby made available, subject to the</p>		

3.B. Rider Revisions and Additions Request

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		<p>following requirements:</p> <ul style="list-style-type: none"> a. Amounts available shall be expended prior to utilization of any General Revenue available for the same purposes; and b. In the event General Revenue has been expended prior to the receipt of program income, the Commission shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent accumulation of program income balances. <p>The preceding paragraph shall be the exclusive appropriation authority for receipt from the above identified sources and none of these receipts shall be appropriated by a provision of Article IX of this Act.</p> <p><i>Rider has been updated for biennial date changes.</i></p>		
HHSC 14	II-88	<p>Use of Additional CHIP Experience Rebates. For the purpose of this provision, CHIP Experience Rebates are defined as: 1) refunds/rebates of previously paid CHIP premiums and related interest earnings; and 2) managed care rebates and related interest earnings as described below. Amounts defined as CHIP Experience Rebates are to be deposited into the General Revenue Fund. The Health and Human Services Commission is authorized to receive and spend experience rebates generated in accordance with its contractual agreements with managed care organizations and other providers who participate in the CHIP, Immigrant Health Insurance, School Employee Health Insurance, and CHIP Perinatal programs. Expenditures shall be made from CHIP Experience Rebates generated in fiscal years <u>2012 2040</u> and <u>2013 2044</u>. The method of financing items, Experience Rebates –CHIP, for appropriations made above, includes unexpended and unobligated balances of Experience Rebates – CHIP remaining as of August 31, <u>2011 2009</u>, and receipts earned in fiscal years <u>2012 2040</u> and <u>2013 2044</u>.</p> <p>The use of CHIP Experience Rebates is limited to health care services for CHIP clients. CHIP Experience Rebates shall be expended as they are received as a first source, and General Revenue shall be used as a second source, to support CHIP– related programs. In the event that these revenues should be greater than the amounts identified in the method of finance above as Experience Rebates – CHIP, the department is hereby appropriated and authorized to expend these General Revenue Funds thereby made available, subject to the following requirements:</p> <ul style="list-style-type: none"> a. Amounts available shall be expended prior to utilization of any General revenue available for the same purposes; and b. In the event General Revenue has been expended prior to the receipt of CHIP Experience Rebates, the 		

3.B. Rider Revisions and Additions Request

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		<p style="text-align: center;">Commission shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent accumulation of CHIP Experience Rebate balances.</p> <p>The preceding paragraph shall be the exclusive appropriation authority for receipts from the above identified sources and none of these receipts shall be appropriated by a provision of Article IX of this Act.</p> <p><i>Rider has been updated for biennial date changes.</i></p>		
HHSC 15	II-89	<p>CHIP: Unexpended Balances and Allocation of Funds.</p> <p>a. Unexpended Balances between Biennia. Unexpended balances in General Revenue Funds appropriated for Goal C (CHIP) strategies to the Health and Human Services Commission (HHSC) for the fiscal year ending August 31, 2011 2009 (estimated to be \$0 136,400,000) are appropriated to the agency and included above for the fiscal year beginning September 1, 2011 2009, only upon prior written approval by the Legislative Budget Board and the Governor. These General Revenue Funds are contingent on an unexpended balance from fiscal year 2011 2009. The amount of the appropriation is limited to the amount of the unexpended balance.</p> <p>b. Unexpended Balances within the Biennium. Unexpended balances in General revenue Funds appropriated for Goal C (CHIP) strategies to HHSC for the fiscal year ending August 31, 2012 2010 (estimated to be \$0) are appropriated to the agency for the fiscal year beginning September 1, 2012 2010, only upon prior written approval by the Legislative Budget Board and Governor.</p> <p>c. For authorization to expend the funds, HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time. The agency shall provide a copy of the request to the Comptroller of Public Accounts. The request must be organized by fiscal year as follows:</p> <p>(1) The following information shall be provided for the fiscal year with an unexpended balance:</p> <ul style="list-style-type: none"> (i) an explanation of the causes of the unexpended balance(s); (ii) the amount of the unexpended balance(s) by strategy; and (iii) the associated incremental change in service levels compared to performance targets in this Act for that fiscal year. <p>(2) The Following information shall be provided for the fiscal year receiving the funds:</p>		

3.B. Rider Revisions and Additions Request

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		<p style="margin-left: 40px;">(i) an explanation of purpose for which the unexpended balance(s) will be used and whether the expenditure will be one-time or ongoing;</p> <p style="margin-left: 40px;">(ii) the amount of the expenditure by strategy;</p> <p style="margin-left: 40px;">(iii) the incremental change in service levels compared to performance targets in this Act for that fiscal year;</p> <p style="margin-left: 40px;">(iv) the capital budget impact.</p> <p>The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval with 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.</p> <p>The Comptroller of Public Accounts shall not allow the use of unexpended balances authorized by any of the above subsections if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p>d. It is the intent of the Legislature that tobacco settlement receipts appropriations made above in Goal C, CHIP Services, include \$324.4293.9 million for fiscal year 2012 2010 and \$334.2 302.6 million for fiscal year 2013 2014 in tobacco settlement receipts paid to the State pursuant to the Comprehensive Tobacco Settlement and Release. In the event that the state has not received a tobacco settlement payment for fiscal year 2012 2010 and fiscal year 2013 2014 by September 1 of each year of the biennium, the Comptroller of Public Accounts is hereby authorized to use general revenue funds as needed for program expenditures for cash flow purposes between the beginning of the fiscal year and the receipt by the state of the tobacco settlement payment for the fiscal year. Upon receipt of the tobacco settlement payment, the general revenue fund shall be reimbursed with tobacco settlement receipts for all expenditures made pursuant to this provision.</p> <p><i>Rider was updated for biennial date changes, estimated unexpended balance to be zero at the end of FY 2011, and FY2012-13 requested tobacco funding.</i></p>		
HHSC 22	II-91	<p>Temporary Assistance for Needy Families (TANF) Maintenance of Effort. It is the intent of the Legislature that all General Revenue appropriated above for TANF maintenance of effort shall be expended within the appropriate fiscal year</p>		

3.B. Rider Revisions and Additions Request

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		<p>for that purpose in order to secure the TANF federal block grant for the state. Out of funds appropriated above in Strategy D.1.1, TANF (Cash Assistance) Grants, \$62,851,931 in General Revenue is appropriated for TANF maintenance of effort for fiscal year 2012 2010, and \$62,851,931 in General Revenue is appropriated for TANF maintenance of effort for fiscal year 2013 2011. None of the General Revenue appropriated for TANF maintenance of effort in Strategy D.1.1, TANF (Cash Assistance) Grants, may be transferred to any other item of appropriation or expended for any purpose other than the specific purpose for which the funds are appropriated. However, General Revenue appropriated for TANF maintenance of effort may be transferred to Strategy A.1.2, Integrated Eligibility and Enrollment, subject to the following limitations:</p> <ul style="list-style-type: none"> a. Declines or shifts in TANF caseloads prevent the Health and Human Services Commission from expending all General Revenue appropriated for TANF maintenance of effort in Strategy D.1.1, TANF (Cash Assistance) Grants, within the appropriate fiscal year; b. The amount of TANF MOE General Revenue transferred from Strategy D.1.1, TANF Cash Assistance) Grants, shall be expended as TANF maintenance of effort within Strategy A.1.2, Integrated Eligibility and Enrollment, for TANF program operating costs, within the appropriate fiscal year; and c. At least 30 days prior to transferring General Revenue Funds between Strategy D.1.1, TANF (Cash Assistance) Grants, and Strategy A.1.2, Integrated Eligibility and Enrollment, the Health and Human Services Commission shall notify the Legislative Budget Board and the Governor. <p><i>Rider was updated for biennial date changes. There is an exceptional item relating to maintaining TANF current services but TANF MOE was not requested, only GR. Additional state funding could be designated as TANF MOE with adjustments at other state agencies.</i></p>		
HHSC 24	II-91	<p>Performance Reporting for the Prescription Drug Rebate Program. The Commission shall report on an annual basis the following information to the Legislative Budget Board, the State Auditor's Office and the Governor: the outstanding prescription drug rebate balances for the Medicaid, CHIP, Kidney Health, and Children with Special Health Care Needs programs. The report shall include rebate principal and interest outstanding, age of receivables, and annual collection rates. The reports shall specify amounts billed, dollar value of pricing and utilization adjustments, and dollars collected. The Commission shall report these data on each year for which the Prescription Drug Rebate program has collected rebates and also on a cumulative basis for all years.</p> <p><i>Rider should be deleted. The origin of the report required in the rider was a negative SAO audit finding in 2003. All</i></p>		

3.B. Rider Revisions and Additions Request

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		<p><i>issues identified from that audit have been addressed and were verified by SAO years ago. This annual report provides a lot of repeat information each year because it requires HHSC to report on the history of the Medicaid rebate program, which began in 1991. Both the text descriptions of the program and the year-by-year tables are mostly repeat information.</i></p>		
HHSC 25	II-92	<p>TANF (Cash Assistance) Grants. Out of funds appropriated above in Strategy D.1.1, TANF (Cash Assistance) Grants, the commission shall adjust the TANF grant amount each year to ensure that the maximum monthly grant for a family of three is at least 17 percent of the federal poverty level and provide a one-time per year grant of up to \$30 <u>\$23.49</u> for each TANF child on August 1 of each year.</p> <p><i>Rider is amended to reflect reduced grant amount based upon on funding limitations in the FY 2012-13 Base Request. Funding to restore TANF grant amounts are reflected in Exceptional Item #3 and an Exceptional Rider version is on page 40.</i></p>		
HHSC 26	II-92	<p>Texas Integrated Eligibility Redesign Systems (TIERS). To fund the debt related to TIERS, the commission may seek funding from the most cost-effective type of financing, including but not limited to cash acquisition, commercial financing, and financing provided by the Texas Public Finance Authority. From any funds appropriated to the Health and Human Services Commission for the purpose of implementing the project, an amount not to exceed \$5,682,018 <u>\$6,131,027</u> (amounts needed for Master Lease Purchase Program) for the biennium in All Funds may be transferred to the Texas Public Finance Authority for lease payments to the Texas Public Finance Authority to pay debt service on the obligations issued by the Texas Public Finance Authority on behalf of the commission for the above-mentioned project.</p> <p><i>Rider is updated for MLPP amount for the 2012-13 biennium.</i></p>		
HHSC 30	II-93	<p>Office for Prevention of Developmental Disabilities. The Health and Human Services Commission shall expend, from funds otherwise appropriated to the commission by this Act, an amount not to exceed \$111,805 each fiscal year for salaries, benefits, travel expenses, and other support of the Office for Prevention of Developmental Disabilities. However, grants and donations received through the authority provided by Article IX Sec. 8.01, Acceptance of Gifts of Money, are not subject to this limit and may be expended by the Office. <u>All grant funding unexpended at the end of the August 31, 2011 is hereby authorized for expenditure for the biennium beginning September 1, 2011.</u></p> <p><i>Rider is amended to address issues with the availability of grant funding at the conclusion of a biennium.</i></p>		

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HHSC 33	II-93	<p>Appropriation of Unexpended Balances – Master Lease Purchase Program (MLPP). Any unexpended balances of MLPP funds for the TIERS project from previous appropriations, estimated to be \$12,658,228, are hereby authorized for the Health and Human Services Commission. The commission shall provide to the Legislative Budget Board and the Governor a detailed description of the project and cost at least 45 days prior to the expenditure of such funds.</p> <p><i>Rider should be deleted as there are no remaining unexpended balances available for this purpose.</i></p>		
HHSC 37	II-94	<p>Unexpended Balance Authority for Eligibility Determination Services. Unexpended balances in General Revenue Funds appropriated in Strategy A.1.2, Integrated Eligibility and Enrollment, for the fiscal year ending August 31, <u>2012</u> 2010, are appropriated to the agency for the following fiscal year only upon prior written approval by the Legislative Budget Board and the Governor. For authorization to expend the funds, an agency shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request must be organized by fiscal year as follows:</p> <ul style="list-style-type: none"> a. The following information shall be provided for the fiscal year with an unexpended balance: <ul style="list-style-type: none"> (1) an explanation of the causes of the unexpended balance(s); (2) the amount of the unexpended balance(s) by strategy; and (3) the associated incremental change in service levels compared to performance targets in this Act for that fiscal year. b. The following information shall be provided for the fiscal year receiving the funds: <ul style="list-style-type: none"> (1) an explanation of purpose for which the unexpended balance(s) will be used and whether the expenditure will be one-time or ongoing; (2) the amount of the expenditure by strategy; (3) the incremental change in service levels compared to performance targets in this Act for that fiscal year; and (4) the capital budget impact. <p>The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of</p>		

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		<p>the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.</p> <p>The Comptroller of Public Accounts shall not allow the use of unexpended balances authorized by any of the above subsections if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p><i>Rider has been updated for biennial date changes.</i></p>		
HHSC 39	II-94	<p>Upper Payment Limit Reimbursement for Children's Hospitals. Out of the funds appropriated above in Strategy B.2.5, Upper Payment Limit, the Health and Human Services Commission shall use the amounts of \$12,500,000 in fiscal year 2012 2010 and \$12,500,000 in fiscal year 2013 2014 in General Revenue to provide upper payment limit reimbursement to children's hospitals (having a separate provider number). The Health and Human Services Commission shall implement Medicaid upper payment limit reimbursement to cover the actual costs incurred in providing Medicaid inpatient and outpatient services and Graduate Medical Education at children's hospitals. In the event that appropriations are insufficient to cover these Medicaid costs in all children's hospitals, the Health and Human Services Commission shall prioritize this Medicaid upper payment limit reimbursement to reduce the Medicaid losses in any children's hospital with a Medicaid patient load that exceeds 60 percent of the hospital's total inpatient days.</p> <p><i>The rider has updated for biennial date changes.</i></p>		
HHSC 40	II-95	<p>Hospital Uncompensated Care. No funds appropriated under this Article for medical assistance payments may be paid to a hospital if the Health and Human Services Commission determines that the hospital has not complied with the Commission's reporting requirements. The Commission shall ensure that the reporting of uncompensated care (defined to include bad debt, charity care and unreimbursed care) by Texas hospitals is consistent for all hospitals and subjected to a standard set of adjustments that account for payments to hospitals that are intended to reimburse uncompensated care. These adjustments are to be made in such a way that a reliable determination of the actual cost of uncompensated care in Texas is produced. In pursuing this objective, the commission, in coordination with the Attorney General, and with advice from representatives from the hospital industry, will:</p> <ul style="list-style-type: none"> a. review the current instruments for reporting uncompensated care by Texas hospitals to ensure that accounting for uncompensated care as well as its reporting is consistent across hospitals; b. coordinate the different instruments for reporting uncompensated care in Texas, e.g., Statement of Community Benefits, Annual Hospital Survey, and DSH Survey, so that there is consistency in reporting among these 		

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		<p style="text-align: center;">instruments while maintaining the integrity of each instrument's purpose;</p> <p style="text-align: center;">c. identify the sources of funding to hospitals that are intended to offset uncompensated care;</p> <p style="text-align: center;">d. develop a standard set of adjustments that apply the funding sources to reported uncompensated care in such a manner that a reliable determination of the actual cost to a hospital for uncompensated care can be made; and</p> <p style="text-align: center;">e. identify a standard ratio of cost to charges (RCC) to standardize the conversion of reported charges to costs.</p> <p>The commission shall conduct an appropriate number of audits to assure the accurate reporting of the cost of uncompensated hospital care.</p> <p>The commission shall submit a biennial report on uncompensated care costs, which considers the impact of patient specific and lump sum funding as offsets to uncompensated costs, to the Governor and Legislative Budget Board no later than December 1, <u>2012</u> 2010. The commission may report by hospital type.</p> <p><u>The commission shall also review the impact of health care reform efforts on the funding streams that reimburse uncompensated care, assess the need for those funding streams in future biennia, and consider which funds might be redirected to provide direct health coverage.</u></p> <p><i>Rider is updated for biennial dates and is amended to review the impact of health care reform. With the input of the hospital industry, HHSC has already adopted a methodology for the analysis of uncompensated care. This methodology converts charges to costs and considers offsetting revenue. HHSC will submit the first report in compliance with the current rider. While the state has and will improve its understanding of the impact of uncompensated care via this analysis, the nature of uncompensated care may dramatically change as health care reform is implemented. There is a continued need to assess previous uncompensated care impacts on hospitals and there is an equally important need to consider how health reform will impact available funding and the variable effect it may have by hospital type.</i></p>		
HHSC 41	II-95	<p>Hospital Reimbursement. Contingent upon federal approval, and to the extent allowed by law, no funds appropriated under this Article for the payment of inpatient hospital fees and charges under the medical assistance program may be expended, except under a prospective payment methodology for all Medicaid inpatient claims that employs sound cost reimbursement principles and:</p> <ul style="list-style-type: none"> a. enhances the Health and Human Services Commission's ability to be a prudent purchaser of health care; b. reflects costs that are allowable, reasonable and medically necessary to deliver health care services to the 		

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		<p>state's Medicaid population;</p> <ul style="list-style-type: none"> c. reduces the variability in the Medicaid reimbursement rates paid to hospitals for treating patients with the same diagnoses; d. promotes and rewards increased efficiency in the operation of hospitals; e. emphasizes and rewards quality of outcomes and improves the treatment of Medicaid patients through pay-for-performance principles; f. recognizes, through add-on payments or other methods, the unique needs of rural hospitals; <u>and</u> g. reformulates the Disproportionate Share Hospital (DSH) supplemental payment methodology to increase its focus on paying hospitals for uncompensated care and reduces the existence of the inpatient Medicaid shortfall that prevents the State from achieving this objective; and h. reimburses inpatient services in freestanding psychiatric facilities similar to the prospective payment system used by the Centers for Medicare and Medicaid Services. <p><i>Rider is revised to remove subsection h which has been implemented during the current biennium.</i></p>		
HHSC 42	II-96	<p>Payments to Health Centers for Medicaid Family Planning. It is the intent of the Legislature that the Health and Human Services Commission shall, to the extent allowed by federal law, reimburse Federally Qualified Health Centers for family planning services under Medicaid, including the Women's Health Program, using a prospective payment system at a per visit rate, not to exceed three payments during a calendar year.</p> <p><i>Rider should be deleted.</i></p>		
HHSC 43	II-96	<p>Payments to Hospital Providers. Until the Health and Human Services Commission implements a new reimbursement system for Fee-for-Service (FFS) and Primary Care Case Management (PCCM) inpatient services, hospitals that meet one of the following criteria: 1) located in a county with 50,000 or fewer persons, or 2) is a Medicare-designated Rural Referral Center (RRC) or Sole Community Hospital (SCH), that are not located in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget, or 3) is a Medicare-designated Critical Access Hospital (CAH), shall be reimbursed the greater of the prospective payment system rate or a cost-reimbursement methodology authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) using the most recent data. Hospitals reimbursed under TEFRA cost principles shall be paid without the imposition of the TEFRA cap. Hospitals that meet the criteria as of September 1, 2011 <u>2009</u>, retain this reimbursement for FFS and PCCM inpatient services.</p>		

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		<i>Rider was updated for biennial date changes.</i>							
HHSC 46	II-97	<p>Enterprise Data Warehouse. Out of funds appropriated above in Strategy A.2.1, Consolidated System Support, the Health and Human Services Commission (HHSC) may expend \$14,899,934 <u>\$4,212,954</u> in General Revenue and any associated matching Federal Funds to develop/implement an enterprise data warehouse for data related to Medicaid services, human services, and public health services. In order to ensure maximum accountability, HHSC shall contract with a single vendor for the data warehouse.</p> <p>HHSC shall submit reports to the Legislative Budget Board and the Governor on September 1, 2011 <u>2009</u> and September 1, 2012 <u>2010</u> reflecting actual expenditures and accomplishments to date. The reports shall also reflect an estimate of planned expenditures and accomplishments for the remainder of the 2012-13 <u>2010-11</u> biennium.</p> <p><i>Rider has been updated for biennial date changes and funding in the 2012-13 base request.</i></p>							
HHSC 47	II-97	<p>Healthy Marriage Development Program. Out of funds appropriated above in Strategy A.1.2, Integrated Eligibility and Enrollment, the Health and Human Services Commission shall devote \$8,435,044 in All Funds, including <u>\$6,130,942</u> 6,181,722 in General Revenue Funds and <u>\$1,710,522</u> 415,544 in TANF Federal Funds for the biennium to a Healthy Marriage Development Program and similar activities that strengthen families.</p> <p><i>This rider is revised to reflect funding requested for the Healthy Marriage Program in the FY 2012-13 Base Request.</i></p>							
HHSC 48	II-97	<p>Physician-administered Biologics and Drugs. To the extent compatible with state and federal law, drugs and biological products are deemed covered benefits of Medicaid if those products are approved for sale by the U.S. Food and Drug Administration and satisfy the criteria of the Omnibus Budget Reconciliation Act of 1990 and the Deficit Reduction Act of 2005. The manufacturers of drugs and biological products which are deemed covered benefits under Medicaid shall obtain a unique HCPCS code of C, Q, or J and a National Drug Code that will enable the state Medicaid office to track the product for the purpose of receiving Medicaid rebates.</p> <p>HHSC shall develop and make available a process to analyze new, "first-in-class," physician-administered drugs and biological products for the purpose of issuing a Medicaid coverage report or opinion.</p> <p>For new physician-administered drugs and biological products slated for inclusion in an existing class covered by Medicaid, HHSC shall develop and make available an expedited process to analyze fiscal impact and incremental cost</p>							

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		<p>over current drug treatment and therapy.</p> <p>HHSC shall develop and make available a process for approving new FDA-approved indications of physician-administered drugs and biological products covered by Medicaid.</p> <p>HHSC may apply any reasonable administrative measures, including medical policy development and utilization controls that it deems prudent as the conditions of coverage that apply to each physician-administered drug or biological product.</p> <p><i>Rider should be deleted as the requirements have been implemented.</i></p>							
HHSC 49	II-97	<p>Medicaid Drug Utilization Review Program. Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall develop and submit a report on strategies implemented by the agency after the effective date of this Act to strengthen the Texas Medicaid Drug Utilization Review Program to the Legislative Budget Board and the Governor by December 1, 2009 and provide a follow-up report on December 1, 2010. Each report should include savings realized during the previous fiscal year and anticipated savings for the following fiscal year.</p> <p><i>This rider should be deleted. The required report was submitted in December 2009 and the follow-up report will be submitted in December 2010.</i></p>							
HHSC 50	II-97	<p>Behavioral Health Service Delivery in STAR and STAR+PLUS. Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall develop and submit a report on strategies implemented by the agency after the effective date of this Act to improve the transparency and accountability of behavioral health service delivery in STAR and STAR+PLUS Medicaid HMOs to the Legislative Budget Board and the Governor by September 1, 2010.</p> <p><i>This rider should be deleted as the required report will be submitted in September 2010.</i></p>							
HHSC 51	II-97	<p>Vendor Drug Program E-prescribing Plan. Out of funds appropriated above in Goal B, Medicaid, the Health and Human Services Commission shall develop an E-prescribing implementation plan, including relevant timeframes and projected expenditures and cost savings per fiscal year, to improve patient safety and to standardize electronic prescribing systems in the state's Vendor Drug Program for the Medicaid and Children's Health Insurance Programs and submit the plan to the Legislative Budget Board and the Governor by January 1, 2010. The Health and Human Services Commission shall also submit a progress report on the E-prescribing implementation plan, including any projected expenditures and cost savings per fiscal year, to the Legislative Budget Board and the Governor by January 1, 2011.</p> <p><i>This rider should be deleted. The required plant was submitted in January 2010 and the progress report will be submitted</i></p>							

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		<i>January 2011.</i>							
HHSC 52	II-98	<p>SAVERR to TIERS. Out of funds appropriated above in Strategy F.1.1, TIERS & Eligibility Supporting Technologies, the Health and Human Services Commission will convert all the remaining SAVERR cases into the TIERS system, contingent upon receipt of required approval by federal funding partners, no later than August 31, 2011.</p> <p><i>This rider should be deleted, conversion of SAVERR cases is scheduled for completion by December 2011.</i></p>							
HHSC 53	II-98	<p>Appropriations Related to Frew Strategic Initiatives. General Revenue appropriated above in Goal B, Medicaid, for Frew strategic initiatives is contingent on an unexpended balance from fiscal year 2009. The amount of appropriation is limited to the amount of the unexpended balance. Unexpended balances in General Revenue Funds appropriated to the Health and Human Services Commission for Frew strategic initiatives for the fiscal year ending August 31, 2009 (estimated to be \$113,000,000) are appropriated to the agency for the fiscal biennium beginning September 1, 2009. This unexpended balance is the remainder of the one-time appropriation of \$150,000,000 in General Revenue Funds that was appropriated for Strategic Initiatives for the 2008-09 biennium by the Eightieth Legislature.</p> <p><i>Rider should be deleted as there is no remaining \$150 million of the Frew Strategic Initiative funding from the 2008-09 biennium requested in the 2012-13 base Request.</i></p>							
HHSC 54	II-98	<p>Medicaid Substance Abuse Treatment.7 Contingent on passage of Senate Bill 796, or similar legislation relating to substance abuse treatment for adult Medicaid clients, the Health and Human Services Commission shall use funds appropriated above in Goal B, Medicaid, to provide coverage for comprehensive substance abuse treatment services for adult Medicaid clients.</p> <p><i>Rider should be deleted. Although Senate Bill 796 did not pass, Article IX, § 17.15 Medicaid Substance Abuse Treatment, directs HHSC to implement provisions of the legislation. The expanded services were implemented January 1, 2010.</i></p>							
HHSC 55	II-98	<p>Medical Transportation. To the extent allowed by federal and state law, a portion Out of the funds appropriated above to Strategy B.2.3, Medical Transportation, the Health and Human Services Commission is authorized shall be used to implement a expand the regionalized full-risk brokerage model upon a determination that the brokerage model is cost-effective, which utilizes a pre-payment methodology (capitation) to reimburse the broker or brokers. This program will be for all Medicaid non-emergency transportation under the Medical Transportation program in areas of the state that the</p>							

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		<p>Commission finds can sustain a regionalized model. To implement this change, the Commission shall apply to the Centers for Medicare and Medicaid Services for a state plan amendment as provided for in the Social Security Act, Section 1902(a)(70), and in accordance with Federal Regulations 42 CFR 440.170(a)(4).</p> <p><i>Rider is amended to allow expansion of transportation brokerage model should the model be determined to be cost-effective.</i></p>		
HHSC 57	II-98	<p>Local Reporting on UPL, and DSH and Indigent Care Expenditures. Out of funds appropriated above, and as the state Medicaid operating agency, the Health and Human Services Commission shall develop a report that non-state public hospitals, <u>and</u> private hospitals, hospital districts, physicians and private administrators shall use to describe any expenditures they make through the Upper Payment Limit (UPL) program <u>and</u>, the Disproportionate Share Hospital (DSH) program, and the Indigent Care program. The commission shall determine the format of the report, which must include expenditures by method of finance per year. In addition, the commission annually shall require contracted hospital providers <u>who receive UPL or UPL funds</u> to report payments to entities who provide consultative services regarding revenue maximization under the medical assistance program and any other governmentally funded program, including UPL and DSH. Information included in the reports of payments to entities providing consultative services from contracted hospitals shall include:</p> <ol style="list-style-type: none"> a. the total amount of aggregated payments to all such entities by county; b. the purpose of the payment(s); c. the source of the payment(s); d. the program for which consultative services were provided; and e. any other information the commission believes pertinent. <p><i>Rider should be amended to report on UPL and DSH expenditures.</i></p>		
HHSC 58	II-99	<p>Umbilical Cord Blood Bank Funding. Out of funds appropriated above in Strategy A.1.1, Enterprise Oversight and Policy, the Health and Human Services Commission shall use \$5,000,000 in General Revenue for the biennium for research and an unrelated donor umbilical cord blood bank, as follows:</p> <ol style="list-style-type: none"> a. The Health and Human Services Commission shall enter into a contract with a public cord blood bank in Texas for \$4,000,000 for the gathering and retention of umbilical cord blood from live births at its unrelated cord blood bank for the primary purpose of making the umbilical cord blood available for transplant 		

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		<p>purposes. The blood bank must be accredited by the American Association of Blood Banks and the International Organization of Standardization. Any unexpended balances of these funds remaining as of August 31, 2012 2010, are appropriated to the Health and Human Services Commission for the fiscal year beginning September 1, 2012 2010, for the same purposes.</p> <p>b. The Health and Human Services Commission shall enter into a contract with a Texas academic health institution for \$1,000,000 for the primary purpose of research leading to new cures derived by the usage of stem cells from umbilical cord blood. Such funds shall be used only for research from stem cells obtained from umbilical cord blood from a live birth. Any unexpended balances of these funds remaining as of August 31, 2012 2010, are appropriated to the Health and Human Services Commission for the fiscal year beginning September 1, 2012 2010, for the same purposes.</p> <p><i>Rider was updated for biennial dates.</i></p>		
HHSC 59	II-99	<p>Medicaid Cost Savings. The appropriations made above to the Health and Human Services Commission assume savings estimated to be \$107.1 million in General Revenue Funds. The Health and Human Services Commission should consider the following cost savings initiatives in order to achieve these savings:</p> <ul style="list-style-type: none"> a. Managed Care b. efforts to increase provider participation in managed care networks; and c. efforts to achieve additional HMO savings; savings amount may include experience rebates. d. Medical Transportation: expand use of broker model. e. Ultra Sound Utilization Project: limit use based on practice guidelines. f. Managed Care for Disabled Children: improve coordination of acute care for existing recipients. g. Market Rating of Managed Care Plans: phase-in market rating that considers the acuity of clients served and whether the hospital is TEFRA reimbursed. h. Third party Sources: efforts to increase third party sources of payment for Medicaid payments and Medicaid recipients. i. Additional Initiatives Identified by the Health and Human Services Commission. <p>The Commission shall provide a report explaining estimated cost savings measure to be utilized and estimating the</p>		

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		<p>savings in General Revenue and All Funds to be achieved during the biennium, including any additional initiatives identified by the Executive Commissioner during the biennium to achieve the targeted savings. The report shall be submitted to the Legislative Budget Board and the Governor by July 1, 2010 prior to implementing any of the saving measures.</p> <p><i>Rider should be deleted as the savings pertain to the 2010-11 biennium and should be achieved.</i></p>		
HHSC 61	II-99	<p>Office of Eligibility Services Staffing. It is the intent of the Legislature that the Executive Commissioner shall ensure that the agency will fill and maintain eligibility staffing at a level necessary to maintain a reasonable workload designed to meet required federal timeliness and reduce error rates.</p> <p style="margin-left: 40px;">a. The Health and Human Services Commission is authorized to maintain staffing, supporting technology and indirect costs at the fiscal year 2009 budgeted level of 9,039 full-time equivalents (FTEs). In determining the need for additional funding, the Commission shall take into account increases in contractor costs and supporting technology to be paid from amounts appropriated in Strategy A.1.2, Integrated Eligibility and Enrollment. Upon a determination that the amounts remaining in Strategy A.1.2 are insufficient to maintain the staffing level of 9,039 FTEs, the Health and Human Services Commission is hereby authorized to transfer from General Revenue appropriations made in Goal B, Medicaid to Strategy A.1.2, Integrated Eligibility and Enrollment, an amount not to exceed \$55 million for the biennium. The Commission shall notify the Governor, the Legislative Budget Board, and the Comptroller 15 days prior to any proposed funding transfer.</p> <p style="margin-left: 40px;">b. The Commission may request to increase its cap by up to 656 FTEs in fiscal year 2010 and up to 822 FTEs in fiscal year 2011 for anticipated workload and caseload growth. Upon a determination that funding in Strategy A.1.2 is insufficient to maintain the costs associated with staffing levels, contractors, supporting technology or any other related costs, the Executive Commissioner may request to transfer from General Revenue appropriations made in Goal B, Medicaid to Strategy A.1.2, Integrated Eligibility and Enrollment, amounts necessary to maintain the support of up to 9,695 FTEs in fiscal year 2010 and up to 9,861 FTEs in fiscal year 2011.</p> <p>Commission shall request approval from the Governor, the Legislative Budget Board, and the Comptroller at least 30 days prior to any proposed funding transfer. The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the</p>		

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		<p>Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.</p> <p><i>Rider should be deleted as it pertains to funding in the 2010-11 biennium.</i></p>							
HHSC 62	II-100	<p>The Respiratory Syncytial Virus. Out of funds appropriated above, the Health and Human Services Medicaid Vendor Drug Program shall implement a pharmacy payment based on the state's reimbursement methodology approved by the Centers for Medicare and Medicaid (CMS) as of August 31, 2007, minus five percent, for drugs used for the prevention of Respiratory Syncytial Virus in newborns. Prior authorization criteria must be met. In order to ensure full access to Respiratory Syncytial Virus prophylaxis, the Health and Human Service Commission shall ensure that providers are informed of the availability of a variety of specialty pharmacies dispensing Respiratory Syncytial Virus prophylaxis.</p> <p><i>Rider should be deleted. Strict application of the rider resulted in reimbursement rates being below pharmacy costs for the product and potential access issues. HHSC policy already allows the Vendor Drug Program to use a payment amount that is lower than under its standard methodology.</i></p>							
HHSC 64	II-100	<p>Women's Health Services Demonstration Project: Savings and Performance Reporting. It is the intent of the Legislature that the Health and Human Services Commission submit an annual report to the Legislative Budget Board and the Governor that includes the following information:</p> <ul style="list-style-type: none"> a. enrollment levels of targeted low-income women, including service utilization by geographic region, delivery system, and age; b. savings or expenditures attributable to enrollment levels as reported in section (a) and; c. descriptions of all outreach activities undertaken for the reporting period. <p><i>Rider should be deleted as the waiver will expire and another waiver will be requested. Required federal reporting could be provided as requested to reduce additional reporting requirements.</i></p>							
HHSC65	II-100	<p>In-patient Psychiatric Services. The Health and Human Services Commission shall analyze the benefit to the state of modification of the Intensive Psychiatric Treatment Program and establishment of a program for the provision of Medicaid inpatient psychiatric services in Psychiatric Residential Treatment Facilities for child and adolescent Medicaid beneficiaries (as defined in Section 483.354 of the Code of Federal Regulations, Title 42). Contingent upon findings that a</p>							

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		<p>Medicaid state plan amendment is cost effective, the Health and Human Services Commission shall seek approval of this amendment and make necessary regulatory changes.</p> <p><i>Rider should be deleted as the study will be complete by January 2011.</i></p>							
HHSC 66	II-101	<p>Study Regarding the Need for Community Support and Residential Services for Individuals Suffering from Acquired Brain Injury.</p> <p>a. It is the intent of the legislature that, out of General Revenue funds appropriated above, the executive commissioner of the Health and Human Services Commission conduct a study, not later than September 1, 2010, regarding the need for a system of community support and residential services for individuals suffering from acquired brain injury. The study must, at a minimum:</p> <ul style="list-style-type: none"> (1) evaluate current services and supports provided by the state to persons suffering from acquired brain injury; (2) assess the need in this state for community support and residential services to persons suffering from acquired brain injury; (3) ascertain opportunities available to this state to draw down federal funds for individuals with acquired brain injury for whom the state currently provides services and supports through general revenue funds; and (4) determine the feasibility and cost effectiveness of implementing a system of community support and residential services through either a Medicaid state plan amendment or medical assistance waiver for persons with acquired brain injury. <p>b. The executive commissioner of the Health and Human Services Commission shall submit the results of the study described above to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and the chairs of the Senate Committee on Health and Human Services and the House Committee on Public Health.</p> <p><i>Rider should be deleted as the study and the report will be completed this biennium.</i></p>							
HHSC 67	II-101	<p>Fiscal Accountability for Programs for Persons with Intellectual or Developmental Disabilities. Contingent upon the implementation of a rate enhancement system or other appropriate financial performance standards for programs for persons with intellectual or developmental disabilities to ensure prudent use of funding appropriated by this Act, the</p>							

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Base
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language		
		<p>Health and Human Services Commission is authorized to discontinue fiscal accountability spending requirements. If, before implementing this provision, the Commission determines that a waiver or authorization from a federal agency is necessary for implementation, the commission shall request the waiver or authorization and may delay implementing this provision until the waiver or authorization is granted.</p> <p><i>Rider should be deleted because a rate enhancement system is being implemented with CMS approval effective September 1, 2010.</i></p>		
HHSC 69	II-102	<p>Hemophilia Reimbursement Rates. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS), the Health and Human Services Commission (HHSC) shall amend the reimbursement methodology provided under the Vendor Drug Program for blood factor products by adding a \$0.05 furnishing fee to each unit of factor reimbursed in a prescription claim. The furnishing fee will be added to the existing dispensing fee methodology.</p> <p><i>Rider should be deleted. The state plan amendment has been submitted to CMS. No decision has been made at this time but either the amendment will be implemented or not during the current biennium based upon the CMS decision.</i></p>		
HHSC 70	II-102	<p>Healthy Marriage Program: Performance Report. Out of funds appropriated above in Strategy A.1.2, Integrated Eligibility and Enrollment, for the Healthy Marriage Program, the Health and Human Services Commission (HHSC) shall provide an annual report to the Legislative Budget Board, Governor, Senate Finance Committee, House Appropriations Committee, Senate Health and Human Services Committee, and House Human Services Committee that includes the following data elements for the past fiscal year:</p> <ul style="list-style-type: none"> a. unduplicated number of couples who received services; b. unduplicated number of couples who requested services, but did not receive them; c. amount of expenditures on direct care, broken out by type of service; d. amount of expenditures not related to direct care, broken out by category. <p>The report shall be submitted October 15 of each year of the biennium in a format specified by the Legislative Budget Board.</p> <p><i>Rider should be deleted. Program has been in place for two biennia.</i></p>		
NEW	NEW	<p><u>Full-time Equivalent Positions (FTE) %Local and Federal Funds.</u></p>		

3.B. Rider Revisions and Additions Request

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		<p>a. <u>Only local funds (appropriated receipts) and federal funds may be used to pay salaries and benefits for Full-time Equivalent Positions (FTE)–Local and Federal Funds, identified as local/federal out-stationed workers. The Health and Human Services Commission may utilize the FTE authority contained in the Number of Full-time Equivalent Positions (FTE)–Local and Federal Funds only to the extent that local and federal funds are readily available. Under no circumstances may unfilled FTE positions from the Number of Full-time Equivalent Positions (FTE)–Local and Federal Funds be transferred to the Number of Full-time Equivalent Positions (FTE)–State and Federal Funds.</u></p> <p>b. <u>The Health and Human Services Commission is authorized to increase the level of Full-time Equivalent Positions (FTE)%Local and Federal Funds upon a written notification to the Legislative Budget Board and the Governor at least 30 days prior to adjusting budgeted FTE levels hat includes the following information:</u></p> <ul style="list-style-type: none"> (1) <u>Number of FTEs</u> (2) <u>Location and Name of Host Facility, and</u> (3) <u>Estimated Annual Cost of the FTE Increase.</u> <p><i>Requested new rider would require an additional entry for the number of Agency FTEs who are out- stationed eligibility workers in hospitals and clinics and subtracted from the total agency FTE cap. The host facility provides the local funds as the state match for federal funds to HHSC. HHSC has approximately 503 out-stationed workers whose salaries and benefits are paid under contract by the host facility (nursing home, hospital, clinic, etc.). The positions are provided at the request of the facility and otherwise would not be requested by HHSC. Facilities realize a return on the investment because these patients otherwise go uninsured. Additionally, the inclusion of these FTEs in the HHSC agency FTE total may misrepresent the workforce and revenue needed for eligibility services. The new rider also provides a mechanism to respond to requests for additional out-stationed workers from these host facilities. The legacy Department of Human Services had a similar rider.</i></p>		
NEW	NEW	<p><u>All-Patient Refined –Diagnosis Related Payment Reimbursement.</u> The Health and Human Services Commission shall adopt rules and implement the All Patient Refined – Diagnosis Related Grouping (APR-DRG) payment methodology for all hospitals participating in the medical assistance program. The Commission shall implement the APR-DRG reimbursement methodology in a phased approach beginning with all acute care hospitals that are currently reimbursed under the Medicare Severity-Diagnosis Related Group (MS-DRG) methodology no later than September 1, 2012. The Commission shall evaluate whether to apply a full rebasing APR-DRG methodology to Tax Equity and Fiscal</p>		

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Base
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language		
		<p><u>Responsibility Act (TEFRA) and state-owned teaching facilities and will initiate implementation of these if they are determined to be feasible no later than September 1, 2013.</u></p> <p><i>This new rider would provide legislative intent for the transition from the current MS-DRG program to the APR-DRG program. This change in the DGR program would allow HHSC to more accurately compute a representative payment for inpatient hospital stays.</i></p>		
Article XII Section 22	XII-12	<p>Temporary Assistance for Needy Families Emergency Contingency Funding. Notwithstanding Rider 25 in the General Appropriations Act, Article II, Health and Human Services Commission (Conference Committee Report on Senate Bill No. 1, 84 Legislature, Regular Session), the Health and Human Services Commission may use Temporary Assistance for Needy Families (TANF) Emergency Contingency Funds received under the federal American Recovery and Reinvestment Act (ARRA) of 2009 to fund up to an additional \$75 for each TANF child for one-time grants (for a total of up to \$105 for each TANF child) in August 2010 in an effort to maximize federal ARRA funding to the state. Any additional ARRA TANF Emergency Contingency Funds that become available are hereby appropriated for the biennium beginning September 1, 2009 for the purpose of refinancing expenditures that have been made from regular TANF federal block grant funds and increasing the TANF reserves balance. The refinancing is expected to yield an estimated increase in the TANF reserves balance of \$3,100,000 by August 2011.</p> <p><i>Rider should be deleted as it pertains to FY 2010-11 ARRA funding.</i></p>		

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Exceptional																																																																																
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HHSC 1	I-82	<p>Performance Measure Targets. The following is a listing of the key performance target levels for the Health and Human Services Commission. It is the intent of the Legislature that appropriations made by this Act be utilized in the most efficient and effective manner possible to achieve the intended mission of the Health and Human Services Commission. In order to achieve the objectives and service standards established by this Act, the Health and Human Services Commission shall make every effort to attain the following designated key performance target levels associated with each item of appropriation.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="text-align: center;"><u>2010</u></th> <th style="text-align: center;"><u>2011</u></th> <th style="text-align: center;"><u>2012</u></th> <th style="text-align: center;"><u>2013</u></th> </tr> </thead> <tbody> <tr> <td colspan="5">A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY</td> </tr> <tr> <td colspan="5">Outcome (Results/Impact):</td> </tr> <tr> <td>Average Medicaid and CHIP Children Recipient Months Per Month</td> <td style="text-align: right;">2,677,484</td> <td style="text-align: right;">2,720,740</td> <td style="text-align: right;">3,681,419</td> <td style="text-align: right;">3,778,234</td> </tr> <tr> <td colspan="5">Output (Volume):</td> </tr> <tr> <td>Average Monthly Number of Eligibility Determinations:</td> <td style="text-align: right;">513,226</td> <td style="text-align: right;">522,397</td> <td style="text-align: right;">890,000</td> <td style="text-align: right;">940,000</td> </tr> <tr> <td colspan="5">Efficiencies:</td> </tr> <tr> <td>Average Cost Per Eligibility Determination</td> <td style="text-align: right;">56.93</td> <td style="text-align: right;">57.24</td> <td style="text-align: right;">48.22</td> <td style="text-align: right;">47.12</td> </tr> <tr> <td colspan="5">Explanatory:</td> </tr> <tr> <td>Percent of Poverty Met by TANF, Food Stamps, and Medicaid Benefits</td> <td style="text-align: right;">76.9%</td> <td style="text-align: right;">76.62%</td> <td style="text-align: right;">87.61%</td> <td style="text-align: right;">87.59%</td> </tr> <tr> <td>Total Value of Food Stamps Distributed</td> <td style="text-align: right;">2,710,000,000</td> <td style="text-align: right;">2,716,000,000</td> <td style="text-align: right;">5,561.00</td> <td style="text-align: right;">5,573.00</td> </tr> <tr> <td colspan="5">B. Goal: MEDICAID</td> </tr> <tr> <td colspan="5">Outcome (Results/Impact):</td> </tr> <tr> <td>Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month</td> <td style="text-align: right;">3,105,445</td> <td style="text-align: right;">3,168,320</td> <td style="text-align: right;">3,884,105</td> <td style="text-align: right;">3,986,810</td> </tr> <tr> <td colspan="5">B.1.4. Strategy: CHILDREN & MEDICALLY NEEDY</td> </tr> <tr> <td colspan="5">Output (Volume):</td> </tr> </tbody> </table>				<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	A. Goal: HHS ENTERPRISE OVERSIGHT & POLICY					Outcome (Results/Impact):					Average Medicaid and CHIP Children Recipient Months Per Month	2,677,484	2,720,740	3,681,419	3,778,234	Output (Volume):					Average Monthly Number of Eligibility Determinations:	513,226	522,397	890,000	940,000	Efficiencies:					Average Cost Per Eligibility Determination	56.93	57.24	48.22	47.12	Explanatory:					Percent of Poverty Met by TANF, Food Stamps, and Medicaid Benefits	76.9%	76.62%	87.61%	87.59%	Total Value of Food Stamps Distributed	2,710,000,000	2,716,000,000	5,561.00	5,573.00	B. Goal: MEDICAID					Outcome (Results/Impact):					Average Medicaid Acute Care (Includes STAR+PLUS) Recipient Months Per Month	3,105,445	3,168,320	3,884,105	3,986,810	B.1.4. Strategy: CHILDREN & MEDICALLY NEEDY					Output (Volume):				
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3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Exceptional		
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language				
		Average Number of Legal Permanent Resident Recipient Months per Month	29,323	47,166	<u>83,812</u>	<u>84,581</u>
		B.1.5. Strategy: MEDICARE PAYMENTS				
		Output (Volume):				
		Average Supplemental Medical Insurance Part B (SMIB) Recipient Months Per Month	536,425	551,479	<u>567,180</u>	<u>593,232</u>
		Efficiencies:				
		Average Supplemental Medical Insurance Benefits (SMIB) Premium Per Month	100.33	106.03	<u>127.82</u>	<u>139.33</u>
		B.1.6. Strategy: STAR+PLUS (INTEGRATED MANAGED CARE)				
		Output (Volume):				
		Average Aged and Medicare-eligible Recipient Months Per Month: STAR+PLUS	86,982	88,595	<u>154,046</u>	<u>179,724</u>
		Average Disabled and Blind Recipient Months Per Month: STAR+PLUS	78,250	81,594	<u>142,265</u>	<u>161,500</u>
		B.2.1. Strategy: COST REIMBURSED SERVICES				
		Output (Volume):				
		Average Number of Non-citizens Recipient Months Per Month	9,529	9,756	<u>10,951</u>	<u>11,463</u>
		B.2.2. Strategy: MEDICAID VENDOR DRUG PROGRAM				
		Output (Volume):				
		Total Medicaid Prescriptions Incurred	28,738,444	29,365,160	<u>14,279,559</u>	<u>10,056,766</u>
		B.3.3. Strategy: EPSDT COMPREHENSIVE CARE PROGRAM				
		Output (Volume):				
		Average Number of Texas Health Steps (EPSDT) Comprehensive Care Program Recipient Month per Month				

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Exceptional		
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language				
		(Fee-for-Service Only)	508,835	517,292	<u>681,969</u>	<u>701,558</u>
		B.4.1. Strategy: STATE MEDICAID OFFICE				
		Output (Volume):				
		Medicaid Acute Care Recipient Months Per Month:				
		Managed Care	2,178,617	2,207,410	<u>2,864,571</u>	<u>2,972,917</u>
		C. Goal: CHIP SERVICES				
		Outcome (Results/Impact):				
		Average CHIP Programs Recipient Months Per Month (Includes all CHIP Programs)	530,504	537,742	<u>593,836</u>	<u>611,418</u>
		Average CHIP Programs Benefit Cost with Prescription Benefit Per Recipient Month (Includes all CHIP Programs)	152.53	153.34	<u>163.35</u>	<u>169.59</u>
		C.1.4. Strategy: CHIP PERINATAL SERVICES				
		Output (Volume):				
		Average Perinate Recipient Months Per Month	70,017	73,399	<u>38,869</u>	<u>39,802</u>
		C.1.5. Strategy: CHIP VENDOR DRUG PROGRAM				
		Output (Volume):				
		Total Number of CHIP Prescriptions (Includes all CHIP Programs)	1,966,138	1,982,616	<u>2,419,528</u>	<u>2,521,949</u>
		Efficiencies:				
		Average Cost Per CHIP Prescription (Includes all CHIP Programs)	62.98	62.98	<u>69.63</u>	<u>73.26</u>
		D. Goal: ENCOURAGE SELF SUFFICIENCY				
		D.1.1. Strategy: TANF (CASH ASSISTANCE) GRANTS				
		Output (Volume):				

3.B. Rider Revisions and Additions Request

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		Average Number of TANF Recipients Per Month	405,273	405,273	<u>126,491</u>	<u>129,621</u>
		Average Number of State Two-Parent Cash Assistance Program Recipients Per Month	4,424	4,589	<u>6,719</u>	<u>6,886</u>
		Efficiencies:				
		Average Monthly Grant: Temporary Assistance for Needy Families (TANF)	68.45	69.42	<u>74.96</u>	<u>77.49</u>
		Average Monthly Grant: State Two-Parent Cash Assistance Program	66.54	67.45	<u>71.50</u>	<u>73.89</u>
		D.1.2. Strategy: REFUGEE ASSISTANCE				
		Output (Volume):				
		Number of Refugees Receiving Contracted Social Services, Financial Assistance, or Medical Assistance	7,800	7,800	<u>15,000</u>	<u>15,000</u>
		D.2.1. Strategy: FAMILY VIOLENCE SERVICES				
		Output (Volume):				
		Number of Persons Women and Children Served by Family Violence Programs/Shelters	80,942	80,942	<u>83,250</u>	<u>83,250</u>
		Efficiencies:				
		Health and Human Services Average Cost Per Person Receiving Emergency Shelter and/or Nonresident Services through the Family Violence Program	284.36	284.36	<u>811.10</u>	<u>865.18</u>
		D.2.2. Strategy: ALTERNATIVES TO ABORTION				
		Output (Volume):				
		Number of Persons Receiving Pregnancy Support Services as an Alternative to Abortion	16,000	16,000	<u>14,400</u>	<u>14,400</u>
		<i>Rider performance measures have been updated for exceptional item requests performance for FY 2012-13.</i>				

3.B. Rider Revisions and Additions Request

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HHSC 2	II-83	<p>Capital Budget. None of the funds appropriated above may be expended for capital budget items except as listed below. The amounts shown below shall be expended only for the purposes shown and are not available for expenditure for other purposes. Amounts appropriated above and identified in the provision as appropriations either for "Lease Payments to the Master Equipment Purchase Program" or for items with an "(MLPP)" notation shall be expended only for the purpose of making lease-purchase payments to the Texas Public Finance Authority pursuant to the provisions of Government Code § 1232.103.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="text-align: right; width: 10%;"><u>2010</u></th> <th style="text-align: right; width: 10%;"><u>2011</u></th> <th style="text-align: right; width: 10%;"><u>2012</u></th> <th style="text-align: right; width: 10%;"><u>2013</u></th> </tr> </thead> <tbody> <tr> <td colspan="5">a. <u>Repairs or Rehabilitation</u></td> </tr> <tr> <td>(1) <u>Security Improvements – Winters Data Center</u></td> <td></td> <td></td> <td style="text-align: right;">\$ 3,375,000</td> <td style="text-align: right;">\$ 1,125,000</td> </tr> <tr> <td 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(1) <u>Security Improvements – Winters Data Center</u>			\$ 3,375,000	\$ 1,125,000																																																																																					
ab. <u>Acquisition of Information Resource Technologies</u>																																																																																									
(1) <u>Data Center Consolidation</u>	\$ 51,574,463	\$ 39,307,855	44,995,394	33,108,044																																																																																					
(2) <u>Seat Management Services (PCs, Laptops, & Servers)</u>	9,325,574	9,321,168	12,611,668	13,081,871																																																																																					
(3) <u>Compliance with Federal HIPAA (Health Insurance Portability and Accountability Act) Regulations</u>	4,036,000	2,535,430	4,635,366																																																																																						
(4) <u>Enterprise Messaging and Collaboration</u>	406,575	406,575																																																																																							
<u>Enterprise Telecom Managed Services</u>			12,903,159	13,129,801																																																																																					
(5) <u>Enterprise Telecommunications Enhancements</u>	-3,163,705	0																																																																																							
(5) <u>Enterprise Info & Asset Mgt (Data Warehouse)</u>	12,228,522	12,228,522	11,906,354	12,095,609																																																																																					
(6) <u>Integrated Eligibility Technologies (TIERS)</u>	56,499,724	45,806,946	68,426,440	53,294,645																																																																																					
(7) <u>Medicaid Eligibility and Health Information</u>	12,838,075	6,366,442	7,558,449	7,175,391																																																																																					
(8) <u>Enhance Supports of State Facilities</u>			10,641,500	1,763,950																																																																																					
(9) <u>HHS Security Improvements</u>			5,375,924	6,175,167																																																																																					
(10) <u>MEPD Asset Verification System</u>			3,000,000																																																																																						
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3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Exceptional		
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language				
		Technologies	\$ 156,016,175	\$ 119,525,895	<u>\$ 182,054,254</u>	<u>\$ 139,824,478</u>
		b. Acquisition of Capital Equipment and Items				
		(1) Facility Support Services – Fleet Operations	\$ 585,250	\$ 0	<u>202,295</u>	<u>165,503</u>
		c. Other Lease Payments to the Master Lease Purchase Program (MLPP)				
		(1) TIERS Lease Payments to Master Lease Program	\$ 3,164,354	\$ 2,966,676	<u>2,846,905</u>	<u>2,835,113</u>
		Total, Capital Budget	<u>\$ 159,765,776</u>	<u>\$ 122,492,571</u>	<u>\$ 188,478,454</u>	<u>\$ 143,950,094</u>
		Method of Financing (Capital Budget):				
		<u>General Revenue Fund</u>				
		GR Match for Medicaid	\$ 31,464,624	\$ 24,486,817	<u>\$ 33,086,023</u>	<u>\$ 26,205,349</u>
		GR Match for Title XXI (CHIP)	4,483,753	4,297,982	<u>1,445,792</u>	<u>1,128,115</u>
		GR Match for Food Stamp Administration	19,422,184	16,998,334	<u>27,898,253</u>	<u>21,768,768</u>
		General Revenue Fund	18,016,270	14,954,016	<u>4,261,810</u>	<u>4,068,569</u>
		Subtotal, General Revenue Fund	<u>\$ 70,386,834</u>	<u>\$ 57,737,146</u>	<u>\$ 66,691,878</u>	<u>\$ 53,170,801</u>
		Federal Funds	70,120,942	58,155,650	<u>85,490,626</u>	<u>65,186,097</u>
		Interagency Contracts	6,599,775	6,599,775	<u>36,295,950</u>	<u>25,593,196</u>
		Bond Proceeds – Revenue Bonds	12,658,228	0		
		Subtotal, Other Funds	<u>\$ 19,258,003</u>	<u>\$ 6,599,775</u>		
		Total, Method of Financing	<u>\$ 159,765,776</u>	<u>\$ 122,492,571</u>	<u>\$ 188,478,454</u>	<u>\$ 143,950,094</u>
		<i>Capital Budget Rider is updated to reflect capital projects in the FY 2012-13 Exceptional Items.</i>				
HHSC 25	II-92	TANF (Cash Assistance) Grants. Out of funds appropriated above in Strategy D.1.1, TANF (Cash Assistance) Grants, the commission shall adjust the TANF grant amount each year to ensure that the maximum monthly grant for a family of three is at least 17 percent of the federal poverty level and provide a one-time per year grant of up to \$30 <u>\$23.49</u> or each TANF child on August 1 of each year.				

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: Tracy Henderson	Date: August 23, 2010	Request Level: Exceptional																				
Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language																						
		<i>Rider has been updated to reflect funding related to Exceptional Item #3.</i>																						
NEW		<p><u>Frew Strategic Initiatives.</u> Out of the funds appropriated above, the Health and Human Services Commission is authorized to expend \$91.4 million general revenue and \$96.9 million All Funds during the 2012-13 biennium for compliance with the Frew lawsuit.</p> <p><i>Rider is requested to provide information on funding appropriated during the 2012-13 biennium supporting strategic initiatives as a result of the Frew lawsuit. Frew Strategic Initiative funding is requested in Exceptional Item # 4.</i></p>																						
NEW		<p><u>Informational Rider for Managed Care Expansion Exceptional Items.</u></p> <p>The following information pertains to Exceptional Items ## through ##.</p> <p style="margin-left: 20px;">a. <u>Estimated savings at the Department of Aging and Disability Services (DADS)</u></p> <p style="margin-left: 20px;"><u>Out of the funds appropriated above for expanding Medicaid managed care, the estimated biennial savings at DADS' long term care programs would total \$524,467,400 general revenue and \$1,329,448,416 all funds. The following table provides estimated annual long term care savings assuming current services funding for caseload and costs at DADS and HHSC.</u></p> <table style="margin-left: 40px; width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Exceptional Item</u></th> <th style="text-align: right;"><u>FY 2012</u></th> <th style="text-align: right;"><u>FY 2013</u></th> <th style="text-align: right;"><u>GR</u></th> <th style="text-align: right;"><u>All Funds</u></th> </tr> </thead> <tbody> <tr> <td style="text-align: left;"><u>Expand Managed Care to Urban Contiguous Counties and STAR+Plus to Lubbock and El Paso</u></td> <td style="text-align: right;">(\$37,539,052)</td> <td style="text-align: right;">\$ (95,156,025)</td> <td style="text-align: right;">\$(58,557,607)</td> <td style="text-align: right;">\$(47,553,447)</td> </tr> <tr> <td style="text-align: left;"><u>Expand Medicaid Managed Care to South Texas</u></td> <td style="text-align: right;">(139,597,641)</td> <td style="text-align: right;">(353,859,673)</td> <td style="text-align: right;">(288,773,100)</td> <td style="text-align: right;">(731,997,719)</td> </tr> <tr> <td style="text-align: right;"><u>Total, DADS Savings</u></td> <td style="text-align: right;">(\$177,136,693)</td> <td style="text-align: right;">\$ (445,015,698)</td> <td style="text-align: right;">\$(347,330,707)</td> <td style="text-align: right;">\$(880,432,718)</td> </tr> </tbody> </table>			<u>Exceptional Item</u>	<u>FY 2012</u>	<u>FY 2013</u>	<u>GR</u>	<u>All Funds</u>	<u>Expand Managed Care to Urban Contiguous Counties and STAR+Plus to Lubbock and El Paso</u>	(\$37,539,052)	\$ (95,156,025)	\$(58,557,607)	\$(47,553,447)	<u>Expand Medicaid Managed Care to South Texas</u>	(139,597,641)	(353,859,673)	(288,773,100)	(731,997,719)	<u>Total, DADS Savings</u>	(\$177,136,693)	\$ (445,015,698)	\$(347,330,707)	\$(880,432,718)
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3.B. Rider Revisions and Additions Request

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Current Rider Number	Page Number in 2010-11 GAA	Proposed Rider Language																													
		<p>b. <u>Estimated Premium Tax Collected</u></p> <p><u>Out of the funds appropriated above for expanding Medicaid managed care, the estimated biennial increase of premium tax revenue collected by the Comptroller would total \$237,974,163. The following table provides estimated annual revenue collection based upon expenditures incurred by managed care organizations assuming current services funding for caseload and costs at DADS and HHSC.</u></p> <table style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Exceptional Item</u></th> <th colspan="2" style="text-align: center;"><u>Fiscal Year</u></th> </tr> <tr> <th></th> <th style="text-align: center;"><u>FY 2012</u></th> <th style="text-align: center;"><u>FY 2013</u></th> </tr> </thead> <tbody> <tr> <td><u>Expand Managed Care to Urban contiguous counties and STAR+Plus to Lubbock and El Paso</u></td> <td style="text-align: right;"><u>\$4,106,098</u></td> <td style="text-align: right;"><u>\$ 15,250,517</u></td> </tr> <tr> <td><u>Expand Medicaid Managed Care to South Texas</u></td> <td></td> <td style="text-align: right;"><u>40,699,510</u></td> </tr> <tr> <td><u>Replace Medicaid PCCM service delivery with EPO Coverage</u></td> <td></td> <td style="text-align: right;"><u>40,997,358</u></td> </tr> <tr> <td><u>Capitate Medicaid Dental Services in Managed Care</u></td> <td></td> <td style="text-align: right;"><u>48,637,766</u></td> </tr> <tr> <td><u>Carve In STAR+Plus hospital Costs in Managed Care</u></td> <td></td> <td style="text-align: right;"><u>9,502,365</u></td> </tr> <tr> <td><u>Capitate Medicaid and CHIP Vendor Drug Programs</u></td> <td style="text-align: right;"><u>11,561,621</u></td> <td style="text-align: right;"><u>67,218,928</u></td> </tr> <tr> <td style="text-align: right;"><u>Total, Estimated Premium Tax Revenue</u></td> <td style="text-align: right;"><u>\$15,667,719</u></td> <td style="text-align: right;"><u>\$222,306,444</u></td> </tr> </tbody> </table> <p><i>This new rider would provide information on savings and revenue impact associated with the expansion of Medicaid managed care and the capitation of certain Medicaid services in Exceptional Items 16 through 21. The inclusion of the rider would depend on how funding was appropriated or reduced depending on the agency.</i></p>			<u>Exceptional Item</u>	<u>Fiscal Year</u>			<u>FY 2012</u>	<u>FY 2013</u>	<u>Expand Managed Care to Urban contiguous counties and STAR+Plus to Lubbock and El Paso</u>	<u>\$4,106,098</u>	<u>\$ 15,250,517</u>	<u>Expand Medicaid Managed Care to South Texas</u>		<u>40,699,510</u>	<u>Replace Medicaid PCCM service delivery with EPO Coverage</u>		<u>40,997,358</u>	<u>Capitate Medicaid Dental Services in Managed Care</u>		<u>48,637,766</u>	<u>Carve In STAR+Plus hospital Costs in Managed Care</u>		<u>9,502,365</u>	<u>Capitate Medicaid and CHIP Vendor Drug Programs</u>	<u>11,561,621</u>	<u>67,218,928</u>	<u>Total, Estimated Premium Tax Revenue</u>	<u>\$15,667,719</u>	<u>\$222,306,444</u>
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3.B. Rider Revisions and Additions Request

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Sec. 7	II-105	<p>Federal Match Assumptions and Limitations on use of Available General Revenue Funds.</p> <p>a. Federal Match Assumptions. The following percentages reflect federal match assumptions used in Article II of this Act.</p> <p style="margin-left: 40px;">Federal Medical Assistance Percentage (FMAP)</p> <table style="margin-left: 80px; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>2012</u></th> <th style="text-align: center;"><u>2010</u></th> <th style="text-align: center;"><u>2013</u></th> <th style="text-align: center;"><u>2011</u></th> </tr> </thead> <tbody> <tr> <td>Federal Fiscal Year</td> <td style="text-align: center;">60.55%</td> <td style="text-align: center;">58.73%</td> <td style="text-align: center;">60.55%</td> <td style="text-align: center;">58.29%</td> </tr> <tr> <td>State Fiscal Year</td> <td style="text-align: center;">60.55%</td> <td style="text-align: center;">58.79%</td> <td style="text-align: center;">60.55%</td> <td style="text-align: center;">58.33%</td> </tr> </tbody> </table> <p style="margin-left: 40px;">Enhanced Federal Medical Assistance Percentage (EFMAP)</p> <table style="margin-left: 80px; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;"><u>2012</u></th> <th style="text-align: center;"><u>2010</u></th> <th style="text-align: center;"><u>2013</u></th> <th style="text-align: center;"><u>2011</u></th> </tr> </thead> <tbody> <tr> <td>Federal Fiscal Year</td> <td style="text-align: center;">72.39%</td> <td style="text-align: center;">71.41%</td> <td style="text-align: center;">72.39%</td> <td style="text-align: center;">70.80%</td> </tr> <tr> <td>State Fiscal Year</td> <td style="text-align: center;">72.39%</td> <td style="text-align: center;">71.45%</td> <td style="text-align: center;">72.39%</td> <td style="text-align: center;">70.83%</td> </tr> </tbody> </table> <p>b. Limitations on Use of Available General Revenue Funds. In the event the actual FMAP and EFMAP should be greater than shown in Section (a), the health and human services agencies listed in chapter 531, Government Code, are authorized to expend the General Revenue Funds thereby made available only upon prior written approval from the Legislative Budget Board and Governor.</p> <p>To request authorization to expend available General Revenue Funds, an agency shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information, by fiscal year:</p> <ol style="list-style-type: none"> (1) a detailed explanation of the proposed use (s) of the available General Revenue Funds and whether the expenditure (s) will be one-time or ongoing; (2) the amount available by strategy; (3) the strategy (ies) in which the funds will be expended and the associated amounts, including any matching federal funds; (4) an estimate of performance levels and, where relevant, a comparison to targets included in this Act; and (5) the capital budget and/or full-time equivalent impact. 				<u>2012</u>	<u>2010</u>	<u>2013</u>	<u>2011</u>	Federal Fiscal Year	60.55%	58.73%	60.55%	58.29%	State Fiscal Year	60.55%	58.79%	60.55%	58.33%		<u>2012</u>	<u>2010</u>	<u>2013</u>	<u>2011</u>	Federal Fiscal Year	72.39%	71.41%	72.39%	70.80%	State Fiscal Year	72.39%	71.45%	72.39%	70.83%
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		<p>Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board.</p> <p>The request shall be considered to be approved unless the Legislative Budget Board or the Governor issue a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.</p> <p>The Comptroller of Public Accounts shall not allow the expenditure of General Revenue Funds made available if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p><i>Rider has been amended for biennial dates and the FFIS estimated FMAP rates for FFY 2012 published April 2010.</i></p>		
Sec. 11	II-106	<p>Limitations on Transfer Authority. Notwithstanding the general transfer provisions of this Act, but in concert with agency-specific limitations on transfer authority in this Article, the Executive Commissioner of the Health and Human Services Commission is authorized to make transfers of funding, full-time equivalents (FTEs), and capital budget authority within and between health and human services agencies as listed in Chapter 531, Government Code. <u>Transfers which exceed \$1,000,000 in general revenue, capital authority in excess of \$100,000 or FTE adjustments of more than 10 FTEs are subject to the prior written approval of the Legislative Budget Board and the Governor. Transfers below these thresholds require written notification to the Legislative Budget Board and Governor.</u> No single transfer may exceed 12.5 percent of the originating strategy's appropriation for funding or FTEs for the fiscal year.</p> <p>To request a transfer, the Executive Commissioner of the Health and Human Services Commission shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information:</p> <ul style="list-style-type: none"> a. a detailed explanation of the purpose(s) of the transfer, including the following: <ul style="list-style-type: none"> (1) a description of each initiative with funding and FTE information by fiscal year; and (2) an indication of whether the expenditure will be one-time or ongoing. b. the names of the originating and receiving agencies and/or strategies and the method of financing and FTEs for 		

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		<p>each strategy by fiscal year;</p> <p>c. an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and the receiving agencies and/or strategies; and</p> <p>d. the capital budget impact.</p> <p>Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board.</p> <p>The Comptroller of Public Accounts shall not allow the transfer of funds if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p>In the case of disaster or other emergency, this provision is superseded by the emergency-related transfer authority in Article IX of this Act.</p> <p><i>This rider is amended to request flexibility with certain transfers and to reduce the number of requests submitted that require approval.</i></p>																				
Sec. 14	II-107	<p>Medicaid Information Rider. This rider is informational and does not make any appropriations. The Health and Human Services Commission is the single state agency for Title XIX, the Medical Assistance Program (Medicaid) in Texas. Other agencies receive appropriations for and responsible for the operations of various Medicaid Programs. Appropriations made elsewhere in this Act and certain appropriations made in House Bill 4586, Eighty-first Legislature, related to the Medicaid program include the following:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Agency Name</u></th> <th style="text-align: right;"><u>FY 2010</u></th> <th style="text-align: right;"><u>FY 2011</u></th> </tr> </thead> <tbody> <tr> <td>Department of Aging and Disability Services</td> <td style="text-align: right;">\$ 6,205,722,826</td> <td style="text-align: right;">\$ 6,267,709,624</td> </tr> <tr> <td>Department of Assistive and Rehabilitative Services</td> <td style="text-align: right;">74,688,630</td> <td style="text-align: right;">79,760,440</td> </tr> <tr> <td>Department of Family And Protective Services</td> <td style="text-align: right;">20,593,944</td> <td style="text-align: right;">20,675,778</td> </tr> <tr> <td>Department of State Health Services</td> <td style="text-align: right;">171,586,284</td> <td style="text-align: right;">170,410,003</td> </tr> <tr> <td>Health and Human Services Commission</td> <td style="text-align: right;">15,811,441,567</td> <td style="text-align: right;">16,081,151,347</td> </tr> </tbody> </table>			<u>Agency Name</u>	<u>FY 2010</u>	<u>FY 2011</u>	Department of Aging and Disability Services	\$ 6,205,722,826	\$ 6,267,709,624	Department of Assistive and Rehabilitative Services	74,688,630	79,760,440	Department of Family And Protective Services	20,593,944	20,675,778	Department of State Health Services	171,586,284	170,410,003	Health and Human Services Commission	15,811,441,567	16,081,151,347
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		<p>Article II, Special Provisions 0 0</p> <p>Total, Medical Assistance Program \$22,284,033,251 \$22,619,707,192</p> <p>Method of Financing:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">General Revenue for Medicaid</td> <td style="width: 20%; text-align: right;">\$8,949,921,821</td> <td style="width: 20%; text-align: right;">\$9,243,209,168</td> </tr> <tr> <td>Tobacco Settlement Receipts For Medicaid</td> <td style="text-align: right;">236,092,691</td> <td style="text-align: right;">227,410,026</td> </tr> <tr> <td style="padding-left: 20px;">Subtotal, General Revenue Funds</td> <td style="text-align: right;">9,186,014,512</td> <td style="text-align: right;">9,470,619,194</td> </tr> <tr> <td>General Revenue – Dedicated</td> <td style="text-align: right;">62,149,979</td> <td style="text-align: right;">61,649,979</td> </tr> <tr> <td>Federal Funds</td> <td style="text-align: right;">12,942,855,738</td> <td style="text-align: right;">12,994,424,995</td> </tr> <tr> <td>Interagency Contracts</td> <td style="text-align: right;">2,169,092</td> <td style="text-align: right;">2,169,092</td> </tr> <tr> <td>Medicaid Subrogation Receipts</td> <td style="text-align: right;">38,417,543</td> <td style="text-align: right;">38,417,543</td> </tr> <tr> <td>Appropriated Receipts – Match for Medicaid</td> <td style="text-align: right;">31,669,354</td> <td style="text-align: right;">31,669,354</td> </tr> <tr> <td>MR Collections for Patient Support And Maintenance</td> <td style="text-align: right;">20,757,033</td> <td style="text-align: right;">20,757,035</td> </tr> <tr> <td style="padding-left: 20px;">Subtotal, Other Funds</td> <td style="text-align: right;">93,013,022</td> <td style="text-align: right;">93,013,024</td> </tr> <tr> <td>Total, All Funds</td> <td style="text-align: right;">\$22,284,033,251</td> <td style="text-align: right;">\$22,619,707,192</td> </tr> </table> <p><i>Rider will need to be updated for Medicaid appropriations in the General Appropriations Act.</i></p>			General Revenue for Medicaid	\$8,949,921,821	\$9,243,209,168	Tobacco Settlement Receipts For Medicaid	236,092,691	227,410,026	Subtotal, General Revenue Funds	9,186,014,512	9,470,619,194	General Revenue – Dedicated	62,149,979	61,649,979	Federal Funds	12,942,855,738	12,994,424,995	Interagency Contracts	2,169,092	2,169,092	Medicaid Subrogation Receipts	38,417,543	38,417,543	Appropriated Receipts – Match for Medicaid	31,669,354	31,669,354	MR Collections for Patient Support And Maintenance	20,757,033	20,757,035	Subtotal, Other Funds	93,013,022	93,013,024	Total, All Funds	\$22,284,033,251	\$22,619,707,192
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Sec. 16	II-109	<p>Rate Limitations and Reporting Requirements. Notwithstanding other provisions of this Act, the use of appropriated funds for a rate paid by a health and human services agency as listed in Chapter 531, Government Code, shall be governed by the specific limitations included in this provision.</p> <p>For purposes of this provision, "rate" is defined to include all provider reimbursements (regardless of methodology) that account for significant expenditures by a health and human services agency, <u>not to include rates based on a cost settlement methodology</u>. Additionally, estimates of fiscal impacts should be based on the most current caseload forecast submitted by the Health and Human Services Commission pursuant to other provisions in this Act and should specify General Revenue Funds, TANF Federal Funds, and All Funds. Fiscal estimates that impact multiple risk groups may be</p>																																			

3.B. Rider Revisions and Additions Request

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		<p>reported at an aggregate level.</p> <p>a. Notice of Initial Rates. No later than September 1 of each fiscal year, the Executive Commissioner of the Health and Human Services Commission shall submit the following information in writing to the Legislative Budget Board, the Governor, and the State Auditor:</p> <ol style="list-style-type: none"> (1) a list of each rate in effect on September 1 of the fiscal year and each rate in effect at the beginning and the end of the prior fiscal year; (2) an estimate of the fiscal impact, by agency and by year, for each rate change listed for subsection (1); and (3) a schedule and description of the rate-setting process for all rates listed for subsection (1). (4) <u>a schedule identifying an estimate of the amount of General Revenue Funds, TANF Federal Funds, and All Funds, if any, by which expenditures at such rate levels would exceed appropriated funding.</u> <p>b. Quarterly Reporting Notice of New or Revised Rates. At least 30 calendar days prior to the payment of a rate not initially reported in section (a) or to increase a rate that would have an annual fiscal impact greater than \$1,000,000 in General Revenue-related funds or TANF Federal Funds or other non-matching federal funds for the 2010-11 biennium, the <u>On a quarterly basis</u>, in a format specified by the Legislative Budget Board, the Health and Human Services Commission shall provide a summary of all rate actions implemented, including those not requiring prior written approval. The Executive Commissioner of the Health and Human Services Commission shall submit the following information in writing to the Legislative Budget Board, the Governor, and the State Auditor <u>quarterly for all rate changes implemented in the preceding quarter (excluding any rate changes initially reported under section (a)), regardless of the fiscal impact of the rate change:</u></p> <ol style="list-style-type: none"> (1) a list of each new rate <u>(or rate category for acute care services)</u> and/or each rate that will be increased, including the current and proposed rate; (2) an estimate of the fiscal impact, by agency and by year, for each rate <u>(or rate category for acute care services)</u> listed for subsection (1); (3) a schedule and description of the rate-setting process, if different from the original submission as required by section (a); and (4) an explanation of the factors related to <u>the change in rates in each rate (or rate category for acute care services)</u> listed for subsection (1). <p>c. <u>Prior Approval of New Rates and Rate Changes.</u> Limitation on Rates that Exceed Appropriated Funding.</p>		

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		<p>Without the prior written approval of the Legislative Budget Board and the Governor, no agency listed in Chapter 531, Government Code, may implement a new rate or a rate increase <u>pay a rate</u> that would result in <u>increased expenditures that exceed \$1,000,000 in General Revenue-related funds or TANF Federal Funds or other non-matching federal funds</u>, in any fiscal year, the amounts appropriated by this Act to a strategy for the services to which the rate applies, unless the <u>rate reimbursement level</u> was in effect prior to September 1, 2011 <u>2009</u>; or <u>is less than the reimbursement level in effect on that date</u>. <u>The request for approval shall be submitted at least 30 days prior to the payment of a rate that this section applies.</u></p> <p><u>This subsection shall not apply to new procedure cods required to conform to the federal Healthcare Common Procedure Coding System (HCPS); to revised rates occurring as a result of the Health and Human Services Commission's Biennial Calendar Fee Review, or to rates resulting from policy changes approved by actions of the Eighty-second Legislature.</u></p> <p>To request authorization for such a <u>new rate or rate increase</u>, the Executive Commissioner of the Health and Human Services Commission shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information:</p> <ol style="list-style-type: none"> (1) a list of each new rate <u>(or rate category for acute care services)</u> and/or each rate for which an increase is proposed; (2) an estimate of the fiscal impacts of the new rate <u>(or rate category for acute care services)</u> and/or rate increase, by agency and by fiscal year.; and (3) the amount of General Revenue Funds, TANF Federal Funds, and All Funds, by fiscal year, by which each rate would exceed appropriated funding for each fiscal year. <p>The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the request for authorization for the rate and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.</p> <p>d. Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. Notifications, requests and information provided subsequently shall be prepared in a format specified by</p>		

3.B. Rider Revisions and Additions Request

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		<p>the Legislative Budget Board.</p> <p>e. The Office of the State Auditor may review the fiscal impact information provided under sections (a) and through (c) along with supporting documentation, supporting records, and justification for the rate increase provided by the Health and Human Services Commission and report back to the Legislative Budget Board and the Governor before the rate is implemented by the Health and Human Services Commission or operating agency.</p> <p>f. The Comptroller of Public Accounts shall not allow the expenditure of funds for a new or increased rate if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p style="text-align: center;"><i>Rider has been amended to correct operational issues with rate reporting experienced during the 2010-11 biennium.</i></p>		
Sec.19	II-111	<p>General Revenue Funds for Medicaid Mental Health and Mental Retardation Services. For the purposes of this section and appropriation authority for the Medicaid mental health and mental retardation program responsibilities of the Department of State Health Services and the Department of Aging and Disability Services, the following subsections provide governance relating to appropriate use, classification and expenditure of funds.</p> <p>a. General Revenue Match for Medicaid. ABEST Method of Financing Code 758 - GR Match for Medicaid shall be used to report general revenue expenditures and request general revenue appropriations for the state's share of Medicaid payments for the following Medicaid mental health and mental retardation services:</p> <ol style="list-style-type: none"> (1) Community-based Intermediate Care Facilities for the Mentally Retarded (ICF-MR) that are privately operated through contractual arrangements between private providers and the Department of Aging and Disability Services; (2) Community-based Intermediate Care Facilities for the Mentally Retarded (ICF-MR), also known as Bond Homes, that are operated by the Department of Aging and Disability Services; (3) Home and Community-based Services (HCS) authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and the Department of Aging and Disability Services; (4) Home and Community-based Services - Omnibus Budget Reconciliation Act of 1981 (HCS-O) authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and the Department of Aging and Disability Services; 		

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		<p>(5) Texas Home Living services authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and the Department of Aging and Disability Services;</p> <p>(6) Mental Retardation Local Authority (MRLA) waiver services;</p> <p>(7) Mental health services provided through contracts with Behavioral Health Organizations as a component of the NorthSTAR Project; and</p> <p>(8) Rehabilitation Services as approved in the State Medicaid Plan which are provided by Mental Health Authorities and Mental Retardation Authorities;</p> <p>(9) Targeted Case Management Services as approved in the State Medicaid Plan provided by Mental Health Authorities and Mental Retardation Authorities;</p> <p>(10) Service coordination Services as approved in the State Medicaid Plan provided by Mental Health Authorities and Mental Retardation Authorities; and</p> <p>(811) Salaries and operating costs related to direct program administration and indirect administration of the Departments.</p> <p>b. General Revenue Certified as Match for Medicaid. The Department of State Health Services and the Department of Aging and Disability Services shall use ABEST Method of Financing code 8032 - General Revenue Certified Match for Medicaid to identify general revenue funds requested and reported as expended for the purpose of drawing federal funds and to document that State funds have been spent for Medicaid mental health and mental retardation services and administrative expenditures for the following services:</p> <p>(1) Intermediate care facilities for the mentally retarded that are operated by the State and known as "state Schools supported livings centers";</p> <p>(2) Services delivered in mental health state hospitals operated by the Department of State Health Services including inpatient services for clients under the age of 21 and services that qualify under the federally approved Institutions for Mental Diseases (IMD) option for clients over the age of 65; and</p> <p>(3) Rehabilitation Services as approved in the State Medicaid Plan which are provided by Mental Health Authorities and Mental Retardation Authorities; and</p> <p>(4) Targeted Case Management Services as approved in the State Medicaid Plan provided by Mental Health Authorities and Mental Retardation Authorities;</p>		

3.B. Rider Revisions and Additions Request

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		<p>(5) Service Coordination Services as approved in the State Medicaid Plan provided by Mental Health Authorities and Mental Retardation Authorities; and</p> <p>(63) Medicaid Administrative Claims as approved in the State Medicaid Plan which are based on certain activities of Mental Health Authorities and Mental Retardation Authorities.</p> <p>c. Reporting requirements related to General Revenue Matching Funds for Medicaid Mental Health and Mental Retardation Services. The Department of State Health Services and the Department of Aging and Disability Services shall report monthly to the Legislative Budget Board, Comptroller of Public Accounts and Governor on the expenditures of General Revenue for Medicaid federal matching purposes by the method of financing codes identified above and the amounts of local, non-profit expenditures certified as state match for Medicaid federal funds by the departments for services provided by Mental Health Authorities and Mental Retardation Authorities.</p> <p>d. Medicaid Federal Funds. The Department of State Health Services and the Department of Aging and Disability Services shall report their expenditures and request legislative appropriations for federal Medicaid matching funds for client services, program administration and agency indirect administration. Automated Budgeting and Evaluation System of Texas (ABEST) Method of Financing Code (MOF) 555 and Medicaid CFDA 93.778 shall be used for the following:</p> <ol style="list-style-type: none"> (1) Federal funds drawn from the U.S. Centers for Medicare and Medicaid Services (CMS) using general revenue funds classified as General Revenue Match for Medicaid (ABEST MOF Code 758), General Revenue Certified as Match for Medicaid (ABEST MOF Code 8032), Tobacco Settlement Receipts Match for Medicaid (ABEST MOF Code 8024) or Tobacco Receipts Certified as Match for Medicaid (ABEST MOF Code 8023); (2) Federal funds drawn from CMS using the departments' certification of local, non-profit expenditures made by the Mental Health Authorities and Mental Retardation Authorities on behalf of Medicaid-eligible individuals; (3) Federal funds received from CMS for services rendered to certain Medicaid-eligible individuals over the age of 65 by federally recognized Institutions for Mental Diseases (IMD Medicaid option) based on billings from mental health state hospitals operated by the Department of State Health Services to the claims processing agent for the Texas Medicaid program in its capacity as the State's fiscal agent for certain 		

3.B. Rider Revisions and Additions Request

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		<p style="margin-left: 40px;">Medicaid payments; and</p> <p>(4) Federal funds received from CMS for general Medicaid health services including the Comprehensive Care Program for children based on billings from the state mental health and mental retardation facilities operated by the Department of State Health Services and the Department of Aging and Disability Services to the claims processing agent for the Texas Medicaid program in its capacity as the State's fiscal agent for certain Medicaid payments.</p> <p>e. Appropriation authority and accounting for Federal Funds for Medicaid Mental Health and Mental Retardation Services. Amounts defined as Medicaid Federal Funds shall be used as a first source, and general revenue which was not used as matching funds shall not be used to fund Medicaid eligible services. In the event that these revenues should be greater than the amounts included above in Federal Funds for mental health and mental retardation services for the Department of State Health Services and the Department of Aging and Disability Services, the departments are hereby appropriated and authorized to expend these federal funds made available, subject to the following requirements:</p> <p style="margin-left: 20px;">(1) Amounts made available shall be expended prior to utilization of any general revenue made available for the same purpose;</p> <p style="margin-left: 20px;">(2) In the event general revenue has been expended prior to the receipt of Medicaid Federal Funds, the departments shall reimburse general revenue upon receipt of the revenue. This process shall be completed on a monthly basis in order to not have an excess balance of Medicaid Federal Funds; and</p> <p style="margin-left: 20px;">(3) The departments shall report monthly to the Legislative Budget Board, Comptroller of Public Accounts and Governor on the amounts of Medicaid Federal Funds drawn and expended.</p> <p>f. Responsibility for proportionate share of indirect costs and benefits. Nothing in this provision shall exempt the departments from provisions of Article IX of this Act which apply equally to direct recoveries of benefits and indirect costs and to amounts recovered through an approved rate structure for services provided. Specifically, the departments do not have appropriation authority for Medicaid federal funds claimed on behalf of services provided by other agencies, including:</p> <p style="margin-left: 20px;">(1) Health and retirement services for active and retired Department of State Health Services and Department of Aging and Disability Services employees paid by the Employee Retirement System;</p> <p style="margin-left: 20px;">(2) Social Security payments, salary increases authorized in General Provisions, and Benefit Replacement</p>		

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		<p>Pay for Department of State Health Services and Department of Aging and Disability Services employees paid by the Comptroller of Public Accounts;</p> <p>(3) Debt service amounts paid on behalf of the Department of State Health Services and Department of Aging and Disability Services by the Texas Public Finance Authority; and</p> <p>(4) Indirect cost allocation plans negotiated with CMS for the purposes of the State-wide Cost Allocation Plan (SWCAP).</p> <p>g. Exclusive Appropriation Authority. The preceding subsections of this provision shall be the exclusive appropriation authority for Medicaid mental health and mental retardation services Federal Fund receipts from the above identified sources and none of these receipts shall be appropriated by a provision of Article IX of this Act.</p> <p><i>Rider has been updated for reference to State Supported Living Centers and for additional DADS programs financed with Medicaid.</i></p>		
Sec. 22	II-115	<p>Mental Health (MH) and Mental Retardation (MR) Medicare Receipts.</p> <p>a. For the purposes of this section and appropriation authority, MH and MR Medicare Receipts are classified as deposits in Revenue Object Code 3634 that are collected by the Department of State Health Services and the Department of Aging and Disability Services as payment for:</p> <p>(1) hospital, physician and other services rendered to Medicare-eligible individuals in state mental health <u>facilities</u> and mental retardation facilities <u>State Supported Living Centers</u> operated by the departments;</p> <p>(2) cost settlements for services rendered in state mental health <u>facilities</u> and <u>State Supported Living Centers</u> mental retardation facilities operated by the department as authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); and</p> <p>(3) prescription drugs reimbursed through the Medicare, Part D, prescription drug program.</p> <p>b. Accounting and Reporting. Amounts defined as MH and MR Medicare Receipts shall be deposited into the General Revenue Fund according to the identified Comptroller Revenue Object Code above. The departments shall report monthly to the Legislative Budget Board, Comptroller of Public Accounts and Governor on MH and MR Medicare Receipts collections by Comptroller Revenue Object Code, expenditures and anticipated revenues and balances.</p>		

3.B. Rider Revisions and Additions Request

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		<p>c. Mental Health Medicare Receipts. Included in the General Revenue Funds appropriated above to the Department of State Health Services in Strategy C.1.3, Mental Health State Hospitals, is \$23,821,799 per year for the 2012-13 2010-11 biennium, contingent upon generation of funds from MH Medicare Receipts collections. These funds shall be expended as collected and only within Strategy C.1.3, Mental Health State Hospitals. Appropriations made elsewhere in this Act for employee benefits include approximately \$2,227,201 per year from MH Medicare Receipts. MH Medicare Receipts collections above \$26,049,000 per year (excluding any amounts needed to comply with Article IX, Sec. 6.08, Benefits Paid Proportional by Fund) are hereby appropriated as Method of Financing Code 8034 - MH Medicare Receipts (General Revenue Funds) to the department for expenditures in Strategy C.1.3, Mental Health State Hospitals, pursuant to the limitations of this provision.</p> <p>d. Mental Retardation Medicare Receipts. Included in the GR Match for Medicaid Funds appropriated above to the Department of Aging and Disability Services in Strategy A.8.1, <u>State Supported Living Centers</u> MR State Schools Services, is \$17,995,46721,806,467 per year for the 2012-13 2010-11 biennium, contingent upon generation of funds from MR Medicare Receipts collections. These funds shall be expended as collected and only within Strategy A.8.1, <u>State Supported Living Centers</u> MR State Schools Services. Appropriations made elsewhere in this Act for employee benefits include approximately \$376,533 per year from MR Medicare Receipts. MR Medicare Receipts collections above \$18,372,00022,183,000 per year (excluding any amounts needed to comply with Article IX, Sec. 6.08, Benefits Paid Proportional by Fund) are hereby appropriated as Method of Financing Code 8097 - MR Medicare Receipts (General Revenue Funds) to the department for expenditures in Strategy A.8.1, <u>State Supported Living Centers</u> MR State Schools Services, pursuant to the limitation of this provision.</p> <p><i>Rider is amended for biennial dates, references to State Supported Living Centers, and funding for the 2012-13 biennium.</i></p>		
Sec. 41	II-119	<p>Limitation on Unexpended Balances: General Revenue for Medicaid. Unexpended balances in General Revenue Funds appropriated for the Medicaid program (GR Match for Medicaid and GR Certified as Match for Medicaid) to the Health and Human Services Commission, the Department of Aging and Disability Services, and the Department of State Health Services for fiscal year 2012 2010 are appropriated for the same purposes to the respective agencies for fiscal year 2013 2011 only upon prior written approval by the Legislative Budget Board and the Governor.</p>		

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		<p>For authorization to expend the funds, an agency shall submit a written request to the Legislative Budget Board and the Governor by April 1, 2012 2010. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request must be organized by fiscal year as follows:</p> <ul style="list-style-type: none"> a. The following information shall be provided for fiscal year 2012 2010: <ul style="list-style-type: none"> (1) a detailed explanation of the cause(s) of the unexpended balance(s); (2) the amount of the unexpended balance(s) by strategy; and (3) an estimate of performance levels and, where relevant, a comparison to targets in this Act. b. The following information shall be provided for fiscal year 2013 2011: <ul style="list-style-type: none"> (1) a detailed explanation of the purpose(s) for which the unexpended balance(s) will be used and whether the expenditure will be one-time or ongoing; (2) the amount of the expenditure by strategy; (3) an estimate of performance levels and, where relevant, a comparison to targets in this Act; and (4) the capital budget impact <p>An agency shall submit a revised written request by October 1, 2012 2010 if the amount of the estimated unexpended balance(s) varies by more than five percent from the amount estimated in the original request.</p> <p>Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board.</p> <p>The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.</p> <p>The Comptroller of Public Accounts shall not allow the use of unexpended balances if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p><i>Rider has been amended for biennial date changes.</i></p>		

3.B. Rider Revisions and Additions Request

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Sec. 42	II-120	<p>Appropriation of Receipts: Civil Monetary Damages and Penalties. Included in the amounts appropriated above for the 2012-13 2040-44 biennium are the following:</p> <ul style="list-style-type: none"> a. \$2,660,000 in General Revenue Match for Medicaid for the Department of Aging and Disability Services; b. \$1,414,870 in General Revenue Match for Medicaid for the Health and Human Services Commission; and c. \$520,000 in General Revenue Match for the Department of State Health Services. <p>These amounts are contingent upon the collection of civil monetary damages and penalties under Human Resources Code § 32.021 and Health and Safety Code § 431.047. Any amounts collected above these amounts by the respective agency are hereby appropriated to the respective agency in amounts equal to the costs of the investigation and collection proceedings conducted under those sections, and any amounts collected as reimbursement for claims paid by the agency.</p> <p><i>Rider has been amended for biennial dates.</i></p>								
Sec. 44	II-120	<p>Appropriation of Unexpended Balances: Funds Recouped from Local Authorities. Notwithstanding other provisions of this Act, any state funds appropriated for fiscal year 2012 2040 recouped by the Department of Aging and Disability Services or the Department of State Health Services from a local mental health or mental retardation authority for failing to fulfill its performance contract with the State, are hereby appropriated to the respective agency for the same strategy, to reallocate to other local mental health or mental retardation authorities in fiscal year 2013 2044.</p> <p>Each agency shall provide a report to the Legislative Budget Board and the Governor by June 1, 2012 2040 that includes the amount of the recoupment by strategy, the reasons for the recoupment, the local authorities involved, any performance contract requirements that were not met, and the purposes of the reallocation.</p> <p><i>Rider has been modified for biennial date changes.</i></p>								
Sec. 45	II-121	<p>Enterprise Support Services. Out of funds appropriated above, the following amounts are allocated for enterprise support services:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Enterprise Support Service Category</u></th> <th style="text-align: center;"><u>2010</u></th> <th style="text-align: center;"><u>2011</u></th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>			<u>Enterprise Support Service Category</u>	<u>2010</u>	<u>2011</u>			
<u>Enterprise Support Service Category</u>	<u>2010</u>	<u>2011</u>								

3.B. Rider Revisions and Additions Request

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		1. Regional Cost Pools	\$ 136,197,671	\$ 136,677,341
		2. Consolidated System Support	\$ 111,771,968	\$ 108,215,326
		3. Centralized Cost Pools	\$ 35,422,093	\$ 35,422,093
		4. Regional Program Support	\$ 16,720,244	\$ 16,720,244
		5. Enterprise Oversight and Policy	\$ 16,081,748	\$ 16,081,748
		6. Central Program Support	\$ 13,894,027	\$ 13,894,027
		7. IT Program Support	\$ 11,909,752	\$ 11,909,752
		8. Office of Inspector General	\$ 10,811,479	\$ 10,811,479
		9. Seat Management	\$ 9,547,694	\$ 9,585,157
		10. Peoplesoft (HHSAS)	\$ 8,774,264	\$ 11,143,264
		Total, All Funds for Article II	\$ 371,130,940	\$ 370,460,431
		<p>Limitation on Assessments. The Health and Human Services Commission may not collectively assess agencies more than the total amount per fiscal year indicated above for all enterprise support service categories without prior written approval from the Legislative Budget Board and the Governor.</p> <p>For authorization to make an assessment that exceeds the total amount per fiscal year indicated above, the Executive Commissioner of the Health and Human Services Commission shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the Executive Commissioner shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information by fiscal year:</p> <p style="margin-left: 40px;">(1) a detailed explanation of the reasons for the assessment and why it exceeds the total amount per fiscal year indicated above;</p> <p style="margin-left: 40px;">(2) the amount of the assessment by enterprise support service category at both the agency and enterprise levels;</p> <p style="margin-left: 40px;">(3) the amount of the assessment by major fund type at both the agency and enterprise levels; and</p> <p style="margin-left: 40px;">(4) the impact of the assessment on each agency's performance levels.</p> <p>Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the</p>		

3.B. Rider Revisions and Additions Request

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		<p>Legislative Budget Board.</p> <p>The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposed assessment 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.</p> <p>b. Reporting Requirements.</p> <p>(1) Annual Assessments. The Executive Commissioner of the Health and Human Services Commission shall submit to the Legislative Budget Board and the Governor, by September 1 of each fiscal year, a report that indicates the amounts assessed for enterprise support services for the new and two prior fiscal years. The report shall include the following information at both the agency and enterprise levels:</p> <ul style="list-style-type: none"> (i) amounts by service category; and (ii) amounts by major fund type. <p>(2) Monthly Expenditures. No later than 30 days following the close of each fiscal quarter, the Executive Commissioner shall submit to the Legislative Budget Board and the Governor a report that provides information about actual monthly expenditures for enterprise support services for the current and two prior fiscal years by service category.</p> <p>(3) Annual Expenditures. No later than October 1 of each year, the Executive Commissioner shall submit to the Legislative Budget Board and the Governor a report that provides information about actual annual expenditures for enterprise support services for the two prior fiscal years. The report shall include the following information at both the agency and enterprise levels:</p> <ul style="list-style-type: none"> (i) amounts by service category; and (ii) amounts by major fund type <p>The reports shall be prepared in a format approved by the Legislative Budget Board.</p> <p>e. Controlling Expenditures and Minimizing Use of General Revenue Funds. The Health and Human Services Commission shall critically examine the current methodologies (including cost allocation plans) used to allocate</p>		

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		<p>enterprise support services expenses among agencies and their strategies, including the resulting allocation of expenses to General Revenue Funds.</p> <p>The examination should compare enterprise support services expenditures across at least three fiscal years and include recommendations and/or cite actions taken to control expenditures and to minimize the General Revenue Fund share of such expenditures.</p> <p>The report, including supporting analysis and explanation, shall be prepared in a format approved by the Legislative Budget Board and submitted to the Legislative Budget Board and the Governor no later than April 1, 2010.</p> <p>The Comptroller of Public Accounts shall not allow the expenditure of funds for an increased assessment if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p><i>Rider has been modified to delete subsection(c) for a report that was submitted during the 2010-11 biennium and for subsection (a) to provide flexibility during the biennium</i></p>		
Sec. 46	II-122	<p>Integrated Model of Care – Aged/Blind/Disabled Population. It is the intent of the Legislature that the Health and Human Services Commission implement the most cost effective integrated managed care model for the aged/blind/disabled population in the Dallas and Tarrant service area.</p> <p>It is specifically provided that funds appropriated for the provision of services to the Medicaid aged/blind/disabled population may not be expended to implement an integrated managed care model which would eliminate the revenues received for hospital and physician payments under the current federal Upper Payment Limit (UPL) program.</p> <p>Medicaid funds appropriated to the Department of Aging and Disability Services and the Health and Human Services Commission may be transferred between the agencies during the 2010-11 biennium to support the implementation of an integrated model of care under this provision, with prior approval.</p> <p>The Commission shall request approval from the Governor and the Legislative Budget Board at least 30 days prior to any proposed funding transfer. The request shall indicate the impact to performance measures at both agencies.</p> <p>The request shall be considered to be approved unless the Legislative Budget Board or the Governor issues a written</p>		

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		<p>disapproval within 15 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor.</p> <p><i>Rider should be deleted as an integrated care model will be implemented during February 2011.</i></p>		
Sec. 48	II-123	<p>Contingency Appropriation for the Reshaping of the System for Providing Services to Individuals with Developmental Disabilities. \$207,900,000 in General Revenue Funds and \$256,603,063 in Federal Funds (\$464,503,063 in All Funds) appropriated elsewhere in this Act to the Department of Aging and Disability Services (DADS) and the Health and Human Services Commission (HHSC) for the 2010-11 biennium is contingent upon changes outlined below. These funds are appropriated for home and community-based programs and 1915(c) waivers for persons with mental retardation, intellectual disabilities, and developmental disabilities as an effort to reduce the disproportionately long wait time for services, expand waiver-related community services slots by 7,832 by August 2011, and to provide specific direction related to reshaping the system of care for persons with developmental disabilities.</p> <p>DADS is required to increase the number of Home and Community-Based Services (HCS) slots during fiscal years 2010 and 2011 for (1) individuals moving out of medium and large ICFs/MR, (2) children aging out of foster care services at the Department of Family and Protective Services, (3) children who are at risk of being institutionalized in ICFs/MR, and (4) individuals who are at imminent risk of institutionalization as a result of emergency or crisis situations.</p> <p>Additionally, the appropriation is contingent upon the following:</p> <ul style="list-style-type: none"> a.— DADS reducing the number of state school residents, through census management, not closure, and limiting the number of residents residing at each state school, without removing a state school resident from a state school against the resident's will or against the will of the resident's legally authorized guardian for the purpose of meeting any potential capacity limits, and without denying admission to a state school on the basis that the admission would cause the state school to exceed any potential capacity limit. It is the intent of the Legislature that the costs of serving reallocated residents be financed through reduced expenditures for the operation of state schools. b.— DADS identifying state school residents through the community living options information process who could move into community programs; and c.— transferring the case management function from HCS providers to local Mental Retardation Authorities (MRAs). 		

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		<p>The appropriation includes the following amounts:</p> <ul style="list-style-type: none"> a. \$157,700,000 in General Revenue to expand community service options as identified below for persons with mental retardation. <ul style="list-style-type: none"> 1) \$37,500,000 in General Revenue to Strategy A.3.3. Community Living Assistance and Support Services (CLASS) to add 1,890 CLASS slots; 2) \$99,400,000 in General Revenue to Strategy A.3.2. Home and Community-Based Services (HCS) to add 5,120 HCS slots; 3) \$100,000 in General Revenue to Strategy A.3.4. Deaf-Blind Multiple Disabilities (DBMD) to add 6 DBMD slots; 4) \$16,100,000 in General Revenue to Strategy A.3.2. Home and Community-Based Services (HCS) to add 620 Promoting Independence slots; and 5) \$4,600,000 in General Revenue to Strategy A.3.2. Home and Community-Based Services (HCS) to add 196 Emergency Institutionalization slots; b. \$10,200,000 in General Revenue in A.1.1, Intake, Access, and Eligibility for DADS and MRAs to train and hire case managers to provide targeted case management;; c. \$15,000,000 in General Revenue to Strategy A.4.2. MR Community Services; d. \$2,100,000 in General Revenue to Strategies B.1.1. Facility/Community-Based Regulation; e. \$22,900,000 in General Revenue transferred from the Strategy A.3.2. Home and Community-Based Services to A.1.1, Intake, Access, and Eligibility; and f. \$22,900,000 in General Revenue to Strategies A.3.2, Home and Community-Based Services and A.1.1, Intake, Access, and Eligibility. HHSC is directed to allocate \$22,900,000 in General Revenue to implement rate increases for Home and Community-Based Services across the supervised living/residential support services, foster/companion care, and supported home living service types and is authorized to allocate funding as appropriate to the direct and indirect portions of each service rate. This authorization is granted to the extent allowed by state and federal law. <p>Transfers related to reshaping the system of services for individuals with developmental disabilities to meet the objectives</p>		

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		<p>described above are subject to DADS Rider 9, Limitation: Medicaid Transfer Authority.</p> <p>It is the intent of the Legislature that the fiscal impact on each strategy and associated with each initiative be estimated and identified as to fully understand the cost implications to other agencies.</p> <p>It is the intent of the Legislature that HHSC and DADS shall jointly design a plan to implement a capitated or non-capitated pilot to serve persons with intellectual and developmental disabilities. The agency may contract to conduct a study, which shall include input from individuals receiving services, their families, service providers, mental retardation authorities, advocate organizations, and other interested parties. The plan shall include managed care models employed by other states for this population.</p> <p>HHSC and DADS shall provide a report to the Governor's Office, Lieutenant Governor's Office, Speaker's Office, Senate Finance Committee, House Appropriations Committee, Senate Health and Human Services Committee, House Human Services Committee, and the Legislative Budget Board by December 1, 2010. The report shall include recommendations for the pilot regarding: geographic scope, options for consolidating waiver services, costs and financing, utilization review, provider network, eligibility, service coordination, quality management, waiver development and federal requirements, and other issues as appropriate.</p> <p><i>Rider should be deleted as it relates to funding in the 2010-11 biennium.</i></p>		
Sec. 50	II-125	<p>Advisory Committee Limitation and Reporting Requirement. Notwithstanding other provisions of this Act, the use of appropriated funds for a reimbursement to an advisory committee for travel and related expenses that occur during the 2010-11 biennium and are paid by a health and human services agency shall be governed by the following limitation and reporting requirement:</p> <ul style="list-style-type: none"> a. An advisory committee shall be reimbursed for travel and related expenses that occur during the 2010-11 biennium only if that committee has met at least one time between January 1, 2007 and January 1, 2009. A committee created after January 1, 2009 is exempted from this restriction. b. Reimbursements made according to section (a) shall not exceed \$10,000 per committee in any given fiscal year unless a higher amount is specifically authorized for the committee by another provision of this Act. c. The Health and Human Services Commission shall submit a report to the Legislative Budget Board, the Governor, and the Comptroller of Public Accounts by September 1, 2009 that includes the following 		

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		<p>information:</p> <p>(1) a list, by agency, of all advisory committees;</p> <p>(2) an indication, for each committee listed, of whether or not the committee is eligible for reimbursement during the 2010-11 biennium; and</p> <p>(3) the amount budgeted by fiscal year, for each committee eligible for reimbursement.</p> <p><i>Rider should be deleted as it does not consider frequency of committee meetings or the size and composition of committees. Rider has caused hardship on required federally-required committees and members. Each HHS agency has a rider which limits total compensation. HHSC programs would rather manage within an overall agency cap to allow discretion in allocating funding</i></p>		
Sec. 51	II-125	<p>Rio Grande State Center. Out of funds appropriated above to the Department of Aging and Disability Services (DADS) in Strategy A.8.1, MR State School Services, DADS shall enter into an interagency contact with the Department of State Health Services (DSHS) to transfer \$2,736,420 in All Funds for each fiscal year of the biennium to DSHS, Strategy C.1.3, Mental Health State Hospitals, to fund 79.5 full-time equivalents and related services at the Rio Grande State Center.</p> <p><i>Rider should be deleted as it relates to FY 2010-11 funding and staffing.</i></p>		
Sec. 52	II-125	<p>Expansion of Community-based Services. This section does not make any appropriations. It summarizes appropriations made elsewhere in this Act to expand community-based services.</p> <p>a. Limitations and Reporting. Funds appropriated elsewhere in this Act, totaling \$190,220,675 in General Revenue Funds and \$433,202,506 in All Funds for the 2010-11 biennium, are contingent upon each agency listed in the tables below providing the following information to the Legislative Budget Board and the Governor:</p> <p>(1) by September 1, 2009, a written report detailing, by month and fiscal year, planned client service levels, average monthly cost per client, and total expenditures for each listed strategy for fiscal year 2010 and fiscal year 2011; and</p> <p>(2) no later than 30 days following the close of a fiscal quarter, a written report on actual client service levels, average monthly cost per client, and total expenditures for each listed strategy for the fiscal year.</p> <p>Each report shall compare the reported service levels, costs, and expenditures to those adopted by the Legislature</p>		

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		<p>in this Act.</p> <p>Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board.</p> <p>The Comptroller of Public Accounts shall not allow the expenditure of funds if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.</p> <p>b. Appropriations. Tables 1 and 2 indicate General Revenue Funds and All Funds annual appropriations (made elsewhere in this Act) to expand community-based programs.</p> <p><i>Table 1</i> <i>General Revenue Appropriations</i></p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">FY2010</th> <th style="width: 10%; text-align: center;">FY 2011</th> <th style="width: 20%; text-align: center;">Biennial</th> </tr> </thead> <tbody> <tr> <td>Agency/Strategy/Program</td> <td></td> <td></td> <td></td> </tr> <tr> <td>DADS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>A.3.1. Community Based Alternatives (CBA)</td> <td style="text-align: right;">\$ 1,530,237</td> <td style="text-align: right;">\$ 4,610,732</td> <td style="text-align: right;">\$ 6,149,969</td> </tr> <tr> <td>A.3.2. Home and Community-based Services (HCS)*</td> <td style="text-align: right;">\$ 28,747,802</td> <td style="text-align: right;">\$ 81,921,391</td> <td style="text-align: right;">\$ 110,669,193</td> </tr> <tr> <td><i>includes the following:</i></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Independent Living</td> <td style="text-align: right;">\$ 22,760,277</td> <td style="text-align: right;">\$ 67,236,747</td> <td style="text-align: right;">\$ 89,997,024</td> </tr> <tr> <td>Promoting Independence</td> <td style="text-align: right;">\$ 4,800,465</td> <td style="text-align: right;">\$ 11,318,387</td> <td style="text-align: right;">\$ 16,118,852</td> </tr> <tr> <td>Preventing Institutionalization</td> <td style="text-align: right;">\$ 1,187,060</td> <td style="text-align: right;">\$ 3,366,257</td> <td style="text-align: right;">\$ 4,553,317</td> </tr> <tr> <td>A.3.3. Community Living Assistance and Support Services (CLASS)*</td> <td style="text-align: right;">\$ 7,808,350</td> <td style="text-align: right;">\$ 23,467,839</td> <td style="text-align: right;">\$ 31,276,189</td> </tr> <tr> <td>A.3.4. Deaf-Blind Multiple Disabilities (DBMD)*</td> <td style="text-align: right;">\$ 19,682</td> <td style="text-align: right;">\$ 79,228</td> <td style="text-align: right;">\$ 98,910</td> </tr> </tbody> </table>				FY2010	FY 2011	Biennial	Agency/Strategy/Program				DADS				A.3.1. Community Based Alternatives (CBA)	\$ 1,530,237	\$ 4,610,732	\$ 6,149,969	A.3.2. Home and Community-based Services (HCS)*	\$ 28,747,802	\$ 81,921,391	\$ 110,669,193	<i>includes the following:</i>				Independent Living	\$ 22,760,277	\$ 67,236,747	\$ 89,997,024	Promoting Independence	\$ 4,800,465	\$ 11,318,387	\$ 16,118,852	Preventing Institutionalization	\$ 1,187,060	\$ 3,366,257	\$ 4,553,317	A.3.3. Community Living Assistance and Support Services (CLASS)*	\$ 7,808,350	\$ 23,467,839	\$ 31,276,189	A.3.4. Deaf-Blind Multiple Disabilities (DBMD)*	\$ 19,682	\$ 79,228	\$ 98,910
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		A.3.5. Medically Dependent Children Program (MDCP)	\$ 609,506	\$ 1,840,085	\$ 2,449,591
		A.3.6. Consolidated Waiver Program	\$ -	\$ -	\$ -
		A.4.1. Non-Medicaid Community Services	\$ 294,555	\$ 890,105	\$ 1,184,660
		A.4.4. In-home and Family Support	\$ 170,994	\$ 512,981	\$ 683,975
		A.4.5. Mental Retardation In-home Services	\$ -	\$ -	\$ -
		Primary Home Care/Community Attendant Services Offset	\$ (378,913)	\$ (1,132,600)	\$ (1,511,513)
		Administration/FTEs	\$ 598,974	\$ 1,113,824	\$ 1,712,795
		Subtotal, DADS	\$ 39,401,187	\$ 113,312,582	\$ 152,713,769
		<i>Waiver subset</i>	\$ 38,715,57	\$ 111,928,275	\$ 150,643,852
		<i>* related to Special Provisions Sec. 48</i>			
		DARS			
		B.3.3. Independent Living Services	\$ 190,837	\$ 198,855	\$ 389,692
		B.3.4. Comprehensive Rehabilitation	\$ 2,016,033	\$ 2,356,402	\$ 4,372,435
		Administration/FTEs	\$ -	\$ -	\$ -
		Subtotal, DARS	\$ 2,206,870	\$ 2,555,257	\$ 4,762,127
		DSHS			
		A.3.4. Children with Special Health Care Needs	\$ 1,987,109	\$ 2,160,940	\$ 4,148,049
		B.2.2. Mental Health Services for Children	\$ 2,677,068	\$ 2,677,070	\$ 5,354,138
		Administration/FTEs	\$ 290,016	\$ 257,893	\$ 547,909
		Subtotal, DSHS	\$ 4,954,193	\$ 5,095,903	\$ 10,050,096
		HHSC			
		STAR+PLUS	\$ 149,165	\$ 451,230	\$ 600,695
		Acute Care for Medical Assistance Waiver Clients	\$ 3,310,933	\$ 10,262,562	\$ 13,573,495

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		Incremental Vendor Drug cost for Waiver Clients	\$ 1,907,104	\$ 6,277,343	\$ 8,184,447
		Administration/FTEs	\$ 114,875	\$ 221,171	\$ 336,046
		Subtotal, HHSC	\$ 5,482,377	\$ 17,212,306	\$ 22,694,683
		Grand Total	\$ 52,044,627	\$ 138,176,048	\$ 90,220,675
		<i>Table 2</i>			
		<i>All Funds Appropriations</i>			
			FY2010	FY2011	Biennial
		Agency/Strategy/Program			
		DADS			
		A.3.1. Community Based Alternatives (CBA)	\$ 3,713,265	\$ 11,251,174	\$ 14,964,439
		A.3.2. Home and Community-based Services (HCS)*	\$ 67,787,850	\$ 197,353,830	\$ 265,141,680
		<i>includes the following:</i>			
		<i>-Independent Living</i>	\$ 55,041,794	\$ 163,384,286	\$ 218,426,080
		<i>-Promoting Independence</i>	\$ 9,865,542	\$ 25,771,158	\$ 35,636,700
		<i>-Preventing Institutionalization</i>	\$ 2,880,514	\$ 8,198,386	\$ 11,078,900
		A.3.3. Community Living Assistance and Support Services (CLASS)*	\$ 18,901,276	\$ 57,064,945	\$ 75,966,221
		A.3.4. Deaf-Blind Multiple Disabilities (DBMD)*	\$ 47,761	\$ 192,956	\$ 240,717
		A.3.5. Medically Dependent Children Program (MDCP)	\$ 1,479,024	\$ 4,481,454	\$ 5,960,478
		A.3.6. Consolidated Waiver Program	\$ —	\$ —	\$ —
		A.4.1. Non-Medicaid Community Services	\$ 294,555	\$ 890,105	\$ 1,184,660
		A.4.4. In-home and Family Support	\$ 170,994	\$ 512,981	\$ 683,975

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		A.4.5. Mental Retardation In-home Services Primary Home Care/Community Attendant Services Offset	\$ ————— \$ (919,468)	\$ ————— \$ (2,758,402)	\$ ————— \$ (3,677,870)
		Administration/FTEs	\$ 993,014	\$ 1,854,892	\$ 2,847,906
		Subtotal, DADS	\$ 92,468,271	\$ 270,843,935	\$ 363,312,206
		Waiver subse	\$ 91,929,176	\$ 270,344,359	\$ 362,273,535
		* related to Special Provisions Sec. 48			
		DARS			
		B.3.3. Independent Living Services	\$ 190,837	\$ 198,855	\$ 389,692
		B.3.4. Comprehensive Rehabilitation Administration/FTEs	\$ 2,016,033	\$ 2,356,402	\$ 4,372,435
		Subtotal, DARS	\$ 2,206,870	\$ 2,555,257	\$ 4,762,127
		DSHS			
		A.3.4. Children with Special Health Care Needs	\$ 1,987,109	\$ 2,160,940	\$ 4,148,049
		B.2.2. Mental Health Services for Children Administration/FTEs	\$ 2,677,068	\$ 2,677,070	\$ 5,354,138
		Subtotal, DSHS	\$ 4,954,193	\$ 5,095,903	\$ 10,050,096
		HHSC			
		STAR+PLUS Acute Care for Medical Assistance Waiver Clients	\$ 362,691	\$ 1,098,952	\$ 1,461,643
			\$ 8,034,294	\$ 24,994,064	\$ 33,028,358
		Incremental Vendor Drug cost for Waiver Clients Administration/FTEs	\$ 4,627,769	\$ 15,288,219	\$ 19,915,988
		Subtotal, HHSC	\$ 13,254,503	\$ 41,823,574	\$ 55,078,077

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Special Provisions	Page Number in S.B. 1	Special Provisions																																					
		<p>Grand Total \$ 112,883,837 \$320,318,669 \$ 433,202,506</p> <p>c. Targets for Selected Community-based Programs. Tables 3 through 5 reflect performance targets as established by this Act for each of the strategies/programs listed below. Reports required by section (a) of this provision and by other provisions of this Act shall include comparisons and variance explanations relative to these targets.</p> <p>(1) Table 3, Continuing Clients/Slots, indicates the number of client/slots in fiscal year 2009 who will continue to receive services in the 2010-11 biennium.</p> <p>(2) Table 4, Expansion Clients/Slots indicates the number of additional clients/slots who will be served as a result of increased funding specified in subsection (a).</p> <p>(3) Table 5 indicates the combined continuing and new clients/slots.</p> <p>The "End of Year Clients" column indicates the number of clients/slots who will be served in the final month of the fiscal year. The "Average Monthly" column indicates the number of clients/slots to be served on average for the fiscal year overall. Average monthly values reflect the approved rollout of new slots and tie to performance targets established within each agency's bill pattern.</p>																																					
		<p>Table 3 Continuing Client/Slots</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th colspan="2" style="text-align: center;">End of Year Clients</th> <th colspan="2" style="text-align: center;">Average Monthly Caseload</th> </tr> <tr> <th style="width: 50%;"></th> <th style="text-align: center;"><u>FY 2010</u></th> <th style="text-align: center;"><u>FY 2011</u></th> <th style="text-align: center;"><u>FY 2010</u></th> <th style="text-align: center;"><u>FY 2011</u></th> </tr> </thead> <tbody> <tr> <td>Agency/Strategy/Program</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Agency/Strategy/Program</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>DADS</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>A.3.1. Community Based Alternatives (CBA)</td> <td style="text-align: center;">26,087</td> <td style="text-align: center;">26,087</td> <td style="text-align: center;">26,087</td> <td style="text-align: center;">26,087</td> </tr> <tr> <td>A.3.2. Home and Community-based Services (HCS)</td> <td style="text-align: center;">15,516</td> <td style="text-align: center;">15,516</td> <td style="text-align: center;">15,516</td> <td style="text-align: center;">15,516</td> </tr> </tbody> </table>				End of Year Clients		Average Monthly Caseload			<u>FY 2010</u>	<u>FY 2011</u>	<u>FY 2010</u>	<u>FY 2011</u>	Agency/Strategy/Program					Agency/Strategy/Program					DADS					A.3.1. Community Based Alternatives (CBA)	26,087	26,087	26,087	26,087	A.3.2. Home and Community-based Services (HCS)	15,516	15,516	15,516	15,516
	End of Year Clients		Average Monthly Caseload																																				
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3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: David Kinsey	Date: August 23, 2010	Request Level: Base		
Special Provisions	Page Number in S.B. 1	Special Provisions				
		A.3.3. Community Living Assistance and Support Services (CLASS)	4,199	4,199	4,199	4,199
		A.3.4. Deaf-Blind Multiple Disabilities (DBMD)	154	154	154	154
		A.3.5. Medically Dependent Children Program (MDCP)	2,745	2,745	2,745	2,745
		A.3.6. Consolidated Waiver Program	160	160	160	160
		A.3.7. Texas Home Living Waiver	994	994	994	994
		A.4.1. Non-Medicaid Community Services	39,005	39,005	39,005	39,005
		A.4.2. Mental Retardation Community Services	39,005	39,005	39,005	39,005
		A.4.2. Mental Retardation Community Services	12,927	12,927	12,927	12,927
		A.4.4. In-home and Family Support	4,590	4,590	4,590	4,590
		A.4.5. Mental Retardation In-home Services	3,060	3,060	3,060	3,060
		Primary Home Care/Community Attendant Services Offset	0	0	0	0
		Subtotal DADS	109,437	109,437	109,437	109,437
		Waiver Subsett	49,855	49,855	49,855	49,855
		DARS				
		B.3.3. Independent Living Services	1,743	1,743	221	221
		B.3.4. Comprehensive Rehabilitation	581	581	185	185
		Subtotal, DARS	2,324	2,324	406	406
		DSHS				

3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: David Kinsey	Date: August 23, 2010	Request Level: Base		
Special Provisions	Page Number in S.B. 1	Special Provisions				
		A.3.4. Children with Special Health Care Needs	1,650	1,650	2,600	2,600
		B.2.2. Mental Health Services for Children	18,664	19,554	12,100	12,100
		Subtotal, DSHS	20,314	21,204	14,700	14,700
		Grand Total	132,072	132,965	124,543	124,543
		<i>Table 4 Expansion Client/Slots</i>				
			<u>End of Year Clients</u>		<u>Average Monthly Caseload</u>	
			<u>FY 2010</u>	<u>FY 2011</u>	<u>FY 2010</u>	<u>FY 2011</u>
		Agency/Strategy/Program				
		DADS				
		A.3.1. Community Based Alternatives (CBA)	430	861	215	645
		A.3.2. Home and Community-based Services (HCS)*	2,968	5,936	1,501	4,469
		<i>includes the following</i>				
		<i>-Independent Living</i>	2,560	5,120	1,280	3,840
		<i>-Promoting Independence</i>	310	620	168	478
		<i>-Preventing Institutionalization</i>	98	196	53	151
		A.3.3. Community Living Assistance and Support Services (CLASS)*	945	1,890	472	1,417
		A.3.4. Deaf-Blind Multiple Disabilities (DBMD)*	3	6	1	4
		A.3.5. Medically Dependent Children Program (MDCP)	174	348	87	261
		A.3.6. Consolidated Waiver Program	0	0	0	0
		A.3.7. Texas Home Living Waiver	0	0	0	0
		A.4.1. Non-Medicaid Community Services	249	498	125	374

3.B. Rider Revisions and Additions Request

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		<p>A.4.2. Mental Retardation Community Services</p> <p>A.4.4. In-home and Family Support</p> <p>A.4.5. Mental Retardation In-home Services</p> <p>Primary Home Care/Community Attendant Services Offset</p> <p>Subtotal, DADS</p> <p>Waiver subset</p> <p><i>* related to Special Provisions Sec. 48</i></p> <p>DARS</p> <p>B.3.3. Independent Living Services</p> <p>B.3.4. Comprehensive Rehabilitation</p> <p>Subtotal, DARS</p> <p>DSHS</p> <p>A.3.4. Children with Special Health Care Needs</p> <p>B.2.2. Mental Health Services for Children</p> <p>Subtotal, DSHS</p> <p>Grand Total</p> <p>Table 5 Total Client/Slots (Continuing and Expansion)</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"></td> <td style="width: 25%; text-align: right;">0</td> <td style="width: 25%; text-align: right;">0</td> <td style="width: 25%; text-align: right;">0</td> </tr> <tr> <td></td> <td style="text-align: right;">326</td> <td style="text-align: right;">651</td> <td style="text-align: right;">163</td> </tr> <tr> <td></td> <td style="text-align: right;">0</td> <td style="text-align: right;">0</td> <td style="text-align: right;">0</td> </tr> <tr> <td></td> <td style="text-align: right;">(215)</td> <td style="text-align: right;">(431)</td> <td style="text-align: right;">(108)</td> </tr> <tr> <td></td> <td style="text-align: right;">4,880</td> <td style="text-align: right;">9,759</td> <td style="text-align: right;">2,456</td> </tr> <tr> <td></td> <td style="text-align: right;">4,520</td> <td style="text-align: right;">9,041</td> <td style="text-align: right;">2,276</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td style="text-align: right;">8</td> <td style="text-align: right;">8</td> <td style="text-align: right;">6</td> </tr> <tr> <td></td> <td style="text-align: right;">12</td> <td style="text-align: right;">13</td> <td style="text-align: right;">21</td> </tr> <tr> <td></td> <td style="text-align: right;">20</td> <td style="text-align: right;">21</td> <td style="text-align: right;">27</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td style="text-align: right;">87</td> <td style="text-align: right;">87</td> <td style="text-align: right;">87</td> </tr> <tr> <td></td> <td style="text-align: right;">412</td> <td style="text-align: right;">412</td> <td style="text-align: right;">412</td> </tr> <tr> <td></td> <td style="text-align: right;">499</td> <td style="text-align: right;">499</td> <td style="text-align: right;">499</td> </tr> <tr> <td></td> <td style="text-align: right;">5,399</td> <td style="text-align: right;">10,279</td> <td style="text-align: right;">2,982</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">End of Year Clients</td> <td style="text-align: center;">Average Monthly Caseload</td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">FY 2010</td> <td style="text-align: center;">FY 2011</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;">FY 2010</td> </tr> <tr> <td></td> <td></td> <td></td> <td style="text-align: center;">FY 2011</td> </tr> </table>		0	0	0		326	651	163		0	0	0		(215)	(431)	(108)		4,880	9,759	2,456		4,520	9,041	2,276						8	8	6		12	13	21		20	21	27						87	87	87		412	412	412		499	499	499		5,399	10,279	2,982							End of Year Clients	Average Monthly Caseload			FY 2010	FY 2011				FY 2010				FY 2011
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3.B. Rider Revisions and Additions Request

Agency Code: 529	Agency Name: Health & Human Services Commission	Prepared By: David Kinsey	Date: August 23, 2010	Request Level: Base		
Special Provisions	Page Number in S.B. 1	Special Provisions				
		Agency/Strategy/Program				
		DADS				
		A.3.1. Community-Based Alternatives (CBA)	26,517	26,948	26,302	26,732
		A.3.2. Home and Community-based Services (HCS)	18,484	21,452	17,017	19,985
		A.3.3. Community Living Assistance and Support Services (CLASS)	5,144	6,089	4,671	5,616
		A.3.4. Deaf-Blind Multiple Disabilities (DBMD)	457	460	155	158
		A.3.5. Medically Dependent Children Program (MDCP)	2,919	3,093	2,832	3,006
		A.3.6. Consolidated Waiver Program	160	160	160	160
		A.3.7. Texas Home Living Waiver	994	994	994	994
		A.4.1. Non-Medicaid Community Services	39,254	39,503	39,130	39,379
		A.4.2. Mental Retardation Community Services	12,927	12,927	12,927	12,927
		A.4.4. In-home and Family Support	4,916	5,241	4,753	5,079
		A.4.5. Mental Retardation In-home Services	3,060	3,060	3,060	3,060
		Primary Home Care/Community Attendant Services Offset	(215)	(431)	(108)	(323)
		Subtotal, DADS	114,317	119,196	111,893	116,773
		Waiver subset	54,375	58,896	52,131	56,651
		DARS				
		B.3.3. Independent Living Services	1,751	1,751	227	227
		B.3.4. Comprehensive Rehabilitation	593	594	206	209
		Subtotal, DARS	2,344	2,345	433	436

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Sec. 53	II-130	<p>Informational Listing of Stimulus Funds in Article II Agencies. The following is an informational list of the amounts in Article XII, American Recovery and Reinvestment Act funding related to agencies in Article II, Health and Human Services, and does not make appropriations.</p> <p><u>Department of Aging and Disability Services:</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Senior Nutrition Program - Congregate Nutrition</td> <td style="width: 10%; text-align: right;">\$</td> <td style="width: 20%; text-align: right;">4,000,000</td> </tr> <tr> <td>Senior Nutrition Program - Home Delivered Meals</td> <td style="text-align: right;">\$</td> <td style="text-align: right;">2,000,000</td> </tr> <tr> <td>Title XX</td> <td style="text-align: right;">\$</td> <td style="text-align: right;">4,200,00</td> </tr> <tr> <td>Title XX- Reduce GR</td> <td style="text-align: right;">\$</td> <td style="text-align: right;">(4,200,000)</td> </tr> </table> <p><u>Department of Assistive and Rehabilitative Services:</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">IDEA, Part C, Special Education Grants for Infants and Families</td> <td style="width: 10%; text-align: right;">\$</td> <td style="width: 20%; text-align: right;">39,400,000</td> </tr> <tr> <td>Independent Living Services - State Grants</td> <td style="text-align: right;">\$</td> <td style="text-align: right;">1,100,000</td> </tr> <tr> <td>Independent Living Services - Elderly/Blind</td> <td style="text-align: right;">\$</td> <td style="text-align: right;">2,300,000</td> </tr> <tr> <td>Vocational Rehabilitation Services</td> <td style="text-align: right;">\$</td> <td style="text-align: right;">44,800,000</td> </tr> </table> <p><u>Department of Family and Protective Services:</u></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Child Care and Development Block Grant (CCDBG)</td> <td style="width: 10%; text-align: right;">\$</td> <td style="width: 20%; text-align: right;">16,388,233</td> </tr> <tr> <td>Temporary Assistance for Needy Families (TANF)</td> <td style="text-align: right;">\$</td> <td style="text-align: right;">47,982,709</td> </tr> </table> <p><u>Department of State Health Services:</u></p>			Senior Nutrition Program - Congregate Nutrition	\$	4,000,000	Senior Nutrition Program - Home Delivered Meals	\$	2,000,000	Title XX	\$	4,200,00	Title XX- Reduce GR	\$	(4,200,000)	IDEA, Part C, Special Education Grants for Infants and Families	\$	39,400,000	Independent Living Services - State Grants	\$	1,100,000	Independent Living Services - Elderly/Blind	\$	2,300,000	Vocational Rehabilitation Services	\$	44,800,000	Child Care and Development Block Grant (CCDBG)	\$	16,388,233	Temporary Assistance for Needy Families (TANF)	\$	47,982,709
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Special Provisions	Page Number in S.B. 1	Special Provisions		
		<p>Section 317 Immunizations (Prevention and Wellness) \$ 3,160,681</p> <p>Prevention and Wellness Fund: Prevention Services and Programs \$ 400,000</p> <p>Infection Reduction Activities \$ 2,137,389</p> <p>Temporary Assistance for Needy Families (TANF to Title XX) \$ 4,200,000</p> <p>Reduce Federal Funds – Title XX \$ (4,200,000)</p> <p><u>Health and Human Services Commission:</u></p> <p>Food Stamps (Supplemental Nutritional Assistance Program) \$ 27,600,000</p> <p>Medicaid-Enhanced FMAP \$ 2,513,000,000</p> <p>Medicaid-Enhanced FMAP – Reduce GR \$ (2,513,000,000)</p> <p>Prevention and Wellness Fund: Prevention Services and Programs \$ 2,126,424</p> <p><i>Rider should be deleted as it relates to FY 2010-11 funding.</i></p>		
Sec. 54	II-131	<p>Information on Funding Provided for One-time Attendant Wage and Provider Rate Increases.</p> <p>a. Appropriations made elsewhere in this Act for the 2010-11 biennium, totaling \$229.2 million in General Revenue and \$524.5 million in All Funds, include \$129.5 million in General Revenue and \$300.2 million in All Funds for a one step and temporary attendant wage increase and \$99.7 million in General Revenue and \$224.3 million in All Funds for a one step and temporary provider rate increase. The following biennial amounts (in millions) are allocated to the health and human services agencies as listed below (All Funds amounts are estimated):</p> <p>1) Department of Aging and Disability Services: \$186.8 in General Revenue, \$439.6 in All Funds</p> <p style="padding-left: 20px;">(i) Attendant Wage Increase: \$118.6 in General Revenue, \$273.8 in All Funds</p> <p style="padding-left: 20px;">(ii) Provider Rate Increase: \$68.2 in General Revenue, \$165.8 in All Funds</p> <p>2) Department of Family and Protective Services: \$20.8 in General Revenue, \$32.2 in All Funds for foster care provider rate increases</p> <p>3) Health and Human Services Commission: \$21.6 in General Revenue, \$52.6 in All Funds</p> <p style="padding-left: 20px;">(i) Attendant Wage Increase: \$10.9 in General Revenue, \$26.4 in All Funds</p> <p style="padding-left: 20px;">(ii) Provider Rate Increase: \$10.7 in General Revenue, \$26.2 in All Funds</p>		

3.B. Rider Revisions and Additions Request

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Special Provisions	Page Number in S.B. 1	Special Provisions		
		<p>b. Article XII of this Act includes \$29 million for Early Childhood Intervention (ECI) temporary provider rate increases at the Department of Assistive and Rehabilitative Services, subject to certain conditions. The estimated one step increase in rates is 8%.</p> <p><i>Rider should be deleted as it relates to funding during the 2010-11biennium.</i></p>		