Rider Comparison Packet

Conference Committee on House Bill 1

2020-21 General Appropriations Bill

Article II - Health and Human Services

House

5. Foster Care Payments, Adoption Subsidies, and Permanency Care Assistance Payments. Notwithstanding Article IX, Sec. 14.01, Appropriation Transfers; Article IX, Sec. 14.03, Transfers - Capital Budget; and Article II, Special Provisions Sec. 6, Limitations on Transfer Authority in this Act, the Department of Family and Protective Services may only transfer funds into or out of Strategy B.1.9, Foster Care Payments, or into or out of Strategy B.1.10, Adoption Subsidy and Permanency Care Assistance Payments, with the prior written approval of the Legislative Budget Board and the Governor.

6. Other Reporting Requirements.

a. **Federal Reports.** The Department of Family and Protective Services (DFPS) shall submit the following information to the Legislative Budget Board and the Governor no later than the date the respective report is submitted to the federal government:

(1) Notification of proposed State Plan amendments or waivers for the Foster Care and Adoption Assistance program, the Child Welfare Services program, and any other federal grant requiring a state plan. State plan amendments and waiver submissions shall also be provided to the Senate Health and Human Services, House Human Services, and House Public Health committees.

(2) A copy of each report or petition submitted to the federal government relating to the Foster Care and Adoption Assistance program, the Child Welfare Services program, and any other federal grant requiring a state plan, including federal petition disapprovals, expenditure reports, cost allocation revisions and any loss of federal funding due to noncompliance with federal regulation.

b. **Federal Issues.** DFPS shall notify the Legislative Budget Board and the Governor on a timely basis about emerging issues that could result in the loss of more than $1 million in federal revenue assumed in the appropriations act.

c. **Monthly Financial Reports.** DFPS shall submit the following information to the Legislative Budget Board and the Governor no later than 30 calendar days after the close of each month:

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c. **Monthly Financial Reports.** DFPS shall submit the following information to the Legislative Budget Board and the Governor no later than 30 calendar days after the close of each month:

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(1) Information on appropriated, budgeted, expended, and projected funds, by strategy and method of finance.

(2) A report detailing revenues, expenditures, and balances for earned federal funds as of the last day of the prior month.

(3) Narrative explanations of significant budget adjustments, ongoing budget issues, and other items as appropriate.

(4) A report providing a breakdown of the budgeted versus actual Child Protective Services Direct Delivery Full-time Equivalents (FTE) by case stage and by region.

(5) Select Child Protective Services performance measures continued from the fiscal year 2017 critical needs reports, as determined by the Legislative Budget Board.

(6) Any other information requested by the Legislative Budget Board or the Governor.

The monthly financial reports shall be prepared in a format specified by the Legislative Budget Board.

d. **Quarterly Updates.** DFPS shall submit the following information to the Legislative Budget Board and the Governor on a quarterly basis for each month in fiscal years 2017 through 2021 beginning September 1, 2019: program expenditures and projected expenditures by method of finance, and performance measure targets for Strategies B.1.1, CPS Direct Delivery Staff; B.1.3, TWC Contracted Day Care; B.1.9, Foster Care Payments; B.1.10, Adoption Subsidy and Permanency Care Assistance Payments; B.1.11, Relative Caregiver Payments; and B.1.12, Community-based Care Payments. DFPS shall also submit data used to calculate the performance measure actuals for Strategy B.1.1, CPS Direct Delivery Staff. The information shall be submitted not later than two months after the end of the quarter.

e. **Litigation Involving Child Welfare Services Providers.** DFPS shall notify the Legislative Budget Board and the Governor in a timely manner about any pending litigation against DFPS or against any entity providing child welfare services under contract with DFPS, and the subject matter of the litigation.

The reports shall be prepared and submitted within 30 days of the end of each quarter in a

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(1) Information on appropriated, budgeted, expended, and projected funds, by strategy and method of finance.

(2) A report detailing revenues, expenditures, and balances for earned federal funds as of the last day of the prior month.

(3) Narrative explanations of significant budget adjustments, ongoing budget issues, and other items as appropriate.

(4) A report providing a breakdown of the budgeted versus actual Child Protective Services Direct Delivery Full-time Equivalents (FTE) by case stage and by region.

(5) Select Child Protective Services performance measures continued from the fiscal year 2017 critical needs reports, as determined by the Legislative Budget Board.

(6) Any other information requested by the Legislative Budget Board or the Governor.

The monthly financial reports shall be prepared in a format specified by the Legislative Budget Board.

d. **Quarterly Updates.** DFPS shall submit the following information to the Legislative Budget Board and the Governor on a quarterly basis for each month in fiscal years 2017 through 2021 beginning September 1, 2019: program expenditures and projected expenditures by method of finance, and performance measure targets for Strategies A.1.1, Statewide Intake; B.1.1, CPS Direct Delivery Staff; B.1.3, Texas Workforce Commission (TWC) Contracted Day Care; B.1.9, Foster Care Payments; B.1.10, Adoption Subsidy and Permanency Care Assistance Payments; B.1.11, Relative Caregiver Payments; and D.1.1, APS Direct Delivery Staff. DFPS shall also submit data used to calculate the performance measure actuals for Strategy A.1.1, Statewide Intake, Strategy B.1.1, CPS Direct Delivery Staff and Strategy D.1.1, APS Direct Delivery Staff as well as other statewide intake data related to call abandonment.

e. **Litigation Involving Child Welfare Services Providers.** DFPS shall notify the Legislative Budget Board and the Governor in a timely manner about any pending litigation against DFPS or against any entity providing child welfare services under contract with DFPS, and the subject matter of the litigation.

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format specified by the Legislative Budget Board.

f. **Monthly Data and Forecasts.** Notwithstanding Article II, Special Provisions, Sec. 8, Caseload and Expenditure Reporting Requirements, DFPS shall submit actual and projected caseloads and related expenditure amounts to the Legislative Budget Board and the Governor, for foster care, adoption assistance, permanency care assistance, relative caregiver, community-based care, and day care. Data for other programs shall be submitted upon request of the Legislative Budget Board or the Governor. The data shall be submitted in a format specified by the Legislative Budget Board. At the request of the Legislative Budget Board or the Governor supporting documentation detailing the sources and methodologies utilized to develop any caseload or expenditure projections and any other supporting material must be provided.

7. Limitation on Expenditures for Texas Workforce Commission (TWC) Contracted Day Care.

(a) Notwithstanding Article IX, Sec. 14.01, Appropriation Transfers; Article IX, Sec. 14.03, Transfers - Capital Budget; and Article II, Special Provisions Sec. 6, Limitations on Transfer Authority in this Act, the Department of Family and Protective Services (DFPS) may not transfer funds into or out of Strategy B.1.3, TWC Contracted Day Care, without the prior written approval of the Legislative Budget Board and the Governor.

To request approval, DFPS shall submit a written request to the Legislative Budget Board and the Governor. A request to transfer funds into Strategy B.1.3, TWC Contracted Day Care, must be submitted within 30 days of the date upon which DFPS produces a forecast indicating a need for additional funds and determines they are unable to operate within available appropriations. A request to transfer funds into Strategy B.1.3, TWC Contracted Day Care, must also be submitted at least 90 days prior to when expenditures are expected to exceed available appropriations. A request must include the following information:

(1) a detailed explanation of the need for day care services and the steps that have been taken to address the need without exceeding the amounts appropriated above;

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The reports shall be prepared and submitted within 30 days of the end of each quarter in a format specified by the Legislative Budget Board.

f. **Monthly Data and Forecasts.** Notwithstanding Article II, Special Provisions, Sec. 8, Caseload and Expenditure Reporting Requirements, DFPS shall submit actual and projected caseloads and related expenditure amounts to the Legislative Budget Board and the Governor, for foster care, adoption assistance, permanency care assistance, relative caregiver, community-based care, and day care. Data for other programs shall be submitted upon request of the Legislative Budget Board or the Governor. The data shall be submitted in a format specified by the Legislative Budget Board. At the request of the Legislative Budget Board or the Governor supporting documentation detailing the sources and methodologies utilized to develop any caseload or expenditure projections and any other supporting material must be provided.

7. Limitation on Expenditures for Texas Workforce Commission (TWC) Contracted Day Care.

(a) Notwithstanding Article IX, Sec. 14.01, Appropriation Transfers; Article IX, Sec. 14.03, Transfers - Capital Budget; and Article II, Special Provisions Sec. 6, Limitations on Transfer Authority in this Act, the Department of Family and Protective Services (DFPS) may not transfer funds out of Strategy B.1.3, TWC Contracted Day Care, and may only transfer funds into Strategy B.1.3, TWC Contracted Day Care, with the prior written approval of the Legislative Budget Board and the Governor.

To request approval, DFPS shall submit a written request to the Legislative Budget Board and the Governor. A request to transfer funds into Strategy B.1.3, TWC Contracted Day Care, must be submitted 30 days of the date upon which DFPS produces a forecast indicating a need for additional funds and determines they are unable to operate within available appropriations. A request to transfer funds into Strategy B.1.3, TWC Contracted Day Care, must also be submitted at least 90 days prior to when expenditures are expected to exceed appropriations. A request must include the following information:

(1) a detailed explanation of the need for day care services and the steps that have been

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(2) the sub-strategies affected by the increase in expenditures; and

(3) the method of financing and impact on performance levels by fiscal year, including a comparison to performance targets included in this Act.

No expenditure in excess of appropriations made above in Strategy B.1.3, TWC Contracted Day Care, may be made until approved. A request shall be considered disapproved unless the Legislative Budget Board and the Governor issue a written approval within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the request and forwards the review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. Any request for additional information made by the Legislative Budget Board shall interrupt the counting of the 30 business days.

(b) Funds appropriated above in Strategy B.1.3, TWC Contracted Day Care, may be used only to acquire child day care services through TWC.

Expenditures for administrative overhead payments to TWC and local workforce boards in connection with any agreement to provide child day care services shall not exceed 5.0 percent of all amounts paid for child day care services out of funds appropriated above in Strategy B.1.3, TWC Contracted Day Care.

11. Reporting Requirement on Child Removals by Race and Ethnic Group. The Department of Family and Protective Services shall report, by October 1 of each year of the biennium, to the House Appropriations Committee, the Senate Finance Committee, the Legislative Budget Board, and the Governor, the number of children removed from their homes by child protective services and the number of children investigated, by race and ethnic group, in the seven largest urban regions of the state during the preceding fiscal year.

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taken to address the need without exceeding the amounts appropriated above;

(2) the sub-strategies affected by the increase in expenditures; and

(3) the method of financing and impact on performance levels by fiscal year, including a comparison to performance targets included in this Act.

No expenditure in excess of appropriations made above in Strategy B.1.3, TWC Contracted Day Care, may be made until approved. A request shall be considered disapproved unless the Legislative Budget Board and the Governor issue a written approval within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the request and forwards the review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. Any requests for additional information made by the Legislative Budget Board shall interrupt the counting of the 30 business days.

(b) Funds appropriated above in Strategy B.1.3, TWC Contracted Day Care, may be used only to acquire child day care services through TWC.

Expenditures for administrative overhead payments to TWC and local workforce boards in connection with any agreement to provide child day care services shall not exceed 5.0 percent of all amounts paid for child day care services out of funds appropriated above in Strategy B.1.3, TWC Contracted Day Care.

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16. **Community-based Care.** Out of funds appropriated above to the Department of Family and Protective Services (DFPS) in Strategy B.1.2, CPS Program Support, the agency shall:

    a. Report selected performance measures identified by the Legislative Budget Board that will allow for comparative analysis between the legacy foster care and the Community-based Care systems. The report shall be prepared in a format specified by the Legislative Budget Board and shall be submitted March 31 and September 30 of each fiscal year of the biennium. The report shall be provided to the Legislative Budget Board, the Governor, the House Committee on Appropriations, the Senate Committee on Finance, the House Committee on Human Services, the Senate Committee on Health and Human Services, and any standing Joint Legislative Oversight Committees, as appropriate. The report shall also be posted on the agency's webpage in order to ensure transparency with stakeholders. The report shall contain: the most recent data for the selected comparative performance measures, an analysis of the data that identifies trends and related impact occurring in the Community-based Care system, identification and analysis of factors negatively impacting any outcomes, recommendations to address problems identified from the data, and any other information necessary to determine the status of the Community-based Care system.

    b. Ensure that all tasks, related FTEs, and associated funding to be transferred from DFPS to a Single Source Continuum Contractor (SSCC) are clearly identified and agreed upon by DFPS and the SSCC prior to each subsequent rollout.

    c. Develop an annual progressive intervention plan and contingency plan for the continuity of foster care service delivery in the event that a Community-based Care contract is terminated. This plan should be published on the DFPS website prior to the first day of each fiscal year.

    The payment rates for foster care redesign may not result in total expenditures for any fiscal year that exceed the amounts appropriated by this Act for that purpose without prior written approval of the Legislative Budget Board and the Governor, except to the extent that any increase in total foster care redesign expenditures is the direct result of caseload growth in foster care.

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15. **Community-based Care.** Out of funds appropriated above to the Department of Family and Protective Services (DFPS) in Strategy B.1.2, CPS Program Support, the agency shall:

    a. Report selected performance measures identified by the Legislative Budget Board that will allow for comparative analysis between the legacy foster care and the Community-based Care systems. The report shall be prepared in a format specified by the Legislative Budget Board and shall be submitted March 1 and September 30 of each fiscal year of the biennium. The report shall be provided to the Legislative Budget Board, the Governor, the House Committee on Appropriations, the Senate Committee on Finance, the House Committee on Human Services, the Senate Committee on Health and Human Services, and any standing Joint Legislative Oversight Committees, as appropriate. The report shall also be posted on the agency's webpage in order to ensure transparency with stakeholders. The report shall contain: the most recent data for the selected comparative performance measures, an analysis of the data that identifies trends and related impact occurring in the Community-based Care system, identification and analysis of factors negatively impacting any outcomes, recommendations to address problems identified from the data, and any other information necessary to determine the status of the Community-based Care system.

    b. Ensure that all tasks, related FTEs, and associated funding to be transferred from DFPS to a Single Source Continuum Contractor (SSCC) are clearly identified and agreed upon by DFPS and the SSCC prior to each subsequent rollout.

    c. Develop an annual progressive intervention plan and contingency plan for the continuity of foster care service delivery in the event that a Community-based Care contract is terminated. This plan should be published on the DFPS website prior to the first day of each fiscal year.

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18. Limitation on Transfers: Relative Caregiver Payments. Notwithstanding Article IX, Sec. 14.01, Appropriation Transfers; Article IX, Sec. 14.03, Transfers - Capital Budget; and Article II, Special Provisions Sec. 6, Limitations on Transfer Authority in this Act, the Department of Family and Protective Services (DFPS) may not transfer funds into or out of Strategy B.1.11, Relative Caregiver Payments, without the prior written approval of the Legislative Budget Board and the Governor. Included in amounts appropriated above in Strategy B.1.11, Relative Caregiver Payments, is $299,036 in General Revenue and $381,964 in TANF Federal Funds for fiscal year 2020 and $234,658 in General Revenue and $391,342 in TANF Federal Funds for fiscal year 2021 for post-permanency payments as authorized by Section 264.755(f), Family Code. Appropriations assume DFPS will account for post-permanency payments in the fiscal year in which the post-permanency payments are made. In the event post-permanency payments are projected to exceed appropriations for that purpose, DFPS shall seek approval from the Legislative Budget Board and the Governor to transfer funds pursuant to other authority in this Act prior to reducing the daily rate paid to relative caregivers.	**17. Limitation on Transfers: Relative Caregiver Payments.** Notwithstanding Article IX, Sec. 14.01, Appropriation Transfers; Article IX, Sec. 14.03, Transfers - Capital Budget; and Article II, Special Provisions Sec. 6, Limitations on Transfer Authority in this Act, the Department of Family and Protective Services may not transfer funds into or out of Strategy B.1.11, Relative Caregiver Payments, without the prior written approval of the Legislative Budget Board and the Governor. Included in amounts appropriated above in Strategy B.1.11, Relative Caregiver Payments, is $299,036 in General Revenue and $381,964 in TANF Federal Funds for fiscal year 2020 and $234,658 in General Revenue and $391,342 in TANF Federal Funds for fiscal year 2021 for post-permanency payments as authorized by Section 264.755(f), Family Code. Appropriations assume DFPS will account for post-permanency payments in the fiscal year in which the post-permanency payments are made.
27. Limitations and Increases: Foster Care Rates. Included in amounts appropriated above in Strategy B.1.9, Foster Care Payments, is $16,221,671 in General Revenue and $5,185,130 in Federal Funds in fiscal year 2020 and $15,778,329 in General Revenue and $4,989,216 in Federal Funds in fiscal year 2021, to provide rate increases for certain foster care providers in the legacy system. Amounts appropriated above in Strategy B.1.9, Foster Care Payments are intended to provide the following per child per day rate in fiscal year 2020 and fiscal year 2021: a. Basic Foster Family: $27.83 b. Basic Child Placing Agency: $51.37 c. Basic Residential: $45.19 d. Moderate Foster Family: $48.70	**26. Informational Listing and Limitations: Foster Care Rates.** Amounts appropriated above in Strategy B.1.9, Foster Care Payments are intended to provide the following per child per day rate in fiscal year 2020 and fiscal year 2021: a. Basic Foster Family: $27.07 b. Basic Child Placing Agency: $48.47 c. Basic Residential: $45.19 d. Moderate Foster Family: $47.37 e. Moderate Child Placing Agency: $85.46 f. Moderate Residential: $103.03

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e. Moderate Child Placing Agency: $90.60

f. Moderate Residential: $113.33

g. Specialized Foster Family: $59.48

h. Specialized Child Placing Agency: $117.36

i. Specialized Residential Facility: $207.57

j. Intense Foster Family: $95.02

k. Intense Child Placing Agency: $201.23

l. Intense Residential Facility: $291.24

m. Intense Plus: $400.72

n. Treatment Foster Care: $277.37

o. Intensive Psychiatric Transition Program: $411.76

p. Emergency Care Services: $146.80

Amounts appropriated above in Strategy B.1.12, Community-based Care Payments, are intended to provide the following daily rates for Single Source Continuum Contractors:

q. Region 3B: Blended Rate of $86.24 and Exceptional Rate of $460.37 in fiscal year 2020 and fiscal year 2021;

r. Region 2: Blended Rate of $85.72 and Exceptional Rate of $460.37 in fiscal year 2020 and fiscal year 2021;

s. Region 8A: Blended Rate of $86.36 and Exceptional Rate of $460.37 in fiscal year 2020 and fiscal year 2021; and

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g. Specialized Foster Family: $57.86

h. Specialized Child Placing Agency: $109.08

i. Specialized Residential Facility: $197.69

j. Intense Foster Family: $92.43

k. Intense Child Placing Agency: $186.42

l. Intense Residential Facility: $277.37

m. Intense Plus: $400.72

n. Treatment Foster Care: $277.37

o. Intensive Psychiatric Transition Program: $374.33

p. Emergency Care Services: $129.53

Amounts appropriated above in Strategy B.1.9, Foster Care Payments, are intended to provide the following daily rates for Single Source Continuum Contractors:

q. Region 3B: Blended Rate of $86.24 and Exceptional Rate of $490.75 in fiscal year 2020 and fiscal year 2021;

r. Region 2: Blended Rate of $85.72 and Exceptional Rate of $460.37 in fiscal year 2020 and fiscal year 2021;

s. Region 8A: Blended Rate of $86.36 and Exceptional Rate of $460.37 in fiscal year 2020 and fiscal year 2021; and

t. All other regions: Blended Rate of $84.03 in fiscal year 2020 and fiscal year 2021; Exceptional Rate of $460.37 in fiscal year 2020 and fiscal year 2021.

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t. All other regions: Blended Rate of $84.03 in fiscal year 2020 and fiscal year 2021; Exceptional Rate of $460.37 in fiscal year 2020 and fiscal year 2021.

Out of funds appropriated above in Strategy B.1.9, Foster Care Payments, the Department of Family and Protective Services (DFPS) is required to reimburse foster families at least $27.83 per day per child during the 2020-21 biennium.

None of the funds appropriated above to the DFPS may be used to reimburse a provider for foster care services in an amount that exceeds the applicable foster care reimbursement rate, as established by the Health and Human Services Commission for a child at that service level, approved by the Legislative Budget Board and the Governor, unless DFPS is unable to locate a provider that is willing and able to provide a safe and appropriate placement at the applicable rate.

30. Limitations: Community-based Care Payments.

(a) Included in amounts appropriated above in Strategy B.1.12, Community-based Care Payments, is $199,484,144 in All Funds ($110,792,603 in General Revenue) in fiscal year 2020 and $222,226,847 in All Funds ($123,989,101 in General Revenue) in fiscal year 2021 for Community-based Care in Regions 3B, 2, 8A, 1, and 8B as authorized by Family Code, Chapter 264. Funding shall be allocated as follows:

(1) In Region 3B:

(A) $42,681,962 in All Funds ($19,513,997 in General Revenue) in fiscal year 2020 and $42,384,743 in All Funds ($19,108,498 in General Revenue) in fiscal year 2021 for foster care payments;

(B) $3,456,696 in General Revenue in fiscal year 2020 and $4,224,836 in General Revenue in fiscal year 2021 for network support payments;

(C) $3,126,001 in General Revenue each fiscal year of the 2020-21 biennium for Stage 1 resource transfers; and

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Out of funds appropriated above in Strategy B.1.9, Foster Care Payments, the Department of Family and Protective Services (DFPS) is required to reimburse foster families at least $27.07 per day per child during the 2020-21 biennium.

None of the funds appropriated above to the DFPS may be used to reimburse a provider for foster care services in an amount that exceeds the applicable foster care reimbursement rate, as established by the Health and Human Services Commission for a child at that service level, approved by the Legislative Budget Board and the Governor, unless DFPS is unable to locate a provider that is willing and able to provide a safe and appropriate placement at the applicable rate.

29. Limitations: Community-based Care Payments.

(a) Included in amounts appropriated above in Strategies B.1.1, CPS Direct Delivery Staff, and B.1.9, Foster Care Payments, is $224,629,320 in All Funds ($134,948,911 in General Revenue) in fiscal year 2020 and $238,995,410 in All Funds ($140,082,572 in General Revenue) in fiscal year 2021 for Community-based Care in Regions 3B, 2, 8A, 1, and 8B as authorized by Family Code, Chapter 264. Funding shall be allocated as follows:

(1) In Region 3B:

(A) $42,681,962 in All Funds ($19,513,997 in General Revenue) in fiscal year 2020 and $42,384,743 in All Funds ($19,108,498 in General Revenue) in fiscal year 2021 in Strategy B.1.9 for foster care payments;

(B) $2,376,078 in General Revenue in fiscal year 2020 and $2,365,997 in General Revenue in fiscal year 2021 in Strategy B.1.9 for network support payments; and $1,207,820 in General Revenue in fiscal year 2020 and $1,207,821 in General Revenue in fiscal year 2021 in Strategy B.1.9 for Stage II network support payments;

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(D) $24,507,262 in All Funds ($22,054,723 in General Revenue) in fiscal year 2020 and $26,628,134 in All Funds ($23,935,253 in General Revenue) for Stage 2 resource transfers.

(2) In Region 2:

(A) $22,909,833 in All Funds ($10,112,768 in General Revenue) in fiscal year 2020 and $22,977,539 in All Funds ($10,070,503 in General Revenue) in fiscal year 2021 for foster care payments;

(B) $1,447,800 in General Revenue in fiscal year 2020 and $1,463,000 in General Revenue in fiscal year 2021 for network support payments; and

(C) $1,350,000 in General Revenue in each fiscal year of the 2020-21 biennium for resource transfers.

(3) In Region 8A:

(A) $60,220,994 in All Funds ($26,582,512 in General Revenue) in fiscal year 2020 and $60,398,103 in All Funds ($26,471,037 in General Revenue) in fiscal year 2021 for foster care payments;

(B) $3,805,700 in General Revenue in fiscal year 2020 and $3,845,600 in General Revenue in fiscal year 2021 for network support payments; and

(C) $4,230,000 in General Revenue in each fiscal year of the 2020-21 biennium for resource transfers.

(4) In Region 1:

(A) $19,992,257 in All Funds ($8,824,903 in General Revenue) in fiscal year 2020 and $26,409,249 in All Funds ($11,574,538 in General Revenue) in fiscal year 2021 for foster care payments;

(B) $360,829 in General Revenue in fiscal year 2020 and $2,459,850 in General Revenue in fiscal year 2021 for network support payments; and

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(C) $3,126,001 in General Revenue each fiscal year of the 2020-21 biennium in Strategy B.1.1 for Stage 1 resource transfers;

(D) $1,805,594 in All Funds ($1,623,752 in General Revenue) in fiscal year 2020 and $1,805,594 in All Funds ($1,623,753 in General Revenue) in fiscal year 2021 in Strategy B.1.1, CPS Direct Delivery Staff for Stage II start-up costs;

(E) $23,513,926 in All Funds ($21,180,019 in General Revenue) in each fiscal year of the 2020-21 biennium in Strategy B.1.1 for Stage II resource transfers; and

(F) $3,827,262 in All Funds ($3,441,818 in General Revenue) in each fiscal year of the 2020-21 biennium in Strategy B.1.1 for additional Stage II resource transfers.

(2) In Region 2:

(A) $22,909,833 in All Funds ($10,112,768 in General Revenue) in fiscal year 2020 and $22,977,539 in All Funds ($10,070,503 in General Revenue) in fiscal year 2021 in Strategy B.1.9 for foster care payments;

(B) $1,447,800 in General Revenue in fiscal year 2020 and $1,463,000 in General Revenue in fiscal year 2021 in Strategy B.1.9 for network support payments; and $988,136 in General Revenue in fiscal year 2020 and $988,137 in General Revenue in fiscal year 2021 in Strategy B.1.9 for Stage II network support payments;

(C) $828,455 in All Funds ($745,021 in General Revenue) in fiscal year 2020 and $828,456 in fiscal year 2021 ($745,022 in General Revenue in Strategy B.1.1 for Stage II start-up;

(D) $1,350,000 in General Revenue in each fiscal year of the 2020-21 biennium in Strategy B.1.1 for resource transfers.

(E) $1,745,398 in All Funds ($1,581,417 in General Revenue) in fiscal year 2020 and $1,745,397 in All Funds ($1,581,417 in General Revenue) in Strategy B.1.1 for Stage II resource transfers; and

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(C) $122,566 in All Funds ($70,770 in General Revenue) in fiscal year 2020 and $1,008,007 in All Funds ($908,539 in General Revenue) for resource transfers.

(5) In Region 8B:

(A) $997,000 in General Revenue in fiscal year 2020 for stage 1 start-up costs;

(B) $9,189,826 in All Funds ($4,056,536 in General Revenue) in fiscal year 2020 and $18,143,304 in All Funds ($7,951,774 in General Revenue) in fiscal year 2021 for foster care payments;

(C) $180,415 in General Revenue in fiscal year 2020 and $2,059,449 in General Revenue in fiscal year 2021 for network support payments; and

(D) $122,566 in All Funds ($70,771 in General Revenue) in fiscal year 2020 and $784,135 in All Funds ($706,581 in General Revenue) for resource transfers.

(6) The amounts identified in subsections (a)(1), (a)(2), (a)(3), (a)(4), (a)(5), and (b) shall be expended only for the specific purposes listed above and are not to be expended on any other item of appropriation, unless approval is granted pursuant to subsection (d) of this rider.

(b) $382,437 in All Funds ($151,182 in General Revenue) in fiscal year 2020 and $334,897 in All Funds ($103,642 in General Revenue) in fiscal year 2021, for consulting services associated with outcome monitoring, data analysis, and development of alternative rate methodologies.

(c) $400,000 in General Revenue in each fiscal year for Child and Adolescent Needs and Strengths (CANS) assessments.

(d) DFPS shall continue the use of an independent evaluation to complete process and outcome evaluations throughout the entire rollout and implementation of Community-based Care in each established catchment area. All evaluations shall be provided to the Legislative Budget Board, the Governor, the House Committee on Appropriations, the Senate Committee on Finance, the House Committee on Human Services, and the Senate Committee on Health

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(F) $3,000,000 in General Revenue in each fiscal year of the 2020-21 biennium in Strategy B.1.1 for additional Stage II resource transfers.

(3) In Region 8A:

(A) $60,220,994 in All Funds ($26,582,512 in General Revenue) in fiscal year 2020 and $60,398,103 in All Funds ($26,471,037 in General Revenue) in fiscal year 2021 in Strategy B.1.9 for foster care payments;

(B) $3,805,700 in General Revenue in fiscal year 2020 and $3,845,600 in General Revenue in fiscal year 2021 in Strategy B.1.9 for network support payments; and $1,940,850 in General Revenue in each fiscal year 2020-21 biennium in Strategy B.1.9 for Stage II network support payments;

(C) $4,230,000 in General Revenue in each fiscal year of the 2020-21 biennium in Strategy B.1.1 for resource transfers;

(D) $2,168,396 in All Funds ($1,950,017 in General Revenue) in fiscal year 2020 and $2,168,397 in fiscal year 2021 ($1,950,017 in General Revenue) in Strategy B.1.1 for Stage II start-up;

(E) $3,873,170 in All Funds ($3,507,687 in General Revenue) in fiscal year 2020 and $3,873,170 in All Funds ($3,507,688 in General Revenue) in Strategy B.1.1 for Stage II resource transfers; and

(F) $4,500,000 in General Revenue in each fiscal year of the 2020-21 biennium in Strategy B.1.1 for additional Stage II resource transfers.

(4) In Region 1:

(A) $19,992,257 in All Funds ($8,824,903 in General Revenue) in fiscal year 2020 and $26,409,249 in All Funds ($11,574,538 in General Revenue) in fiscal year 2021 in Strategy B.1.9 for foster care payments;

(B) $1,228,872 in General Revenue in fiscal year 2020 and $1,228,873 in General Revenue in fiscal year 2021 in Strategy B.1.9 for network support payments; and

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and Human Services.

(e) Notwithstanding Rider 5, Foster Care Payments, Adoption Subsidies, and Permanency Care Assistance Payments; Article IX, Sec. 14.01, Appropriation Transfers; Article IX, Sec. 14.03, Transfers - Capital Budget; and Article II, Special Provisions Sec. 6, Limitations on Transfer Authority in this Act, DFPS may not transfer funds into or out of Strategy B.1.12, Community-based Care Payments, without the prior written approval of the Legislative Budget Board and the Governor. DFPS may only request transfer into or out of Strategies B.1.1, CPS Direct Delivery Staff; B.1.2, CPS Program Support; and B.1.9, Foster Care Payments.

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(C) $277,106 in All Funds ($249,903 in General Revenue) in fiscal year 2020 and $277,106 in All Funds ($249,904 in General Revenue) in Strategy B.1.1 for resource transfers.

(5) In Region 8B:

(A) $997,000 in General Revenue in fiscal year 2020 in Strategy B.1.1 for Stage 1 start-up;

(B) $9,189,826 in All Funds ($4,056,536 in General Revenue) in fiscal year 2020 and $18,143,304 in All Funds ($7,951,774 in General Revenue) in fiscal year 2021 in Strategy B.1.9 for foster care payments;

(C) $863,103 in General Revenue in fiscal year 2020 and $863,103 in General Revenue in fiscal year 2021 in Strategy B.1.9 for network support payments; and

(D) $169,293 in All Funds ($152,713 in General Revenue) in each fiscal year of the 2020-21 biennium in Strategy B.1.1 for resource transfers.

(6) The amounts identified in subsections (a)(1), (a)(2), (a)(3), (a)(4), (a)(5), and (b) shall be expended only for the specific purposes listed above and are not to be expended on any other item of appropriation without the prior written approval of the Legislative Budget Board and the Governor.

(b) $364,488 in General Revenue in fiscal year 2020 and $364,489 in General Revenue in fiscal year 2021 in Strategy B.1.9, Foster Care Payments, for Child and Adolescent Needs and Strengths (CANS) assessments;

(c) DFPS shall continue the use of an independent evaluation to complete process and outcome evaluations throughout the entire rollout and implementation of Community-based Care in each established catchment area. All evaluations shall be provided to the Legislative Budget Board, the Governor, the House Committee on Appropriations, the Senate Committee on Finance, the House Committee on Human Services, and the Senate Committee on Health and Human Services.

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32. Texas Home Visiting Program and Nurse Family Partnership Program. Included in amounts appropriated above to the Department of Family and Protective Services in Strategy C.1.5, Home Visiting Program, is: a. $1,397,000 in General Revenue Funds and $16,176,334 in Federal Funds in fiscal year 2020, and $1,397,000 in General Revenue Funds and $16,176,334 in Federal Funds in fiscal year 2021 for services in the Texas Home Visiting Program; and b. $4,615,760 in General Revenue Funds and $12,265,549 in Federal Funds in fiscal year 2020, and $4,615,760 in General Revenue Funds and $12,265,549 in Federal Funds in fiscal year 2021 for services in the Nurse Family Partnership Program. c. Support costs for these programs are included in Strategy C.1.6, At-Risk Prevention Programs, and are not included in sections (a) through (b).	
	32. Faith and Community Based Partner Coordination. To the extent allowed by federal and state regulations, and in accordance with Ch. 535 of the Government Code, the Department of Family and Protective Services (DFPS) shall use appropriations included in all Strategies in Goal C, Prevention Programs, to maintain a coordinated and comprehensive strategy for engaging and collaborating with faith and community based partners, including the designation of a single point of contact for public and community partners.
34. Contractor Penalties and Incentives. Included in amounts appropriated above in Strategy B.1.2, CPS Program Support, is an amount estimated to be $0 in Appropriated Receipts from Revenue Object Code 3770 for financial penalties collected from contractors under section 40.058(f)(2) of the Human Resources Code for failing to meet specified performance outcomes. Amounts appropriated from Appropriated Receipts from Revenue Object Code 3770 shall be used to award incentives to contactors who exceed contractually specified performance outcomes. Incentive amounts may be paid only from available funds collected for this purpose in Revenue Object Code	**34. Contractor Penalties and Incentives.** The Department of Family and Protective Services (DFPS) is appropriated in Strategy B.1.2, CPS Program Support for the 2020-21 biennium, any revenue collected as of August 31, 2019 and any revenue collected in each fiscal year of the 2020-21 biennium from Revenue Object Code 3770 as Appropriated Receipts from financial penalties collected from contractors under section 40.058(f)(2) of the Human Resource Code for failing to meet specified performance outcomes. Amounts appropriated from Appropriated Receipts from Revenue Object Code 3770 shall be used to award incentives to contractors who exceed

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3770. DFPS shall report the revenue collected in Revenue Object Code 3770 to the Legislative Budget Board and the Governor in the required Monthly Financial Report. Any unexpended and unobligated balances remaining from amounts appropriated as of August 31, 2020 are appropriated for the same purposes for the fiscal year beginning September 1, 2020.

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contractually specified performance outcomes. Incentive amounts may be paid only from available funds collected for this purpose in Revenue Object Code 3770. DFPS shall report all revenue collected in Revenue Object Code 3770 to the Legislative Budget Board and the Governor in the required Monthly Financial Report. Any unexpended and unobligated balances remaining from amounts appropriated as of August 31, 2020 are appropriated for the same purposes for the fiscal year beginning September 1, 2020.

35. **Information Management Protecting Adults and Children in Texas (IMPACT) System Enhancements.** Out of funds appropriated above in Strategy F.1.1, Agency-wide Automated Systems, the Department of Family and Protective Services shall allocate $1,454,829 in General Revenue ($1,696,655 in All Funds) for the following system enhancements to improve data collection:

    (a) track information on child victims of sexual aggression by another child or adult;

    (b) create an automatic notification to primary caseworkers for abuse or neglect reports that will not be investigated by child care investigators; and

    (c) expand tracking of history assessments including initiations of face-to-face contact and case closures.

36. **Limitations: Substance Abuse Purchased Services Appropriations.** Appropriations above in Strategy B.1.7, Substance Abuse Purchased Services for fiscal year 2021 include $7,000,000 in General Revenue that is contingent upon the Department of Family and Protective Services (DFPS) developing and implementing a plan to control costs and remain within appropriations for the 2020-21 biennium. The plan may include evaluating policies relating to the utilization of substance abuse purchased services to ensure they are appropriate and cost-effective and the re-procurement or renegotiation of contracts related to drug testing to ensure the best value for the state.

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	Not later than February 1, 2020, DFPS shall submit the plan to the Legislative Budget Board, the Governor, the Chair of the House Appropriations Committee, the Chair of the Senate Finance Committee, Speaker of the House, and the Lieutenant Governor.
36. Human Trafficking and Child Exploitation Prevention and Intervention. Out of funds appropriated above in Strategy E.1.1, Central Administration, the Department of Family and Protective Services shall allocate a minimum of $839,400 each state fiscal year to the Human Trafficking and Child Exploitation division.	**33. Human Trafficking Prevention.** Out of the funds appropriated above for the Department of Family and Protective Services in Strategy E.1.1, Central Administration, $668,230 in All Funds ($660,459 in General Revenue and $880 in General Revenue Match for Medicaid Account No. 758) and 2.0 FTEs in fiscal year 2020, and $639,269 in All Funds ($632,259 in General Revenue and $793 in General Revenue Match for Medicaid Account No. 758) and 2.0 FTEs for fiscal year 2021, shall be used to fund the continuation and expansion of prevention of human trafficking.
37. Appropriation of Unexpended Balance for Prevention Programs. All unexpended balances appropriated above for strategies in Goal C, Prevention Programs, for the fiscal year ending August 31, 2020, are hereby appropriated for the same purposes for the fiscal year beginning September 1, 2020. The department shall notify the Legislative Budget Board and the Governor as to why the appropriations were unexpended, and how they will be used, prior to budgeting and expending the balances. The notification shall be prepared in a format specified by the Legislative Budget Board.	**37. Caseworker and Management Ratio Study.** Out of funds appropriated above, in Strategy E.1.1, Central Administration, the Department of Family and Protective Services (DFPS) shall evaluate management to caseworker ratios for Child and Adult Protective Services to determine the effects of alternative ratios on expenditures and agency operations. DFPS shall report the findings of the study to the Legislative Budget Board, the Governor, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services and appropriations by September 1, 2020.

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	38. Adult Protective Services (APS) and Statewide Intake (SWI) Salaries. In order to increase employee retention, out of funds appropriated above in Strategy A.1.1, Statewide Intake and Strategy D.1.1, APS Direct Delivery Staff, the Department of Family and Protective Services shall direct funds for pay raises for APS caseworkers and SWI frontline staff to any rate within the employee's salary group range for appropriate merit increases and retention strategies.
38. Investigation of Allegations of Abuse or Neglect of Children. Out of funds appropriated above for Strategy B.1.1, CPS Direct Delivery Staff, it is the intent of the legislature that to the extent authorized by general law, the Department of Family and Protective Services shall investigate allegations of abuse and neglect regarding children being held in residential child care facilities licensed by the Health and Human Services Commission including, but not limited to, the Galveston Multicultural Institute, the South Texas Family Residential Center, the Shiloh Treatment Center, the T. Don Hutto Residential Center, facilities operated under Southwest Key's children's shelter program, facilities operated by Children's Center, Inc., and any other facility conducting operations similar to those facilities.	
	39. Community-based Care (CBC) Appropriations. Included in appropriations above in Strategy B.1.1, CPS Direct Delivery Staff and B.1.9, Foster Care Payments is funding to implement Stage I of CBC in two new regions and to implement Stage II in three regions in the 2020-21 biennium. The Department of Family and Protective Services shall provide status reports on the implementation on October 1 and April 1 of each year to the Legislative Budget Board and the Governor.
	41. Reporting on Disproportionality and Disparities. Out of funds appropriated above to the Department of Family and Protective Services (DFPS) in Strategy E.1.1, Central Administration, DFPS may collaborate with an institution of higher education to research, evaluate, and

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recommend practices, programs, and policies for addressing disproportionality and disparities and ensuring equitable provision of services to and outcomes for children and families served by DFPS. For the purposes of this rider, the term "disproportionality" refers to the ratio between the percentage of persons in a particular racial or ethnic group at a particular decision point or experiencing an event (such as maltreatment, incarceration, school dropouts) compared to the percentage of the same racial or ethnic group in the overall population; and the term "disparity" refers to unequal treatment or outcomes for different groups in the same circumstances or at the same decision point.

Not later than December 1, 2020, DFPS shall submit a report to the Legislative Budget Board, the Governor, the Chair of the House Appropriations Committee, the Chair of the Senate Finance Committee, Speaker of the House, the Lieutenant Governor and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services highlighting recommendations to address disproportionality and disparities and ensure equitable outcomes, including policy recommendations; analysis of child and parent data by race and ethnicity across all stages of service; and a summary of relevant initiatives and programs in place at DFPS during the preceding fiscal year.

42. **Improved Outcomes Pilot.** Out of funds appropriated above in Strategy C.1.4, Other At-Risk Prevention Programs, the Department of Family and Protective Services (DFPS) shall allocate $250,000 in General Revenue in each fiscal year to implement a pilot program aimed at improving outcomes for children at highest risk of re-entering the child protective services system. The pilot shall:

    a. be evidence-based or incorporate promising practices;

    b. be implemented in a county with a population over 800,000; and

    c. aim to reduce the child's interaction with the juvenile justice system, reduce teen pregnancy and increase graduation rates over the span of the child's youth.

    Not later than December 1, 2020, DFPS shall report to the Legislative Budget Board, the Governor, the Chair of the House Appropriations Committee, the Chair of the Senate Finance

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	Committee, Speaker of the House, Lieutenant Governor, and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services on the success of the pilot program in improving outcomes.

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6. Exemption from Article IX, Sec. 8.02 (e), Reimbursements and Payments. Notwithstanding the limitations contained in Article IX, Sec. 8.02 (e), Reimbursements and Payments, the Department of State Health Services may use the reimbursements, refunds, and payments received under Article IX, Sec. 8.02 (a) for any item of appropriation. Article IX, Sec. 8.02 (e) does apply to rebate revenue earned via the HIV Medication Program and deposited under the Comptroller's Revenue Object Code No. 3552 (Vendor Drug Rebates, HIV Program).	
	8. Transfer from the Cancer Prevention and Research Institute of Texas for the Cancer Registry. Out of funds appropriated elsewhere in this Act to the Cancer Prevention and Research Institute of Texas (CPRIT) is $3,118,032 out of General Obligation Bond Proceeds each fiscal year of the 2020-21 biennium which shall be transferred from CPRIT to the Department of State Health Services in Strategy A.1.3, Health Registries, for administration of the Cancer Registry in accordance with the Texas Constitution, Article III, Section 67 and Health and Safety Code, Chapter 102.
19. Tobacco Prevention Funding. Out of funds appropriated above in Strategy A.3.2, Reduce Use of Tobacco Products, funds provided for activities targeting prevention of youth experimentation with nicotine-containing products shall only be expended on evidence-based and promising practices.	**19. Tobacco Prevention Funding.** Out of funds appropriated above in Strategy A.3.2, Reduce Use of Tobacco Products to the Department of State Health Services: a. Funds provided for activities targeting prevention of youth experimentation with nicotine-containing products shall only be expended on evidence-based and promising practices; and b. No funds shall be expended on paid media activities.
	21. Federally Funded Capital Projects. Notwithstanding the limitations in Article IX, Section 14.03, Transfers - Capital Budget, the Department of State Health Services is authorized to transfer from a non-capital budget item to an existing capital budget item or a new capital budget item not present in the agency's bill pattern contingent upon:

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a. implementation of a new, unanticipated project that is 100 percent federally funded; or

b. the unanticipated expansion of an existing project that is 100 percent federally funded; and

c. providing prior written notification to the State Auditor's Office, the Comptroller of Public Accounts, the Legislative Budget Board, and the Governor.

28. Unexpended Balances Between and Within the Biennia: Permanent Tobacco Funds. Included in the amounts appropriated above are unexpended balances remaining as of August 31, 2019, in an amount not to exceed $100,000 from the Permanent Fund for Children and Public Health (Account No. 5045) in Strategy A.1.1, Public Health Preparedness and Coordinated Services, and in an amount not to exceed $350,000 from the Permanent Fund for Emergency Medical Services and Trauma Care (Account No. 5046) in Strategy B.2.1, EMS and Trauma Care Systems, for the same purpose for the biennium beginning September 1, 2019.

Any unexpended balances remaining as of August 31, 2020 from the appropriations made in this rider are appropriated to the Department of State Health Services (DSHS) for the fiscal year beginning September 1, 2020 for the same purpose, subject to DSHS notifying the Legislative Budget Board and the Governor in writing at least 30 days prior to budgeting and expending these balances.

29. Increase Salaries for Trained Laboratory Staff. Included in the amounts appropriated above in Strategy A.4.1, Laboratory Services, the Department of State Health Services (DSHS) shall allocate $2,250,000 in General Revenue in each fiscal year of the 2020-21 biennium to increase retention of trained laboratory staff. DSHS shall direct funds for salary increases to trained laboratory staff, including chemists, data entry operators, laboratory technicians, microbiologists, molecular biologists, and medical technologists, with prioritization given to laboratory position classifications with the highest turnover rate.

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29. Contingency for Legislation Relating to Combating Maternal Mortality and Morbidity. Contingent on the enactment of legislation relating to combating maternal mortality and morbidity, by the Eighty-sixth Legislature, Regular Session, 2019, included in the amounts appropriated above to the Department of State Health Services is $3,500,000 in General Revenue Funds each fiscal year of the 2020-21 biennium in Strategy B.1.1, Maternal and Child Health, to implement the provisions of the legislation, including implementation of maternal safety initiatives statewide, a community health care coordination pilot for women of childbearing age, develop and train providers on use of risk assessment tools, and increase public awareness and prevention activities. Included in the "Number of Full-Time-Equivalents (FTEs)" above is 8.0 FTEs each fiscal year.	
	30. Protective Staging Area for Emergency Response Vehicles. Included in the amounts appropriated above in Strategy A.2.5, TX Center for Infectious Disease, is $979,880 in General Revenue in fiscal year 2020 to build a protective staging area and sheltering for public health emergency response vehicles. The agency may consider utilizing unused property on the San Antonio State Hospital Campus.
30. Cost Analysis of Outbreak Involving Certain Vaccine Preventable Diseases. Out of the funds appropriated above, the Department of State Health Services (DSHS) shall study and assess the economic costs and costs to the department and local public health organizations incurred in responding to vaccine preventable diseases outbreaks. The study shall include the direct costs associated with prophylaxis and treatment of exposed individuals in management of the outbreak. The study shall also include the indirect costs associated with the response phase of an outbreak, which may include factors such as: (1) staff hours expended by the department and local public health organizations to track and investigate the exposure and risk of each person that has been potentially exposed during the outbreak; (2) the value of hours spent for public	

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outreach/education; (3) the impact on businesses relating to lost hours and absenteeism rates; (4) the impact on schools relating to dismissals or early childhood program closures; and (5) any other potential downstream impacts. Not later than September 1, 2020, the department shall: (1) prepare all findings from the study; (2) submit the findings to the relevant House and Senate committees; and (3) submit the findings to the Public Health Funding and Policy Committee.

31. Adult Safety Net Program. Out of the funds appropriated above in Strategy A.2.1, Immunize Children and Adults in Texas, the Department of State Health Services may make available adult safety net vaccines to local health departments to immunize Medicare-D patients whose insurance does not cover the vaccine at the time of presentation at the local health department.

Funds appropriated in Strategy A.2.1, Immunize Children and Adults in Texas, may not be expended to make available adult safety net vaccines for the purposes of this rider without prior written approval from the Legislative Budget Board and the Governor. Additional information requested by the Legislative Budget Board related to this approval shall be provided in a timely manner and shall be prepared in a format specified by the Legislative Budget Board. The request shall be considered to be approved unless the Legislative Budget Board issues a written disapproval within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House of Representatives, and Lieutenant Governor. Any request for additional information from the LBB shall interrupt the counting of the 30 business days.

32. Estimated Appropriation and Unexpended Balance: Permanent Tobacco Funds. Included in the amounts appropriated above out of the Permanent Fund for Health and Tobacco Education and Enforcement (Account No. 5044), Permanent Fund for Children and Public Health (Account No. 5045), and Permanent Fund for Emergency Medical Services and Trauma Care (Account No. 5046) is an amount estimated to be $0 in each fiscal year of the 2020-21 biennium from interest earned from the funds, collected after September 1, 2019. Revenue collected in excess of the amounts estimated above is appropriated to the Department of State Health Services (DSHS),

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contingent on certification by a Comptroller's finding of fact that additional revenue is available for appropriation in Account No. 5044, Account No. 5045, and Account No. 5046 for the given fiscal year.

Any unexpended balances remaining as of August 31, 2020 from the appropriations made in this rider are appropriated to DSHS for the fiscal year beginning September 1, 2020 for the same purpose, subject to DSHS notifying the Legislative Budget Board and the Governor in writing at least 30 days prior to budgeting and expending these balances.

33. Study on Immunization Rates at Child-Care Facilities and Family Homes.

a. Out of amounts appropriated above to the Department of State Health Services for Strategy A.2.1, Immunize Children & Adults in Texas, the department shall allocate an amount as necessary for the purpose of conducting a study to assess the vaccination coverage levels and vaccination compliance with any new and existing vaccination requirements of children enrolled at and attending a licensed child-care facility or registered family home.

b. The study conducted under this rider may identify evidence-based practices to maintain high immunization coverage levels and vaccination compliance in this state.

c. Not later than September 1, 2020, the Department of State Health Services shall prepare and submit to the governor, the legislature, and the Public Health Funding and Policy Committee within the department a report that summarizes the results of the study conducted under this rider.

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4. **Hospital Uncompensated Care.** No funds appropriated above for medical assistance payments may be paid to a hospital if the Health and Human Services Commission (HHSC) determines that the hospital has not complied with the commission's reporting requirements. HHSC 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.

   HHSC shall conduct an appropriate number of audits to assure the accurate reporting of uncompensated hospital care costs.

   HHSC shall submit a biennial report on uncompensated care costs to the Governor and Legislative Budget Board no later than December 1, 2020, which details the impact of patient specific and lump sum funding as offsets to uncompensated costs, impact of health care reform efforts on the funding streams that reimburse uncompensated care, and assess the need for those funding streams in future biennia. HHSC may report by hospital type.

7. **Nursing Home Program Provisions.**

   (a) Tending Home Income Eligibility Cap. It is the intent of the Legislature that the income eligibility cap for nursing home care shall be maintained at the federal maximum level of 300 percent of Supplemental Security Income (SSI).

   (b) Nursing Home Bed Capacity Planning. It is the intent of the Legislature that the Health and Human Services Commission shall control the number of Medicaid beds, decertify unused Medicaid beds, and reallocate some or all of the decertified Medicaid beds, taking into account a facility's occupancy rate and nurse-to-patient ratio.

13. **Hospital Payments.** Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in all Strategies in Goal A, Medicaid Client Services, is $67,971,931 in General Revenue Funds, $100,471,474 in Interagency Contracts, and $259,838,835 in Federal Funds ($428,282,240 in All Funds) in fiscal year 2020 and $64,941,121 in General Revenue Funds,

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4. **Hospital Uncompensated Care.** No funds appropriated above for medical assistance payments may be paid to a hospital if the Health and Human Services Commission (HHSC) determines that the hospital has not complied with the commission's reporting requirements. HHSC shall ensure that the reporting of uncompensated care by Texas hospitals is consistent for all hospitals and subjected to a standard set of adjustments that account for payments to hospitals that are intended to reimburse uncompensated care. These adjustments are to be made in such a way that a reliable determination of the actual cost of uncompensated care in Texas is produced.

   The commission shall conduct an appropriate number of audits to assure the accurate reporting of uncompensated hospital care costs.

   HHSC shall submit a biennial report on uncompensated care costs to the Governor and Legislative Budget Board no later than December 1, 2020, which details the impact of patient specific and lump sum supplemental payments funding as offsets to uncompensated costs, impact of health care reform efforts on the funding streams that reimburse uncompensated care, and assess the need for those funding streams in future biennia. HHSC may report by hospital type. Although HHSC must report on all Texas hospitals, HHSC may use the most accurate data available for each hospital.

132. **Nursing Home Program Provisions.**

   (a) Tending Home Income Eligibility Cap. It is the intent of the Legislature that the income eligibility cap for nursing home care shall be maintained at the federal maximum level of 300 percent of Supplemental Security Income (SSI).

   (b) Nursing Home Bed Capacity Planning. It is the intent of the Legislature that the Health and Human Services Commission shall control the number of Medicaid beds, decertify unused Medicaid beds, and reallocate some or all of the decertified Medicaid beds, taking into account a facility's occupancy rate.

11. **Hospital Payments.** Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in all Strategies in Goal A, Medicaid Client Services, is $41,116,526 in General Revenue Funds, $100,471,474 in Interagency Contracts, and $218,412,000 in Federal Funds ($360,000,000 in All Funds) in fiscal year 2020 and $36,796,526 in General Revenue Funds,

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$100,471,474 in Interagency Contracts, and $268,399,613 in Federal Funds ($433,812,208 in All Funds) in fiscal year 2021 to provide Medicaid hospital add-on payments for trauma care and safety-net hospitals and add-on payments and rate increases for rural hospitals as follows:

(a) $70,794,000 in Interagency Contracts and $109,206,000 in Federal Funds in fiscal year 2020 and $68,634,000 in Interagency Contracts and $111,366,000 in Federal Funds in fiscal year 2021 for trauma care;

(b) $29,317,526 in General Revenue Funds, $29,677,474 in Interagency Contracts, and $91,005,000 in Federal Funds in fiscal year 2020 and $25,357,526 in General Revenue Funds, $31,837,474 in Interagency Contracts, and $92,805,000 in Federal Funds in fiscal year 2021 for safety-net hospitals;

(c) $11,799,000 in General Revenue Funds and $18,201,000 in Federal Funds in fiscal year 2020 and $11,439,000 in General Revenue Funds and $18,561,000 in Federal Funds in fiscal year 2021 for rural hospitals to maintain increases and add-ons related to general outpatient reimbursement rates, outpatient emergency department services that do not qualify as emergency visits, the outpatient hospital imaging services fee schedule, and the outpatient clinical laboratory services fee schedule;

(d) $11,484,360 in General Revenue Funds and $17,715,640 in Federal Funds in fiscal year 2020 and $12,773,550 in General Revenue Funds and $20,726,450 in Federal Funds in fiscal year 2021 for rural hospitals to increase inpatient rates by trending forward from 2013 to 2020 using an inflationary factor; and

(e) $15,371,045 in General Revenue Funds and $23,711,195 in Federal Funds in fiscal year 2020 and $15,371,045 in General Revenue Funds and $24,941,163 in Federal Funds in fiscal year 2021 for rural hospitals to provide increases to inpatient rates in addition to those identified in subsection (d).

HHSC shall develop a methodology to implement the add-on payments pursuant to funding identified in subsection (b) that targets the state's safety-net hospitals, including those hospitals that treat high percentages of Medicaid and low-income, uninsured patients. Total reimbursement for each hospital shall not exceed its hospital specific limit.

For purposes of subsections (c), (d), and (e), rural hospitals are defined as (1) hospitals located in a

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$100,471,474 in Interagency Contracts, and $222,732,000 in Federal Funds ($360,000,000 in All Funds) in fiscal year 2021 to provide Medicaid hospital add-on payments for trauma care, safety-net hospitals, and rural hospitals and allocated between hospital types as follows:

(a) $70,794,000 in Interagency Contracts and $109,206,000 in Federal Funds in fiscal year 2020 and $68,634,000 in Interagency Contracts and $111,366,000 in Federal Funds in fiscal year 2021 for trauma care;

(b) $29,317,526 in General Revenue Funds, $29,677,474 in Interagency Contracts, and $91,005,000 in Federal Funds in fiscal year 2020 and $25,357,526 in General Revenue Funds, $31,837,474 in Interagency Contracts, and $92,805,000 in Federal Funds in fiscal year 2021 for safety-net hospitals; and

(c) $11,799,000 in General Revenue Funds and $18,201,000 in Federal Funds in fiscal year 2020 and $11,439,000 in General Revenue Funds and $18,561,000 in Federal Funds in fiscal year 2021 for rural hospitals.

HHSC shall develop a methodology to implement the add-on payments pursuant to funding identified in subsection (b) that targets the state's safety-net hospitals, including those hospitals that treat high percentages of Medicaid and low-income, uninsured patients. Total reimbursement for each hospital shall not exceed its hospital specific limit.

For purposes of subsection (c), rural hospitals are defined as (1) hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA); or (3) a hospital that has 100 or fewer beds, is designated by Medicare as a CAH, a SCH, or a RRC, and is located in an MSA. Payments to rural hospitals from funds identified in subsection (c) may include a combination of increases in or add-ons to any or all of the following: general outpatient reimbursement rates, outpatient emergency department services that do not qualify as emergency visits, the outpatient hospital imaging services fee schedule, and the outpatient clinical laboratory services fee schedule. No reimbursement may exceed the hospital specific limit and reimbursement for outpatient emergency department services that do not qualify as emergency visits may not exceed 65 percent of cost.

To the extent possible, HHSC shall ensure any funds identified in this rider that are included in

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county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA); or (3) a hospital that has 100 or fewer beds, is designated by Medicare as a CAH, a SCH, or a RRC, and is located in an MSA. No reimbursement may exceed the hospital specific limit and reimbursement for outpatient emergency department services that do not qualify as emergency visits may not exceed 65 percent of cost.

To the extent possible, HHSC shall ensure any funds identified in this rider that are included in Medicaid managed care capitation rates are distributed by the managed care organizations to the hospitals. The expenditure of funds identified in this rider that are not used for targeted increases to hospital provider rates as outlined above shall require the prior written approval of the Legislative Budget Board.

14. Medicaid Medical Transportation.

(a) Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall determine unmet transportation need based on information available from Medicaid client surveys to estimate the percentage of clients who did not use the Medical Transportation Program and experienced either a difficult or very difficult time obtaining transportation to medical appointments. HHSC shall notify the Legislative Budget Board and the relevant standing committees of the Legislature within 90 days of completing survey data collection if unmet transportation needs exceed 16 percent of total Medicaid clients. The notification must outline how the agency will address unmet transportation needs.

(b) HHSC shall report the pre-audit average cost per trip of the most recent fiscal year, and the final average cost per trip of the prior fiscal year. HHSC shall submit the report to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services not later than 180 days after the end of each fiscal year.

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Medicaid managed care capitation rates are distributed by the managed care organizations to the hospitals. The expenditure of funds identified in this rider that are not used for targeted increases to hospital provider rates as outlined above shall require the prior written approval of the Legislative Budget Board.

12. Medicaid Medical Transportation.

(a) Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall determine unmet transportation need based on information available from Medicaid client surveys to estimate the percentage of clients who did not use the Medical Transportation Program and experienced either a difficult or very difficult time obtaining transportation to medical appointments. HHSC shall notify the Legislative Budget Board and the relevant standing committees of the Legislature within 90 days of completing survey data collection if unmet transportation needs exceed 16 percent of total Medicaid clients. The notification must outline how the agency will address unmet transportation needs.

(b) HHSC shall report to the Legislative Budget Board and post on the Commission's website not later than 180 days before the end of each fiscal year. Each report must include the pre-audit coverage cost per trip of the most recent year, and the final average cost per trip of the prior year.

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17. **Medicaid Therapy Services Reporting.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall submit, on a quarterly basis, the following information related to pediatric acute care therapy services (including physical, occupational, and speech therapies) by service delivery area and information regarding whether the items below negatively affect access to care:

    (a) Provider and member complaints by disposition received by the Office of the Ombudsman and HHSC Health Plan Management;

    (b) Provider and member complaints by disposition reported by Medicaid Managed Care Organizations using a standard definition of complaint as defined by HHSC;

    (c) Provider and member appeals by disposition received by HHSC Health Plan Management;

    (d) The number of pediatric acute care therapy provider terminations and the reason for identified terminations;

    (e) The utilization of pediatric acute care therapy services by therapy type and provider type;

    (f) The number of members on a waiting list, defined as 1) those who have been referred to a provider or Medicaid Managed Care Organization, but there is not a treating therapist to perform an initial assessment, and 2) those who have been assessed, but are unable to access pediatric acute care therapy services due to insufficient network capacity; and

    (g) The number of pediatric acute care therapy providers no longer accepting new clients and the reason for identified panel closures.

    HHSC shall submit the quarterly reports to the Legislative Budget Board and the Governor in a format specified by the Legislative Budget Board no later than 30 days after the end of each fiscal quarter. HHSC shall use a standardized, statistically valid and reliable process to obtain all data used in the report and shall ensure that any sample data included is representative of the statewide population of therapy clients and providers by type. HHSC shall develop a process for pediatric therapy providers to submit data directly to HHSC for items (f) and (g), using feedback obtained from an industry workgroup.

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15. **Medicaid Therapy Services Reporting.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall submit, on a quarterly basis, the following information related to pediatric acute care therapy services (including physical, occupational, and speech therapies) and information regarding whether the items below negatively affect access to care:

    (a) Provider and member complaints by disposition received by the Office of the Ombudsman and HHSC Health Plan Management;

    (b) Provider and member complaints by disposition reported by Medicaid Managed Care Organizations;

    (c) The number of pediatric acute care therapy provider terminations and the reason for identified terminations;

    (d) The utilization of pediatric acute care therapy services;

    (e) The number of members on a waiting list, unable to access pediatric acute care therapy services due to insufficient network capacity; and

    (f) The number of pediatric acute care therapy providers no longer accepting new clients and the reason for identified panel closures.

    HHSC shall submit the quarterly reports to the Legislative Budget Board and the Governor in a format specified by the Legislative Budget Board no later than 30 days after the end of each fiscal quarter.

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18. Appropriation Authority for Certain Intergovernmental Transfers.

(a) Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in Strategy A.4.3, Transformation Payments, is $44,770,231 in fiscal year 2020 and $46,084,694 in fiscal year 2021 in Interagency Contracts for intergovernmental transfers (IGT) of funds from institutions of higher education, to be used as the non-federal share of uncompensated care or delivery system reform incentive payments or monitoring costs under the Healthcare Transformation and Quality Improvement Program 1115 Waiver.

(1) In an effort to maximize the receipt of federal Medicaid funding, HHSC is authorized to receive and expend IGT in addition to the funds identified in subsection (a).

(2) Authorization to expend additional IGT is contingent upon HHSC providing prior written notification to the Legislative Budget Board and the Governor.

(b) In addition to amounts appropriated above from Appropriated Receipts - Match for Medicaid No. 8062, HHSC is authorized to receive and expend additional IGT received as Appropriated Receipts - Match for Medicaid No. 8062 for the purpose of matching Medicaid Federal Funds for payments to Medicaid providers.

(1) For authorization to expend the funds, HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include:

(A) The total amount requested and the strategy allocation of the additional IGT, by fiscal year;

(B) The impact to the rate or premium for which the IGT will be used (subject to approval pursuant to Special Provisions, §14, Rate Limitations and Reporting Requirements); and

(C) The specific purpose and program for which the funds will be used.

(2) The request shall be considered to be approved unless the Legislative Budget Board or

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the Governor issues a written disapproval within 30 business days after the date on which the staff of the Legislative Budget Board concludes its review of the request to expend the funds and forwards the review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. Any requests for additional information made by the Legislative Budget Board shall interrupt the counting of the 30 business days.

20. Supplemental Payment Program Reporting.

(a) Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC) shall report on expenditures for supplemental payment programs including the Disproportionate Share Hospital (DSH) program, the Uncompensated Care (UC) Pool, the Delivery System Reform Incentive Payment (DSRIP) Pool, the Network Access Improvement Program (NAIP), the Quality Incentive Payment Program (QIPP), and other programs operated under the Healthcare Transformation and Quality Improvement Program 1115 Waiver and any successor programs.

(1) HHSC shall submit a quarterly report to the Legislative Budget Board and the Governor, due no later than 75 days from the end of each fiscal quarter, that includes for all supplemental payment programs:

(A) Total expenditures made in the previous quarter by method of financing;

(B) The amount of non-federal share by program and source;

(C) The amount distributed to each recipient, by program;

(D) The date such payments were distributed; and

(E) Prospective payment estimates for the upcoming quarter, by program.

(2) In addition to the quarterly report required by subsection (a)(1), and prior to the contract

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effective date for NAIP, HHSC shall submit an annual report to the Legislative Budget Board and the Governor that includes: (A) A list of participating public health related institutions (HRIs), public hospitals, and managed care organization partnerships; and (B) The anticipated amount paid to each MCO by HHSC and the anticipated amount paid to each HRI and public hospital by an MCO. (b) HHSC shall have an annual independent audit of supplemental payment programs conducted, including uncompensated care claims for insured and uninsured individuals, and contractual agreements and shall complete and issue an annual report with findings. The report shall be distributed to the Legislative Budget Board, Governor, Lieutenant Governor, Speaker of the House, and members of the Senate Finance Committee and House Appropriations Committee no later than June 30 of each year.	
21. Health Insurance Providers Fee. Included in amounts appropriated above for fiscal year 2021 is $162,723,951 in General Revenue Funds ($436,572,059 in All Funds) to reimburse managed care organizations for payment of the Health Insurance Providers Fee pursuant to Section 9010 of the Affordable Care Act and associated federal income tax. Contingent upon a judgment of the Supreme Court of the United States declaring Section 9010 unconstitutional, enactment of federal law repealing Section 9010, or judgment of the Supreme Court of the United States or enactment of federal law amending Section 9010 to make reimbursement of the fee optional for states, the Health and Human Services Commission shall cease any reimbursements to managed care organizations for payment of the fee and tax. Unless the Commission obtains prior written approval from the Legislative Budget Board and the Governor to use these funds for an alternate purpose, any amounts identified in this section that remain unexpended shall lapse to the treasury at the end of the fiscal year.	**17. Health Insurance Providers Fee.** Included in amounts appropriated above for fiscal year 2021 is $162,723,951 in General Revenue Funds ($436,572,059 in All Funds) to reimburse managed care organizations for payment of the Health Insurance Providers Fee pursuant to Section 9010 of the Affordable Care Act and associated federal income tax. If a judgment of a court declares Section 9010 of the Affordable Care Act or all of the Act to be unconstitutional and that judgment is not finally overturned on appeal, whether by an intermediate appellate court or a court of last resort, or if a federal law is enacted repealing Section 9010 or amending Section 9010 to make reimbursement of the fee optional for states, then after receiving notification from the Attorney General that Section 9010 no longer requires reimbursement of managed care organizations for payment of the Health Insurance Providers Fee, the Health and Human Services Commission (HHSC) shall cease any reimbursements to managed care organizations for payment of the fee and tax. Unless the Commission obtains prior written approval from the Legislative Budget Board and the Governor to use these funds for an alternate purpose, any amounts identified in this section that remain unexpended shall lapse to the treasury at the end of the fiscal year. HHSC shall provide the Comptroller, Legislative Budget Board, and the Governor with a copy of any notification received from the Attorney General.

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22. Interest List Reduction. Out of administrative funds appropriated above, and for the Home and Community-Based Services waiver, Community Living Assistance and Support Services waiver, Deaf-Blind Multiple Disabilities waiver, Medically Dependent Children Program waiver, Texas Home Living waiver, and STAR+PLUS, the Health and Human Services Commission is directed to consider factors such as length of time on the interest list, size of interest list, demographics, average cost, and crisis stabilization in providing services to interest list clients on a program-specific basis.	
24. Health and Human Services Cost Containment. The Health and Human Services Commission shall develop and implement cost containment initiatives to achieve savings throughout the health and human services system including by increasing fraud, waste, and abuse prevention and detection. HHSC shall provide a plan to the Legislative Budget Board to implement cost containment initiatives by December 1, 2019. It is the intent of the legislature that HHSC shall achieve savings without changing eligibility levels; reducing benefits; adjusting amount, scope, or duration of services; or otherwise negatively impacting access to care. It is the intent of the legislature that prior to making any changes, HHSC shall consider stakeholder input, including complying with any statutory requirements related to rulemaking and public hearings.	**19. Health and Human Services Cost Containment.** The Health and Human Services Commission (HHSC) shall develop and implement cost containment initiatives to achieve savings of at least $350,000,000 in General Revenue Funds for the 2020-21 biennium throughout the health and human services system. These initiatives shall include increasing fraud, waste, and abuse prevention and detection; seeking to maximize federal flexibility under the Medicaid program in compliance with Government Code, Chapter 537; and achieving other programmatic and administrative efficiencies. HHSC shall provide a plan to the Legislative Budget Board to implement cost containment initiatives by December 1, 2019.
25. Ensure Network Adequacy. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC) shall seek to ensure that contracted managed care organizations maintain an adequate network of providers, especially with respect to community attendants.	
26. Policies for Certain Hospital Stays. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, and to the extent allowed by state and federal law, the Health and Human Services Commission shall ensure there are policies, including for managed care services, that specify criteria that do not permit classification of hospital services, including those related to behavioral health, as either inpatient or outpatient for purposes of reimbursement	

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based solely on the duration of the stay.

27. **Evaluation of Children's Hospital Reimbursement.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission shall evaluate Medicaid and CHIP reimbursement methodologies for free-standing, non-profit children's hospitals.

28. **Use of Additional CHIP Experience Rebates.** Included in the amounts appropriated above in Strategy C.1.1, CHIP, are CHIP Experience Rebates. For the purposes of this provision, CHIP Experience Rebates are defined as: 1) refunds/rebates of previously paid CHIP premiums and related interest earnings; and 2) managed care rebates and related interest earnings as described below. Amounts defined as CHIP Experience Rebates are to be deposited into the General Revenue Fund. The Health and Human Services Commission (HHSC) may receive and spend experience rebates generated in accordance with its contractual agreements with managed care organizations and other providers who participate in the CHIP and CHIP Perinatal programs. Expenditures shall be made from CHIP Experience Rebates generated in fiscal years 2020 and 2021. The method of financing item, Experience Rebates - CHIP No. 8054, for appropriations made above, includes unexpended and unobligated balances of Experience Rebates - CHIP remaining as of August 31, 2019, and receipts earned in fiscal years 2020 and 2021.

    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, HHSC is appropriated and authorized to expend these General Revenue Funds thereby made available, subject to the following requirements:

    (a) Amounts available shall be expended prior to utilization of any General Revenue available for the same purposes; and

20. **Use of Additional CHIP Experience Rebates.** Included in the amounts appropriated above in Strategy C.1.1, CHIP, are CHIP Experience Rebates. For the purposes of this provision, CHIP Experience Rebates are defined as: 1) refunds/rebates of previously paid CHIP premiums and related interest earnings; and 2) managed care rebates and related interest earnings as described below. Amounts defined as CHIP Experience Rebates are to be deposited into the General Revenue Fund. The Health and Human Services Commission (HHSC) may receive and spend experience rebates generated in accordance with its contractual agreements with managed care organizations and other providers who participate in the CHIP and CHIP Perinatal programs. Expenditures shall be made from CHIP Experience Rebates generated in fiscal years 2020 and 2021. The method of financing item, Experience Rebates - CHIP No. 8054, for appropriations made above, includes unexpended and unobligated balances of Experience Rebates - CHIP remaining as of August 31, 2019, and receipts earned in fiscal years 2020 and 2021.

    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, HHSC is appropriated and authorized to expend these General Revenue Funds thereby made available, subject to the following requirements:

    (a) Amounts available shall be expended prior to utilization of any General Revenue available for the same purposes; and

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(b) In the event General Revenue has been expended prior to the receipt of CHIP Experience Rebates, HHSC shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent accumulation of CHIP Experience Rebate balances and reported in the Monthly Financial Report required by Rider 110, Other Reporting Requirements. 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.	(b) In the event General Revenue has been expended prior to the receipt of CHIP Experience Rebates, HHSC shall reimburse General Revenue. This process shall be completed on a monthly basis in order to prevent accumulation of CHIP Experience Rebate balances.
34. Mental Health Outcomes and Accountability. Out of funds appropriated above in Goal D, Additional Health-related Services, Strategies D.2.1, Community Mental Health Svcs - Adults, D.2.2, Community Mental Hlth Svcs - Children, and D.2.3, Community Mental Health Crisis Svcs, the Health and Human Services Commission (HHSC) shall place ten percent of the General Revenue quarterly allocation from each Local Mental Health Authority (LMHA) and Local Behavioral Health Authority (LBHA) at risk. Funds placed at risk shall be subject to recoupment for failure to achieve outcome targets set by HHSC. Funds that have been recouped for failure to achieve outcome targets may be used for technical assistance and redistributed as an incentive payment according to a methodology developed by HHSC. Performance shall be assessed and payments made on a six-month interval.	**26. Mental Health Outcomes and Accountability.** Out of funds appropriated above in Goal D, Additional Health-related Services, Strategies D.2.1, Community Mental Health Svcs - Adults, D.2.2, Community Mental Hlth Svcs - Children, and D.2.3, Community Mental Health Crisis Svcs, the Health and Human Services Commission (HHSC) shall place ten percent (10%) of the General Revenue quarterly allocation from each Local Mental Health Authority (LMHA) and Local Behavioral Health Authority (LBHA) at risk. Funds placed at risk shall be subject to recoupment for failure to achieve outcome targets set by HHSC. Funds that have been recouped for failure to achieve outcome targets may be used for technical assistance or redistributed as an incentive payment according to a methodology developed by HHSC. Performance shall be assessed and payments made on a six-month interval.
38. Semiannual Reporting of Waiting Lists for Mental Health Services. The Health and Human Services Commission shall submit semiannually to the Legislative Budget Board and the Governor the current waiting list and related expenditure data for the following: (a) Community mental health services for adults; (b) Community mental health services for children; (c) Forensic state hospital beds; and	**30. Quarterly Reporting of Waiting Lists for Mental Health Services.** The Health and Human Services Commission shall submit to the Legislative Budget Board and the Governor, no later than 60 days from the end of each fiscal quarter, the current waiting list and related expenditure data for the following: (a) Community mental health services for adults; (b) Community mental health services for children;

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(d) Maximum security forensic state hospital beds.

The data shall be submitted in a format specified by the Legislative Budget Board and shall, at a minimum, include the number of clients waiting for all services, the number of underserved clients waiting for additional services, the number of individuals removed from the waiting list, and funds expended to remove individuals on the waiting list in the current fiscal quarter, and the average number of days spent on the waiting list. The information above shall be provided for each Local Mental Health Authority (LMHA) and Local Behavioral Health Authority (LBHA), facility, or other contracted entity. HHSC shall distinguish between waiting lists at LMHAs and LBHAs, state facilities, or other contracted entities that are due to operational or other short-term factors and long-term waiting lists due to insufficient capacity.

40. Funding for Mental Health Programs. Included in amounts appropriated above in Strategy D.2.1, Community Mental Health Services for Adults, is $871,348 in General Revenue in each fiscal year of the 2020-21 biennium to continue funding for recovery-focused clubhouses at fiscal year 2019 service levels. Also included in amounts appropriated above in Strategy D.2.2, Community Mental Health Services for Children, $5,552,235 in General Revenue in fiscal year 2020 and $5,545,210 in fiscal year 2021 for relinquishment prevention slots, including $437,970 in General Revenue in fiscal year 2020 and $430,945 in fiscal year 2021 for program support and administration.

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(c) Forensic state hospital beds; and

(d) Maximum security forensic state hospital beds.

The data shall be submitted in a format specified by the Legislative Budget Board and shall, at a minimum, include the number of clients waiting for all services, the number of underserved clients waiting for additional services, the number of individuals removed from the waiting list, and funds expended to remove individuals on the waiting list in the current fiscal quarter, and the average number of days spent on the waiting list. The information above shall be provided for each Local Mental Health Authority (LMHA) and Local Behavioral Health Authority (LBHA), facility, or other contracted entity. HHSC shall distinguish between waiting lists at LMHAs and LBHAs, state facilities, or other contracted entities that are due to operational or other short-term factors and long-term waiting lists due to insufficient capacity.

42. Breast and Cervical Cancer Services Program: Providers. No funds appropriated above may be expended by the Health and Human Services Commission's Breast and Cervical Cancer Services Program in Strategy D.1.1, Women's Health Programs, to compensate providers that would be ineligible to receive funding to provide Breast and Cervical Cancer Services pursuant to 15 Texas Administrative Code § 392.607. If HHSC is unable to locate a sufficient number of eligible providers offering services in a permanent setting in a certain region, the agency may compensate other local providers for the provision of breast and cervical cancer screening

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services.

43. Consent for Family Planning: Women's Health Services. Out of funds appropriated above to Strategy D.1.1, Women's Health Programs, for the Family Planning Program, no state funds may be used to dispense prescription drugs to minors without parental consent. An exemption shall be made for non-parents and minors pursuant to Family Code Chapter 32.

44. Family Planning Services: Allocation of Funds. The Health and Human Services Commission (HHSC) shall allocate funds appropriated above in Strategy D.1.1, Women's Health Programs, for the Family Planning Program, using a methodology that prioritizes distribution and reallocation to first award public entities that provide family planning services, including state, county, local community health clinics, Federally Qualified Health Centers, and clinics under the Baylor College of Medicine; secondly, non-public entities that provide comprehensive primary and preventative care as a part of their family planning services; and thirdly, non-public entities that provide family planning services but do not provide comprehensive primary and preventative care. HHSC shall in compliance with federal law ensure the distribution and allocation methodology for funds in Strategy D.1.1, Women's Health Programs, for the Family Planning Program, does not severely limit or eliminate access to services to any region.

Out of funds appropriated above in Strategy D.1.1, Women's Health Programs, for the Family Planning Program, up to $1,000,000 per year may be allocated to clinics for core family planning services provided under the auspices of Baylor College of Medicine.

45. Prohibition on Abortions.

(a) It is the intent of the Legislature that no funds shall be used to pay the direct or indirect costs (including overhead, rent, phones, and utilities) of abortion procedures provided by

38. Prohibition on Abortions.

(a) It is the intent of the Legislature that no funds shall be used to pay the direct or indirect costs (including marketing, overhead, rent, phones, and utilities) of abortion procedures provided

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contractors of the Health and Human Services Commission.

(b) It is also the intent of the Legislature that no funds appropriated for Medicaid Family Planning, Healthy Texas Women Program, or the Family Planning Program shall be distributed to individuals or entities that perform elective abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective abortion procedures.

(c) The commission shall include in its financial audit a review of the use of appropriated funds to ensure compliance with this section.

46. Funding for Family Planning Instruction. None of the funds appropriated above may be used to implement human sexuality instruction or family planning instruction, or to provide instructional materials for use in human sexuality instruction or family planning instruction, if the instruction or instructional materials are provided or prepared by an individual or entity that performs elective abortions or an affiliate of an individual or entity that performs elective abortions.

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by contractors of the Health and Human Services Commission.

(b) It is also the intent of the Legislature that no funds appropriated for Medicaid Family Planning, Healthy Texas Women Program, or the Family Planning Program shall be distributed to individuals or entities that perform elective abortion procedures or that contract with or provide funds to individuals or entities for the performance of elective abortion procedures.

(c) The commission shall include in its financial audit a review of the use of appropriated funds to ensure compliance with this section.

45. Medical Treatments. The Health and Human Services Commission (HHSC) may distribute funds for medical, dental, psychological or surgical treatment provided to a minor only if consent to treatment is obtained pursuant to Family Code Chapter 32. In the event that compliance with this rider would result in the loss of Federal Funds to the state, HHSC may modify, or suspend this rider to the extent necessary to prevent such loss of funds, provided that 45-day prior notification is provided to the Governor and the Legislative Budget Board.

39. Funding for Medicaid Family Planning and Family Planning Instruction. Out of funds appropriated above for Medicaid Family Planning, no state funds may be used to dispense prescription drugs to minors without parental consent. An exemption shall be allowed for non-parents and minors pursuant to Family Code Chapter 32. None of the funds appropriated above may be used to implement human sexuality instruction or family planning instruction, or to provide instructional materials for use in human sexuality instruction or family planning instruction, if the instruction or instructional materials are provided or prepared by an individual or entity that performs elective abortions or an affiliate of an individual or entity that performs elective abortions.

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47. **Women's Health Programs: Savings and Performance Reporting.** The Health and Human Services Commission shall submit an annual report on the Healthy Texas Women (HTW), Family Planning Program (FPP), and Breast and Cervical Cancer Services Program, due May 1 of each year, to the Legislative Budget Board and the Governor's Office that includes the following information:

    (a) Enrollment levels of targeted low-income women and service utilization by geographic region, including total number of unduplicated patients served, delivery system, and age from the prior two fiscal years;

    (b) Savings or expenditures in the Medicaid program that are attributable to enrollment levels as reported in section (a);

    (c) Descriptions of all outreach activities undertaken for the reporting period;

    (d) The total number of providers, by geographic region, enrolled in HTW and FPP networks, and providers from legacy Women's Health Programs (including Texas Women's Health Program) not to include duplications of providers or ancillary providers;

    (e) The average and median numbers of program clients, and the total number of unduplicated patients served, detailed by provider;

    (f) The count of women in the Healthy Texas Women Program and the Family Planning Program receiving a long-acting reversible contraceptive;

    (g) The service utilization by procedure code. The annual report submitted as required above must satisfy federal reporting requirements that mandate the most specific, accurate, and complete coding and reporting for the highest level of specificity; and

    (h) Total expenditures, by method of finance and program.

    (i) Number of unduplicated women auto-enrolled into the Healthy Texas Women program from Medicaid for Pregnant women.

    It is the intent of the Legislature that if the findings of the report show a reduction in women

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40. **Women's Health Programs: Savings and Performance Reporting.** The Health and Human Services Commission shall submit an annual report on the Healthy Texas Women (HTW) program, Family Planning Program (FPP), and Breast and Cervical Cancer Services Program, due May 1 of each year, to the Legislative Budget Board and the Governor's Office that includes the following information:

    (a) Enrollment levels of targeted low-income women and service utilization by geographic region, including total number of unduplicated patients served, delivery system, and age from the prior two fiscal years;

    (b) Savings or expenditures in the Medicaid program that are attributable to enrollment levels as reported in section (a);

    (c) Descriptions of all outreach activities undertaken for the reporting period;

    (d) The total number of providers, by geographic region, enrolled in the HTW and FPP networks, and providers from legacy Women's Health Programs (including Texas Women's Health Program) not to include duplications of providers or ancillary providers;

    (e) The average and median numbers of program clients, and the total number of unduplicated patients served, detailed by provider;

    (f) The count of women in the HTW and FPP receiving a long-acting reversible contraceptive;

    (g) The service utilization by procedure code for HTW and FPP. The annual report submitted as required above must satisfy federal reporting requirements that mandate the most specific, accurate, and complete coding and reporting for the highest level of specificity; and

    (h) Total expenditures, by method of finance and program.

    It is the intent of the Legislature that if the findings of the report show a reduction in women enrolled or of service utilization of greater than 10 percent relative to the prior two fiscal years, the agency shall, within existing resources, undertake corrective measures to expand provider capacity and/or client outreach and enrollment efforts.

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enrolled or of service utilization of greater than ten percent relative to the prior two fiscal years, the agency shall, within existing resources, undertake corrective measures to expand provider capacity and/or client outreach and enrollment efforts.	
48. Funding for Healthy Texas Women Program. Funds appropriated above in Strategy D.1.1, Women's Health Programs, include $64,488,353 in General Revenue and $57,695,214 in Federal Funds in fiscal year 2020 and $69,554,101 in General Revenue and $57,960,141 in Federal Funds in fiscal year 2021 for the Healthy Texas Women program. In the event federal matching funds do not become available or are available in a lesser amount, the Health and Human Services Commission shall seek approval to transfer funds from other sources prior to making any reductions to service levels.	**41. Funding for Healthy Texas Women Program.** Funds appropriated above in Strategy D.1.1, Women's Health Programs, include $41,974,721 in General Revenue and $57,695,214 in Federal Funds in fiscal year 2020 and $43,706,356 in General Revenue and $57,960,141 in Federal Funds in fiscal year 2021 for the Healthy Texas Women program. These amounts assume approval of the Healthy Texas Women Section 1115 Demonstration Waiver application. In the event federal matching funds do not become available or are available in a lesser amount, the Health and Human Services Commission shall seek approval to transfer funds from other sources prior to making any reductions to service levels.
50. Primary Care and Specialty Care Provisions. (a) **Consent for Services.** (1) No state funds appropriated above for Medicaid Family Planning or for the Family Planning Program in Strategy D.1.1, Women's Health Programs, may be expended by the Health and Human Services Commission (HHSC) to dispense prescription drugs to minors without parental consent. An exemption shall be allowed for non-parents and minors pursuant to Family Code Chapter 32. (2) HHSC may distribute funds for medical, dental, psychological, or surgical treatment provided to a minor only if consent to treatment is obtained pursuant to Family Code Chapter 32. In the event that compliance with this subsection would result in the loss of Federal Funds to the state, HHSC may modify, or suspend this subsection to the extent necessary to prevent such loss of funds, provided that 45-day prior notification is provided to the Governor and the Legislative Budget Board.	

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(b) **Services Providers: Limitations.** No funds appropriated above may be expended by HHSC on the following:

(1) To compensate providers for the Breast and Cervical Cancer Services Program in Strategy D.1.1, Women's Health Programs, that would be ineligible to participate pursuant to 15 Texas Administrative Code § 392.607. If HHSC is unable to locate a sufficient number of eligible providers offering services in a permanent setting in a certain region, the agency may compensate other local providers for the provision of breast and cervical cancer screening services; and

(2) To contract with providers for the Primary Health Care Program in Strategy D.1.11, Community Primary Care Services, that would be ineligible to participate pursuant to Health and Safety Code § 31.006.

(c) **Allocation of Funds for Family Planning Services.** HHSC shall allocate funds appropriated above in Strategy D.1.1, Women's Health Programs, for the Family Planning Program, using a methodology that prioritizes distribution and reallocation to first award public entities that provide family planning services, including state, county, local community health clinics, Federally Qualified Health Centers, and clinics under the Baylor College of Medicine; secondly, non-public entities that provide comprehensive primary and preventative care as a part of their family planning services; and thirdly, non-public entities that provide family planning services but do not provide comprehensive primary and preventative care. HHSC shall in compliance with federal law ensure the distribution and allocation methodology for funds in Strategy D.1.1, Women's Health Programs, for the Family Planning Program, does not severely limit or eliminate access to services to any region.

Out of funds appropriated above in Strategy D.1.1, Women's Health Programs, for the Family Planning Program, up to $1,000,000 each fiscal year of the 2020-21 biennium may be allocated to clinics for core family planning services provided under the auspices of Baylor College of Medicine.

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54. Limitation on Federal Funds Appropriations for Early Childhood Intervention Services. Included in the amounts appropriated above in Strategy D.1.3, ECI Services, is $43,016,050 in fiscal year 2020 and $46,296,744 in fiscal year 2021 from federal Special Education Grants for Infants and Families (IDEA Part C) funds. The Health and Human Services Commission's total expenditures of IDEA Part C federal funds in each fiscal year in Strategy D.1.3, ECI Services, may not exceed the amounts specified in this rider without written approval from the Legislative Budget Board and the Governor.

To request approval, HHSC shall submit in a timely manner a written request before expending the funds. 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:

a. A detailed explanation of the proposed use of the additional funds and whether the expenditures will be one-time or ongoing.

b. The available balance after the expenditure of the funds; and

c. An estimate of the impact to performance levels and/or targets included in this Act.

56. Autism Program Provisions. Out of funds appropriated above in Strategy D.1.6, Autism Program:

a. The Health and Human Services Commission (HHSC) shall not expend funds on comprehensive Applied Behavioral Analysis (ABA) treatment services; and

b. HHSC shall provide support to the Texas Autism Council and the Texas Autism Research and Resource Center.

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49. Limitation on Federal Funds Appropriations for Early Childhood Intervention Services. Included in the amounts appropriated above in Strategy D.1.3, ECI Services, is $43,016,050 in fiscal year 2020 and $46,296,744 in fiscal year 2021 from federal Special Education Grants for Infants and Families (IDEA Part C) funds. The Health and Human Services Commission's total expenditures of IDEA Part C federal funds in each fiscal year in Strategy D.1.3, ECI Services, may not exceed the amounts specified in this rider.

51. Autism Program Provisions. Out of funds appropriated above in Strategy D.1.6, Autism Program:

a. Expenditures for Applied Behavioral Analysis (ABA) treatment services shall be only for children enrolled in the focused program; and

b. Health and Human Services Commission shall provide support to the Texas Autism Council and the Texas Autism Research and Resource Center.

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	73. Office of Inspector General: Managed Care Organization Performance, Reporting Requirement. Out of funds appropriated above in Strategy K.1.1, Office of the Inspector General, the Office of Inspector General shall collaborate with Medicaid and Children's Health Insurance Program (CHIP) Managed Care Organizations (MCOs) to continue to review cost avoidance and waste prevention activities employed by MCOs throughout the state. The review shall include the strategies MCOs are implementing to prevent waste, including, but not limited to recovering overpayments, reducing Potentially Preventable Events (PPE), and conducting internal monitoring and audits. The review shall also consider the effectiveness of strategies employed by MCOs to prevent waste and the adequacy of current functions. The Office of Inspector General shall submit a report to the Legislative Budget Board and the Governor by March 1, 2020, detailing its findings and recommendations related to cost avoidance and waste prevention activities employed by MCOs.
	74. Dental and Orthodontia Providers in the Texas Medicaid Program. It is the intent of the Legislature that the Health and Human Services Commission (HHSC) use funds appropriated above in Strategy K.1.1, Office of the Inspector General, to strengthen the capacity of the HHSC Office of Inspector General to detect, investigate, and prosecute abuse by dentists and orthodontists who participate in the Texas Medicaid program. Further, it is the intent of the Legislature that HHSC conduct more extensive reviews of medical necessity for orthodontia services in the Medicaid program.
88. Appropriation of Donations: Blindness Education Screening and Treatment. Included in the amounts above in Strategy F.2.2, Blindness Education, Screening, and Treatment (BEST) Program, is $430,000 in General Revenue in fiscal year 2020 and $430,000 in General Revenue in fiscal year 2021 for the BEST Program, contingent upon the generation of funds through donations. Revenues received from donations made in fiscal year 2020 and fiscal year 2021, in amounts not to exceed $860,000 as provided by §521.421 (j) or §521.422 (b), Transportation Code, are appropriated to the Health and Human Services Commission (HHSC) for purposes	**85. Appropriation of Donations: Blindness Education Screening and Treatment.** Included in the amounts above in Strategy F.2.2, Blindness Education, Screening, and Treatment (BEST) Program, is $430,000 in General Revenue in fiscal year 2020 and $430,000 in General Revenue in fiscal year 2021 for the BEST Program, contingent upon the generation of funds through donations. Revenues received from donations made in fiscal year 2020 and fiscal year 2021, in amounts not to exceed $860,000 as provided by §521.421 (j) or §521.422 (b), Transportation Code, are appropriated to the Health and Human Services Commission (HHSC) for purposes

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related to the BEST Program. Any revenue collected in the BEST Program above the amount appropriated each fiscal year is appropriated to HHSC for the same purpose. Any unexpended and unobligated balances remaining in an amount not to exceed $60,000 as of August 31, 2019, are appropriated to HHSC for the same purpose for the fiscal year beginning September 1, 2019, and any unexpended balances remaining as of August 31, 2020, are appropriated to HHSC for the same purpose for the fiscal year beginning September 1, 2020. In the event that actual and/or projected revenue collections are insufficient to offset the costs identified by this provision, the Legislative Budget Board may direct that the Comptroller of Public Accounts reduce the appropriation authority provided above to be within the amount of revenue expected to be available.

89. Mental Health (MH) and Intellectual Disability (ID) Collections for Patient Support and Maintenance.

(a) **Definition.** For the purposes of this section and appropriation authority for the Health and Human Services Commission (HHSC):

(1) MH Collections for Patient Support and Maintenance are defined as reimbursements received for health and other services provided to individuals in state hospitals from third party payers including insurance companies, clients, relatives, trusts and estates, and government retirement benefit programs including the U.S. Civil Service, Federal Railroad, State, Social Security, Teacher and Veteran's Administration; and

(2) ID Collections for Patient Support and Maintenance are defined as reimbursements received for health and other services provided to individuals in state operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and state supported living centers from third party payers including insurance companies, clients, relatives, trusts and estates, and government retirement benefit programs including the U.S. Civil Service, Federal Railroad, State, Social Security, Teacher and Veteran's Administration.

(b) **Classification for depositing revenues and reporting of expenditures.** For the purpose of revenue classification for depositing and expending certain collections related to the support

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related to the BEST Program. Any revenue collected in the BEST Program above the amount appropriated each fiscal year is appropriated to HHSC for the same purpose. Any unexpended and unobligated balances remaining in an amount not to exceed $100,000 as of August 31, 2019, are appropriated to HHSC for the same purpose for the fiscal year beginning September 1, 2019, and any unexpended balances remaining as of August 31, 2020 are appropriated to HHSC for the same purpose for the fiscal year beginning September 1, 2020. In the event that actual and/or projected revenue collections are insufficient to offset the costs identified by this provision, the Legislative Budget Board may direct that the Comptroller of Public Accounts reduce the appropriation authority provided above to be within the amount of revenue expected to be available.

86. Mental Health (MH) and Intellectual Disability (ID) Collections for Patient Support and Maintenance.

(a) **Definition.** For the purposes of this section and appropriation authority for the Health and Human Services Commission (HHSC):

(1) MH Collections for Patient Support and Maintenance are defined as reimbursements received for health and other services provided to individuals in state hospitals from third party payers including insurance companies, clients, relatives, trusts and estates, and government retirement benefit programs including the U.S. Civil Service, Federal Railroad, State, Social Security, Teacher and Veteran's Administration; and

(2) ID Collections for Patient Support and Maintenance are defined as reimbursements received for health and other services provided to individuals in state operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID) and state supported living centers from third party payers including insurance companies, clients, relatives, trusts and estates, and government retirement benefit programs including the U.S. Civil Service, Federal Railroad, State, Social Security, Teacher and Veteran's Administration.

(b) **Classification for depositing revenues and reporting of expenditures.** For the purpose of revenue classification for depositing and expending certain collections related to the support

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and maintenance of patients in state hospitals and state operated ICF/IID and state supported living centers, the following Revenue Object Codes as defined by the Comptroller of Public Accounts shall be used for recording collections, reporting expenditures, and requesting legislative appropriations by HHSC:

(1) Revenue Object Codes 3595, 3606, 3614, and 3618 as defined by the Comptroller of Public Accounts shall be used to record collections and deposits from the above defined sources into the General Revenue Fund:

(A) 3595: Medical Assistance Cost Recovery

(B) 3606: Support and Maintenance of Patients

(C) 3614: Counseling, Care and Treatment of Outpatients

(D) 3618: Welfare/MHMR Service Fees (Child Support)

(2) Automated Budget and Evaluation System of Texas (ABEST) Method of Financing Code 8031- MH Collections for Patient Support and Maintenance, and ABEST Method of Financing Code 8095 - ID Collections for Patient Support and Maintenance, shall be used to report expenditures and request legislative appropriations from collections/deposits related to the support and maintenance of patients in state hospitals and state operated ICF/IID and state supported living centers made to Revenue Object Codes 3595, 3606, 3614, and 3618.

(c) **Appropriation authority and accounting for expenditures of MH and ID Collections for Patient Support and Maintenance.** HHSC may receive and expend MH and ID Collections for Patient Support and Maintenance as a first source, and General Revenue shall be used as a second source, to support state hospitals and state-operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID). In the event that these revenues should be greater than the amounts identified in the method of financing above as MH and ID Collections for Patient Support and Maintenance, the commission is appropriated and authorized to expend these state funds hereby made available, subject to approval through Rider 70, State Supported Living Center Oversight. The expenditure of MH and ID Collections for Patient Support and Maintenance is subject to the following requirements:

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and maintenance of patients in state hospitals and state operated ICF/IID and state supported living centers, the following Revenue Object Codes as defined by the Comptroller of Public Accounts shall be used for recording collections, reporting expenditures, and requesting legislative appropriations by HHSC:

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(A) 3595: Medical Assistance Cost Recovery

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(C) 3614: Counseling, Care and Treatment of Outpatients

(D) 3618: Welfare/MHMR Service Fees (Child Support)

(2) Automated Budget and Evaluation System of Texas (ABEST) Method of Financing Code 8031- MH Collections for Patient Support and Maintenance, and ABEST Method of Financing Code 8095 - ID Collections for Patient Support and Maintenance, shall be used to report expenditures and request legislative appropriations from collections/deposits related to the support and maintenance of patients in state hospitals and state operated ICF/IID and state supported living centers made to Revenue Object Codes 3595, 3606, 3614, and 3618.

(c) **Appropriation authority and accounting for expenditures of MH and ID Collections for Patient Support and Maintenance.** HHSC may receive and expend MH and ID Collections for Patient Support and Maintenance as a first source, and General Revenue shall be used as a second source, to support state hospitals and state-operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID). In the event that these revenues should be greater than the amounts identified in the method of financing above as MH and ID Collections for Patient Support and Maintenance, the commission is appropriated and authorized to expend these state funds hereby made available, subject to approval through Rider 65, State Supported Living Center Oversight. The expenditure of MH and ID Collections for Patient Support and Maintenance is subject to the following requirements:

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

(2) In the event General Revenue has been expended prior to the receipt of MH and ID Collections for Patient Support and Maintenance, the commission shall reimburse General Revenue upon receipt of the revenue. This process shall be completed on a monthly basis in order to maintain a minimum balance on hand in excess MH and ID Collections for Patient Support and Maintenance.

(d) **Responsibility for proportionate share of indirect costs and benefits.** HHSC shall ensure that MH and ID Collections for Patient Support and Maintenance fund their proportionate share of benefits and statewide allocated indirect costs as required and directed in Article IX of this act.

(e) **Exclusive appropriation authority**. The preceding subsections of this rider shall be the exclusive appropriation authority for receipts from the above identified sources and none of these receipts shall be appropriated by a provision of Article IX of this Act.

90. Mental Health (MH) and Intellectual Disability (ID) Appropriated Receipts.

(a) **Definition.** For the purposes of this section and appropriation authority for the Health and Human Services Commission (HHSC), MH Appropriated Receipts are defined as revenues from state hospitals deposited by the commission into the following Revenue Object Codes as defined by the Comptroller of Public Accounts, and ID Appropriated Receipts are defined as revenues from state supported living centers deposited by the commission into the following Revenue Object Codes as defined by the Comptroller of Public Accounts:

(1) 3628: Dormitory, Cafeteria and Merchandise Sales
(2) 3719: Fees for Copies or Filing of Records
(3) 3722: Conference, Seminar, and Training Registration Fees
(4) 3738: Grants - Cities/Counties
(5) 3739: Grants - Other Political Subdivisions
(6) 3740: Gifts/Grants/Donations-Non-Operating Revenue/Program Revenue - Operating

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

(2) In the event General Revenue has been expended prior to the receipt of MH and ID Collections for Patient Support and Maintenance, the commission shall reimburse General Revenue upon receipt of the revenue. This process shall be completed on a monthly basis in order to maintain a minimum balance on hand in excess MH and ID Collections for Patient Support and Maintenance.

(d) **Responsibility for proportionate share of indirect costs and benefits.** HHSC shall ensure that MH and ID Collections for Patient Support and Maintenance fund their proportionate share of benefits and statewide allocated indirect costs as required and directed in Article IX of this act.

87. Mental Health (MH) and Intellectual Disability (ID) Appropriated Receipts.

(a) **Definition.** For the purposes of this section and appropriation authority for the Health and Human Services Commission (HHSC), MH Appropriated Receipts are defined as revenues from state hospitals deposited by the commission into the following Revenue Object Codes as defined by the Comptroller of Public Accounts, and ID Appropriated Receipts are defined as revenues from state supported living centers deposited by the commission into the following Revenue Object Codes as defined by the Comptroller of Public Accounts:

(1) 3628: Dormitory, Cafeteria and Merchandise Sales
(2) 3719: Fees for Copies or Filing of Records
(3) 3722: Conference, Seminar, and Training Registration Fees
(4) 3738: Grants - Cities/Counties
(5) 3739: Grants - Other Political Subdivisions
(6) 3740: Gifts/Grants/Donations-Non-Operating Revenue/Program Revenue - Operating

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Grants and Contributions
(7) 3747: Rental - Other
(8) 3750: Sale of Furniture and Equipment
(9) 3752: Sale of Publications/Advertising (General)
(10) 3754: Other Surplus or Salvage Property/Material Sales
(11) 3767: Supplies/Equipment/Services - Federal/Other (General)
(12) 3769: Forfeitures
(13) 3773: Insurance Recovery in Subsequent Years
(14) 3802: Reimbursements-Third Party
(15) 3806: Rental of Housing to State Employees

(b) **Reporting.** ABEST Method of Financing Code 8033 - MH Appropriated Receipts, and ABEST Method of Financing Code 8096 - ID Appropriated Receipts, shall be used to report expenditures and request legislative appropriations for state mental health and state supported living centers from the Revenue Object Codes identified above.

(c) **Appropriation authority and accounting for MH and ID Appropriated Receipts.** Amounts defined as MH and ID Appropriated Receipts shall be deposited into the General Revenue Fund according to the identified Revenue Object Codes above. HHSC may receive and expend MH and ID Appropriated Receipts as a first source, and General Revenue shall be used as a second source. In the event that these revenues should be greater than the amounts identified in the method of financing above as MH and ID Appropriated Receipts, the commission is appropriated and authorized to expend these state funds hereby made available, subject to approval through Rider 70, State Supported Living Center Oversight. The expenditure of MH and ID Appropriated Receipts is subject to the following requirements:

(1) Amounts available shall be expended prior to utilization of any General Revenue available for the same purpose. In the event General Revenue must be expended, the agency will provide prior notification to the Legislative Budget Board and the Governor; and

(2) In the event General Revenue has been expended prior to the receipt of MH and ID Appropriated Receipts as defined above, the commission shall reimburse General Revenue upon receipt of the revenue. This process shall be completed on a monthly basis in order to maintain a minimum balance on hand in excess MH and ID

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Grants and Contributions
(7) 3747: Rental - Other
(8) 3750: Sale of Furniture and Equipment
(9) 3752: Sale of Publications/Advertising (General)
(10) 3754: Other Surplus or Salvage Property/Material Sales
(11) 3767: Supplies/Equipment/Services - Federal/Other (General)
(12) 3769: Forfeitures
(13) 3773: Insurance Recovery in Subsequent Years
(14) 3802: Reimbursements-Third Party
(15) 3806: Rental of Housing to State Employees

(b) **Reporting.** ABEST Method of Financing Code 8033 - MH Appropriated Receipts, and ABEST Method of Financing Code 8096 - ID Appropriated Receipts, shall be used to report expenditures and request legislative appropriations for state mental health and state supported living centers from the Revenue Object Codes identified above.

(c) **Appropriation authority and accounting for MH and ID Appropriated Receipts.** Amounts defined as MH and ID Appropriated Receipts shall be deposited into the General Revenue Fund according to the identified Revenue Object Codes above. HHSC may receive and expend MH and ID Appropriated Receipts as a first source, and General Revenue shall be used as a second source. In the event that these revenues should be greater than the amounts identified in the method of financing above as MH and ID Appropriated Receipts, the commission is appropriated and authorized to expend these state funds hereby made available, subject to approval through Rider 65, State Supported Living Center Oversight. The expenditure of MH and ID Appropriated Receipts is subject to the following requirements:

(1) Amounts available shall be expended prior to utilization of any General Revenue available for the same purpose. In the event General Revenue must be expended, the agency will provide prior notification to the Legislative Budget Board and the Governor; and

(2) In the event General Revenue has been expended prior to the receipt of MH and ID Appropriated Receipts as defined above, the commission shall reimburse General Revenue upon receipt of the revenue. This process shall be completed on a monthly basis in order to maintain a minimum balance on hand in excess MH and ID

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Appropriated Receipts.

(d) **Exclusive appropriation authority.** The preceding subsections of this provision shall be the exclusive appropriation authority for Appropriated Receipts from the above identified sources and none of these receipts shall be appropriated by a provision of Article IX of this Act.

119. Community Attendant Workforce Development Strategies. Out of funds appropriated above, the Health and Human Services Commission (HHSC) shall develop and implement strategies to recruit, retain, and ensure adequate access to the services of community attendants.

(a) These strategies shall include the following:

(1) Gathering comprehensive data regarding community attendant turnover and retention in both fee-for-service and managed care, including:

(A) number of attendants;

(B) turnover rates for attendants;

(C) vacancy rates for attendants;

(D) number of attendants paid at the base wage rate;

(E) number of attendants paid above the base wage rate; and

(F) any other data the agency deems necessary to describe the community attendant workforce.

(2) Convening a cross-agency forum to develop a state workforce development plan for retention and recruitment of community attendants;

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Appropriated Receipts.

116. Recruitment and Retention Strategic Plan. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall develop an annual strategic plan for the recruitment and retention of community attendants.

The plan shall include the following:

(a) data on the number of community attendants currently providing home- and community-based services by program;

(b) demographics of attendants providing home- and community-based services, including whether the community attendant is a full-time or part-time employee;

(c) projections on workforce needs over the next decade; and

(d) innovative ideas for the recruitment and retention of community attendants, which may include the following:

(1) wage and benefits incentives;

(2) including recruitment and retention of community attendants in Medicaid Managed Care Network Adequacy Standards;

(3) increasing the use of consumer directed services;

(4) training people with disabilities to be community attendants;

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(3) Directing Medicaid managed care organizations to prioritize the development of quality-based payment systems to improve the quality of and access to community attendant services for members. The payment systems shall:

(i) Improve recruitment and retention of community attendants;

(ii) Ensure financial incentives are passed directly to community attendants; and

(iii) Increase members' ability to make informed choices about their care.

(4) Developing and implementing enhanced network adequacy standards for Medicaid managed care organizations ensuring sufficient member access to community care attendants.

(b) HHSC may implement surveys or other methods as necessary to collect the data described in subsection (a)(1) if it is not available from existing sources.

(c) HHSC shall submit an annual report by November 1, 2020, to the Legislative Budget Board and the Governor's Office reflecting actual expenditures, cost savings, and accomplishments implementing recruitment and retention strategies for community attendants.

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(5) options to develop internships for students in the health-related fields such as medicine, nursing, occupational therapy, physical therapy and others; and

(6) recruiting retired seniors to work as community attendants.

In development of the strategic plan, HHSC shall work in consultation with the Aging and Disability Resource Center Advisory Committee, State Medicaid Managed Care Advisory Committee, Texas Council on Consumer Direction and any other advisory committees and stakeholders as determined by the Executive Commissioner of HHSC.

HHSC shall submit the strategic plan and recommendations for implementation of the plan by November 1, 2020 to the Governor, Lieutenant Governor, Speaker of the House, the Senate Finance Committee, the House Appropriations Committee, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services.

126. Enhanced Eligibility Screening Tools. It is the intent of the Legislature that, out of funds appropriated above, the Health and Human Services Commission:

a. Cross match, on a quarterly basis beginning September 1, 2019, statistically significant samples of recipient enrollment records from the medical assistance, financial assistance, supplemental nutrition assistance, and children's health insurance programs against death records, employment and wage records, records of lottery winnings, residency checks, child support enforcement records, out-of-state electronic benefits transactions, the enrollment status of persons in other state administered public assistance programs, and any other data the commission considers appropriate in order to strengthen program integrity, reduce fraud, waste, and abuse, and achieve cost savings in the programs;

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b. Not later than September 1, 2020, prepare and submit a written report to the Legislative Budget Board, Office of the Governor, the Chair of the House Appropriations Committee, the Chair of the Senate Finance Committee, Lieutenant Governor, Speaker of the House of Representatives, and any permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services containing the findings from the cross matches conducted under Subsection (a) of this rider, including findings of incidents of fraud, waste, or abuse in the programs listed in that subdivision; and

c. Based on the findings from the samples of cross matches, conduct a cross match of all recipient enrollment records for the programs listed in Subsection (a) of this rider not later than December 1, 2020.

127. Expansion of Community-based Services.

(a) Appropriations made above to the Health and Human Services Commission (HHSC) for the purpose of reducing interest lists include $24,792,919 in General Revenue ($66,661,790 in All Funds) for the following additional waiver slots:

(1) 60 Medically Dependent Children's Program slots;

(2) 240 Community Living and Support Services slots;

(3) 1,320 Home and Community-based Services slots; and

(4) 8 Deaf-Blind Multiple Disabilities slots.

(b) All waiver slots identified in subsection (a) are end-of-year targets for fiscal year 2021. Appropriations assume equal rollout throughout the 2020-21 biennium. HHSC shall take any action necessary to ensure that persons are enrolled in waiver services as intended by appropriations and shall provide a plan for achieving this goal. The plan shall be submitted by October 1, 2019, and progress reports related to achieving enrollment goals shall be submitted on March 1, 2020; September 1, 2020; and March 1, 2021. Each progress report shall identify the number of persons enrolled in each type of slot, planned

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enrollment for the remainder of the 2020-21 biennium, any issues with enrollment identified by the agency, and how the agency plans to address those issues to achieve the targets by the end of fiscal year 2021. The plan and subsequent progress reports shall be submitted to the Legislative Budget Board, the Governor, the Senate Finance Committee, and the House Appropriations Committee.

(c) Notwithstanding Special Provisions Relating to All Health and Human Services Agencies, Sec. 4(c), Limitations on Use of Available General Revenue Funds, in the event that increased Federal Funds become available due to availability of enhanced match under the Money Follows the Person demonstration, HHSC may expend the General Revenue Funds made available to further reduce interest lists in the strategies where the funds are made available.

(d) HHSC may consider factors such as length of time on the interest list, size of interest list, demographics, average cost, and crisis stabilization in providing services to interest list clients on a program-specific basis.

128. Early Childhood Intervention Funding Maximization. Out of funds appropriated above in Strategy D.1.4, ECI Respite and Quality Assurance, the Health and Human Services Commission (HHSC) shall develop a plan for maximizing funding available to providers of early childhood intervention (ECI) services. Strategies in the plan may include:

(a) Evaluating the Medicaid rate for Specialized Skills Training;

(b) Restructuring ECI provider contracts to ensure expenditure of ECI appropriations, which may include adjusting the maximum reimbursable value to allow expenditure of appropriated funds for quality or incentive payments to ECI providers;

(c) Coordinating with the Texas Education Agency to explore the feasibility of drawing down additional Federal Funds to be transferred to HHSC for ECI services; and

(d) Any additional strategies identified by HHSC.

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HHSC shall submit the plan by September 1, 2019, and progress reports related to maximizing funding available to providers of ECI services on March 1, 2020; September 1, 2020; and March 1, 2021. Each progress report shall identify strategies HHSC has implemented and the impact of the strategies; strategies HHSC plans to implement and a timeframe for implementation; and any challenges in maximizing funding available to providers of ECI services identified by the agency. The plan and subsequent progress reports shall be submitted to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services.

129. **Transition of Day Habilitation Services.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, and in accordance with state and federal laws and regulations, the Health and Human Services Commission (HHSC) shall develop a plan to replace current day habilitation services in waiver programs for individuals with intellectual and developmental disabilities (IDD) with more integrated services that maximize participation and integration of individuals with IDD in the community. HHSC shall submit the plan, including recommendations and an estimate of fiscal impact, by January 1, 2021 to the Legislative Budget Board, Governor, Lieutenant Governor, Speaker of the House, and members of the Senate Finance Committee and House Appropriations Committee.

129. **Pediatric Care in Nursing Facilities.** When using funds appropriated in Strategies A.2.4, Nursing Facility Payments, and A.2.5, Medicare Skilled Nursing Facility, and in addition to consideration of expense in determining the appropriate placement for children who currently receive care in nursing facilities, the Health and Human Services Commission shall, within the requirements of state and federal law, consider the requests of parents concerning either a continued stay in a nursing facility providing skilled pediatric care or an alternate placement.

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130. General Revenue Funds for Medicaid Mental Health and Intellectual Disability Services. For the purposes of this section and appropriation authority for the Medicaid mental health (MH) and intellectual disability (ID) program responsibilities of the Health and Human Services Commission (HHSC), the following subsections provide governance relating to appropriate use, classification and expenditure of funds.

(a) **General Revenue Match for Medicaid.** ABEST Method of Financing Code 758 - GR Match for Medicaid shall be used to report General Revenue expenditures and request General Revenue appropriations for the state's share of Medicaid payments for the following Medicaid MH and ID services:

(1) Community-based Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID) that are privately operated through contractual arrangements between private providers and HHSC;

(2) Community-based Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID), also known as Bond Homes, that are operated by HHSC;

(3) Home and Community-based Services (HCS) authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and HHSC;

(4) Texas Home Living services authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and HHSC;

(5) Mental health services provided through contracts with Behavioral Health Organizations;

(6) Rehabilitation Services as approved in the State Medicaid Plan which are provided by Mental Health Authorities and IDD Local Authorities;

(7) Targeted Case Management Services as approved in the State Medicaid Plan provided by Mental Health Authorities and IDD Local Authorities;

(8) Service Coordination Services as approved in the State Medicaid Plan provided by Mental Health Authorities and IDD Local Authorities;

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134. General Revenue Funds for Medicaid Mental Health and Intellectual Disability Services. For the purposes of this section and appropriation authority for the Medicaid mental health (MH) and intellectual disability (ID) program responsibilities of the Health and Human Services Commission (HHSC), the following subsections provide governance relating to appropriate use, classification and expenditure of funds.

(a) **General Revenue Match for Medicaid.** ABEST Method of Financing Code 758 - GR Match for Medicaid shall be used to report General Revenue expenditures and request General Revenue appropriations for the state's share of Medicaid payments for the following Medicaid MH and ID services:

(1) Community-based Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID) that are privately operated through contractual arrangements between private providers and HHSC;

(2) Community-based Intermediate Care Facilities for individuals with intellectual disabilities (ICF/IID), also known as Bond Homes, that are operated by HHSC;

(3) Home and Community-based Services (HCS) authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and HHSC;

(4) Texas Home Living services authorized by a 1915(c) federal waiver and provided through contractual arrangements between private providers and HHSC;

(5) Mental health services provided through contracts with Behavioral Health Organizations;

(6) Rehabilitation Services as approved in the State Medicaid Plan which are provided by Mental Health Authorities and IDD Local Authorities;

(7) Targeted Case Management Services as approved in the State Medicaid Plan provided by Mental Health Authorities and IDD Local Authorities;

(8) Service Coordination Services as approved in the State Medicaid Plan provided by Mental Health Authorities and IDD Local Authorities;

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(9) Salaries and operating costs related to direct program administration and indirect administration of the HHSC; and

(10) Home and Community-based Services authorized by a 1915(c) Youth Empowerment Services (YES) federal waiver and provided through contractual arrangements between provider agencies and HHSC.

(b) **General Revenue Certified as Match for Medicaid.** The Health and Human Services Commission (HHSC) shall use ABEST Method of Financing code 8032 - General Revenue Certified as 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 intellectual disability services and administrative expenditures for the following services:

(1) Intermediate care facilities for individuals with intellectual disabilities that are operated by the State and known as "state supported living centers";

(2) Services delivered in state hospitals operated by HHSC including inpatient services for clients under the age of 21 and services that qualify under the federally approved Institutions for Mental Diseases (IMD) option for clients over the age of 65; and

(3) Medicaid Administrative Claims as approved in the State Medicaid Plan which are based on certain activities of Mental Health Authorities and IDD Local Authorities.

(c) **Medicaid Federal Funds**. HHSC shall report expenditures and request legislative appropriations for federal Medicaid matching funds for client services, program administration and agency indirect administration. Automated Budgeting and Evaluation System of Texas (ABEST) Method of Financing Code (MOF) 555 and Medicaid CFDA 93.778 shall be used for the following:

(1) Federal Funds drawn from the U.S. Centers for Medicare and Medicaid Services (CMS) using General Revenue funds classified as General Revenue Match for Medicaid (ABEST MOF Code 758), General Revenue Certified as Match for Medicaid (ABEST MOF Code 8032), Tobacco Settlement Receipts Match for Medicaid (ABEST MOF Code 8024) or Tobacco Receipts Certified as Match for Medicaid (ABEST MOF Code 8023);

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(9) Salaries and operating costs related to direct program administration and indirect administration of the HHSC; and

(10) Home and Community-based Services authorized by a 1915(c) Youth Empowerment Services (YES) federal waiver and provided through contractual arrangements between provider agencies and HHSC.

(b) **General Revenue Certified as Match for Medicaid.** The Health and Human Services Commission (HHSC) shall use ABEST Method of Financing code 8032 - General Revenue Certified as 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 intellectual disability services and administrative expenditures for the following services:

(1) Intermediate care facilities for individuals with intellectual disabilities that are operated by the State and known as "state supported living centers";

(2) Services delivered in state hospitals operated by HHSC including inpatient services for clients under the age of 21 and services that qualify under the federally approved Institutions for Mental Diseases (IMD) option for clients over the age of 65; and

(3) Medicaid Administrative Claims as approved in the State Medicaid Plan which are based on certain activities of Mental Health Authorities and IDD Local Authorities.

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(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);

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(2) Federal Funds drawn from CMS using the departments' certification of local, non-profit expenditures made by the Mental Health Authorities and IDD Local Authorities on behalf of Medicaid-eligible individuals;

(3) Federal Funds received from CMS for services rendered to certain Medicaid-eligible individuals over the age of 65 by federally recognized Institutions for Mental Diseases (IMD Medicaid option) based on billings from state hospitals operated by HHSC to the claims processing agent for the Texas Medicaid program in its capacity as the State's fiscal agent for certain Medicaid payments; and

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

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

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

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

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

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(2) Federal Funds drawn from CMS using the departments' certification of local, non-profit expenditures made by the Mental Health Authorities and IDD Local Authorities on behalf of Medicaid-eligible individuals;

(3) Federal Funds received from CMS for services rendered to certain Medicaid-eligible individuals over the age of 65 by federally recognized Institutions for Mental Diseases (IMD Medicaid option) based on billings from state hospitals operated by HHSC to the claims processing agent for the Texas Medicaid program in its capacity as the State's fiscal agent for certain Medicaid payments; and

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

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

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

(2) In the event General Revenue has been expended prior to the receipt of Medicaid Federal Funds, HHSC 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.

(e) **Responsibility for proportionate share of indirect costs and benefits.** Nothing in this provision shall exempt HHSC 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

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(e) **Responsibility for proportionate share of indirect costs and benefits.** Nothing in this provision shall exempt HHSC 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.

(f) **Exclusive Appropriation Authority.** The preceding subsections of this provision shall be the exclusive appropriation authority for Medicaid mental health and intellectual disability services Federal Fund receipts from the above identified sources, and none of these receipts shall be appropriated by a provision of Article IX of this Act.

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approved rate structure for services provided.

(f) **Exclusive Appropriation Authority.** The preceding subsections of this provision shall be the exclusive appropriation authority for Medicaid mental health and intellectual disability services Federal Fund receipts from the above identified sources, and none of these receipts shall be appropriated by a provision of Article IX of this Act.

130. Information on Funding Provided for Rate Enhancements Across Community-based Programs. Included in amounts appropriated above in Strategies in Goal A, Medicaid Client Services, is $9,086,240 in General Revenue and $14,081,608 in Federal Funds for the 2020-21 biennium to fully fund the rate enhancement programs for community care and intellectual and developmental disabilities providers. Funds are intended to increase attendant compensation and may only be used to increase the number of participant levels or enroll additional providers in existing levels.

131. Illegal Child Care Operations Investigation Unit. Included in amounts appropriated above in Strategy H.2.1, Child Care Regulation, is $1,097,458 in General Revenue in fiscal year 2020 and $931,597 in General Revenue in fiscal year 2021 for the purpose of the Health and Human Services Commission (HHSC) establishing and operating a unit to proactively investigate illegal child care operations. Included in the “Number of Full- Time-Equivalents (FTEs)” identified above are 20.0 FTEs per fiscal year allocated to Strategy H.2.1, Child Care Regulation, to establish and operate the unit. Of these FTEs, HHSC shall designate no less than 17.0 as investigators.

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131. Exemption from Waiver Rate Reductions. Amounts appropriated above in Strategy A.3.1, Home and Community-based Services, and A.3.4, Texas Home Living, assume the continued exemption of consumer directed services from rate reductions (implemented August 1, 2017) for Supported Home Living services in the Home and Community-based Services waiver and Community Support Services in the Texas Home Living waiver.

133. Unexpended Balance Authority within the Biennium for the Office of Inspector General. Any unexpended and unobligated balances remaining as of August 31, 2020, from appropriations made to the Health and Human Services Commission (HHSC) in Strategy K.1.1, Office of Inspector General, and Strategy K.1.2, OIG Administrative Support, are appropriated to HHSC for the fiscal year beginning September 1, 2020 for the same purposes related to the operations of the Office of Inspector General.

134. Informational Listing: Promoting Independence Initiative. Included in amounts appropriated above in Strategy A.3.1, Home and Community-based Services, is $57,993,388 in General Revenue and $92,875,237 in Federal Funds for the 2020-21 biennium for the Promoting Independence Initiative, which provides funding for 2,476 Home and Community-based Services (HCS) slots to be allocated as follows:

(a) 500 slots for individuals in crisis and/or at imminent risk of institutionalization;

(b) 500 slots for individuals in state supported livings centers and large or medium intermediate care facilities for individuals with intellectual disabilities;

(c) 236 slots for children aging out of foster care;

(d) 40 slots for children in transition from general residential operations facilities;

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(e) 500 slots for individuals moving from nursing facilities;

(f) 500 slots for individuals diverted from admission to a nursing facility; and

(g) 200 slots for individuals moving from state hospitals.

All slots are end-of-year targets for fiscal year 2021. Appropriations assume equal rollout throughout the 2020-21 biennium. The Health and Human Services Commission shall take any action necessary to ensure that persons are enrolled in waiver services as intended by appropriations and shall provide a plan for achieving this goal. The plan shall be submitted by September 1, 2019, and progress reports related to achieving enrollment goals shall be submitted on March 1, 2020; September 1, 2020; and March 1, 2021. Each progress report shall identify the number of persons enrolled in each type of slot and for each identified purpose; planned enrollment for the remainder of the 2020-21 biennium; any issues with enrollment identified by the agency; and how the agency plans to address those issues to achieve the targets by the end of fiscal year 2021. The plan and subsequent progress reports shall be submitted to the Legislative Budget Board, the Governor, the Senate Finance Committee, and the House Appropriations Committee.

135. Healthy Texas Women Cost Reimbursement Program. Included in amounts appropriated above in Strategy D.1.1, Women's Health Programs, is $15,000,000 in General Revenue in each fiscal year for the Health and Human Services Commission (HHSC) to operate the Healthy Texas Women (HTW) Cost Reimbursement program.

(a) HHSC shall base the amount a participant in the Cost Reimbursement program may expend on administration on measurable outcomes of the participant's activities;

(b) HHSC shall not expend amounts in excess of $15,000,000 in General Revenue in each fiscal year on the HTW Cost Reimbursement program;

(c) Contingent upon prior notification to the Legislative Budget Board and the Governor, HHSC may utilize funds appropriated for the HTW Cost Reimbursement program to provide

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services in the HTW Fee-for-Service program or other client service program within Strategy D.1.1, Women's Health Programs, if the agency determines that doing so would more effectively connect clients to care; and

(d) HHSC shall report contract amounts for each contractor after finalization (signing) of contracts and after any mid-year adjustments to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services.

136. Substance Abuse Treatment Services. Included in amounts appropriated above in Strategy D.2.4, Substance Abuse Services, is $3,569,863 in GR for Substance Abuse Prevention and Treatment Block Grant in fiscal year 2020 and $22,795,293 in GR for Substance Abuse Prevention and Treatment Block Grant in fiscal year 2021 to provide a rate increase for all substance abuse treatment services provided under Strategy D.2.4, Substance Abuse Services. Also included in amounts appropriated above in Strategy D.2.4, Substance Abuse Services, is $23,634,844 in GR for Substance Abuse Prevention and Treatment Block Grant in fiscal year 2020 to reduce the substance abuse treatment waitlist for pregnant women and women with dependent children waiting to receive services provided under Strategy D.2.4, Substance Abuse Services.

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136. Waiver Program Cost Limits.

(a) Out of funds appropriated above in Goal A, Medicaid Client Services, for the Medically Dependent Children Program, Community Living Assistance and Support Services, Deaf-Blind Multiple Disabilities, Home and Community-based Services, and STAR+PLUS Community Based Alternatives waivers, and subject to the terms of subsection (3) below, the Health and Human Services Commission (HHSC) may use General Revenue Funds to pay for services if:

(1) the cost of such services exceeds the individual cost limit;

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(2) federal financial participation is not available to pay for such services; and

(3) HHSC determines that:

(A) the person's health and safety cannot be protected by the services provided within the individual cost limit established for the program; and

(B) there is no other available living arrangement in which the person's health and safety can be protected at that time, as evidenced by:

(i) an assessment conducted by clinical staff of HHSC; and

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

(b) Out of funds appropriated above in Goal A, Medicaid Client Services, for the waiver programs identified in subsection (a) above, and subject to the terms of subsection (c) below, HHSC is authorized to use General Revenue Funds to continue to provide services to a person who was receiving medical assistance waiver program services on September 1, 2005, at a cost that exceeded the individual cost limit specified in the medical assistance waiver program if:

(1) federal financial participation is not available to pay for such services; and

(2) continuation of those services is necessary for the person to live in the most integrated setting appropriate to the needs of the person.

(c) Authority provided in this rider is contingent upon HHSC submitting a report in writing to the Legislative Budget Board and Governor on October 1 of each year. The report shall include the number of clients by program which exceeds cost limits and the unmatched General Revenue associated with each by fiscal year.

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137. Supplemental Payment Program Reporting and Appropriation Authority for Intergovernmental Transfers. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC) shall report certain financial and expenditure information regarding supplemental payment programs, including, but not limited to, the Disproportionate Share Hospital (DSH) program, the Uncompensated Care (UC) Pool, the Delivery System Reform Incentive Payment (DSRIP) Pool, the Network Access Improvement Program (NAIP), supplemental payments where the source of the non-federal share is Local Provider Participation Funds (LPPF), and other programs operated under the Healthcare Transformation and Quality Improvement Program 1115 Waiver, and any successor programs.

(a) HHSC shall report quarterly:

1) Prospective payment estimates, aligning estimated payments reporting with the CMS-37. The report will include a prospective certification that the requisite matching state and local funds are, or will be, available for the certified quarter. The quarterly financial report provides a statement of the state's Medicaid funding requirements for a certified quarter through summary data by each program; and

2) Expenditures made in the previous quarter, aligning expenditure reporting with the CMS- 64. The report will include actual expenditures allowable under state and federal requirements. HHSC will report the recipients of all funds distributed by the commission for all supplemental payment programs. The report shall include:

i. the recipients of funds by program;
ii. the amount distributed to each recipient; and
iii. the date such payments were made.

(b) Intergovernmental transfers (IGTs) of funds from institutions of higher education are appropriated to HHSC for the non-federal share of uncompensated care or delivery system reform incentive payments or monitoring costs under the Healthcare Transformation and Quality Improvement Program 1115 Waiver.

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(c) In an effort to maximize the receipt of federal Medicaid funding, HHSC is appropriated and may expend IGT received as Appropriated Receipts-Match for Medicaid No. 8062 for the purpose of matching Medicaid Federal Funds for payments to Medicaid providers and to offset administrative costs for programs HHSC administers for other entities.

(d) From funds appropriated elsewhere in the act, HHSC shall provide a copy of the annual independent audit conducted of DSH and UC in compliance with federal requirements. HHSC shall provide a report that annually by June 30 to the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, the Senate Finance Committee members, the House Appropriations Committee members, and the Legislative Budget Board.

(e) HHSC will use the sums transferred from state owned hospitals as provided elsewhere in the Act as necessary to apply for appropriate matching Federal Funds and to provide the state's share of disproportionate share payments and uncompensated care payments authorized under the federal Healthcare Transformation and Quality Improvement Waiver, excluding payments for physicians, pharmacies, and clinics, due to state-owned hospitals. Any amounts of such transferred funds not required for these payments shall be deposited by HHSC to the General Revenue Fund as unappropriated revenue. Payments for physicians, pharmacies, and clinics are governed by Special Provisions Relating Only to Agencies of Higher Education, §54.

(f) By October 1 of each fiscal year, HHSC shall present a schedule of projected transfers and payments to the Comptroller of Public Accounts, the Governor, and the Legislative Budget Board.

(g) HHSC shall also evaluate the impact of reductions in funding available under the federal Healthcare Transformation and Quality Improvement Waiver. HHSC shall report on the evaluation and findings to the Governor, the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House of Representatives, and the members of the Senate Finance Committee and House Appropriations Committee by October 1, 2020.

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137. **Rate Increases: Intermediate Care Facilities and Certain Waiver Providers.** Included in amounts appropriated above in Strategy A.2.7, Intermediate Care Facilities - IID; Strategy A.3.1, Home and Community-based Services; and Strategy A.3.4, Texas Home Living is $42,000,000 in General Revenue and $64,788,711 in Federal Funds in fiscal year 2020 and $42,000,000 in General Revenue and $68,149,489 in Federal Funds in fiscal year 2021 to rebase the reimbursement methodologies to reflect current spending levels in all cost categories and to update the reimbursement methodology for facility-based community services to include a seven percent factor. Funding in fiscal year 2021 is contingent on the Health and Human Services Commission (HHSC) creating, in the rate enhancement programs serving individuals with intellectual and developmental disabilities, separate categories to group the services based on the number of attendant hours included in the billing unit. HHSC shall develop the new categories no later than September 1, 2020.

138. **Strategic Planning for Vacant or Underutilized FTE Positions.** Out of funds appropriated above in Strategy L.1.1, HHS System Support, the Health and Human Services Commission (HHSC) shall develop a strategic plan to transition vacant or underutilized full-time equivalent positions (FTEs) to high priority agency functions including contract oversight and management, or to achieve cost savings by reducing vacant or underutilized FTEs. HHSC shall submit the strategic plan by August 31, 2020, and shall report associated data regarding the commission's redistribution, repurposing, or reduction of FTE positions by August 31 of each fiscal year to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services.

139. **Licensed Surgical Assistant Utilization.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC) shall collect information on the utilization of Licensed Surgical Assistants and evaluate options for providing separate Medicaid reimbursement to them, including an assessment of the cost of each

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	option that considers any effect on utilization. HHSC shall provide a report of findings no later than December 1, 2020 to the Legislative Budget Board, House Appropriations Committee, Senate Finance Committee, and Governor.
139. Cost Effectiveness of Delivery System Reform and Incentive Payment Projects. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Admin, the Health and Human Services Commission (HHSC) shall evaluate the cost effectiveness of all Delivery System Reform and Incentive Payment (DSRIP) projects. HHSC shall report on the evaluation and findings and make a recommendation on whether or not the state should continue to provide funding to each DSRIP project after the discontinuation of federal financial participation to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services by October 1, 2020.	
140. Healthy Texas Women Program Provider List Improvement Strategic Plan. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall develop a strategic plan to improve the accuracy of Healthy Texas Women Program (HTW) provider list on the HTW website. The strategic plan shall include methods to ensure the provider list contains: (a) Only providers who are enrolled in HTW and are taking patients; (b) Current provider contact information; (c) Only addresses where services are rendered and not provider administrative offices; and (d) Easily accessible and understandable information. HHSC shall submit the strategic plan to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services by November 1, 2020.	

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141. Evaluation of Client Transition into Women's Health Programs. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall work with Managed Care Organizations (MCOs) to evaluate the current transition process for women who lose eligibility for Medicaid or CHIP and are eligible for the Healthy Texas Women Program (HTW) or Family Planning Program (FPP) and ways to improve the transition process. The evaluation shall examine:

(a) Methods of communicating information regarding loss of Medicaid/CHIP eligibility and potential eligibility for HTW/FPP to clients by MCOs and HHSC; and

(b) Ways in which HHSC and MCOs can make clients aware of any other programs they may be newly eligible for.

HHSC shall report on the evaluation and findings to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services by June 1, 2020.

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141. State Supported Living Centers Planning. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall develop a plan to maximize resources at state supported living centers (SSLCs).

The plan shall include the following:

(a) an examination of existing resources, services, supports, and infrastructure needs to serve individuals residing in SSLCs as well as other individuals with an intellectual or developmental disability (IDD) or behavioral health needs in this state;

(b) consideration of the feasibility of repurposing vacant or unused SSLC buildings and/or property and other resources to support SSLC residents; and

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(c) consideration of service delivery to individuals who are not residents of the SSLC, including those with IDD or behavioral health needs.

In development of the plan, HHSC shall consider SSLC residents' needs and preferences, and/or their legally authorized representatives' preferences; SSLC system operational needs and capacity; and changing demographics of persons served by SSLCs and in the community. HHSC shall coordinate with relevant stakeholders in the development of the plan, including SSLC family associations and local mental health authorities.

HHSC shall submit the plan no later than December 1, 2020, to the Governor, the Legislative Budget Board, and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services.

142. Medicaid and CHIP Physician Payments. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC), in coordination with relevant stakeholders, shall evaluate methods to reimburse physicians in Medicaid and the Children's Health Insurance Program to reward innovative, value-based delivery models; maximize the state's efforts to improve patient health outcomes and lower costs; and address Texas' critical health care challenges, including improving maternal and child health, increasing the availability of mental health and substance use disorder treatment, and strengthening rural, border, and underserved physician networks. HHSC shall submit a report with the results of the evaluation, including recommendations, to the Legislative Budget Board and the Governor no later than June 1, 2020.

142. Home Delivered Meals Program. Included in amounts appropriated above in Strategy F.1.2, Non-Medicaid Services, is $3,894,973 in General Revenue in each fiscal year of the 2020-21 biennium to increase the maximum rate for Home Delivered Meals to $5.42 per meal.

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143. **Transfer of Unused Long-acting Reversible Contraceptive Devices.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Admin, and Strategy L.1.1, HHS System Supports, the Health and Human Services Commission shall coordinate with the State Board of Pharmacy to determine the feasibility of implementing a process in which unused long-acting reversible contraceptive devices prescribed for clients enrolled in Medicaid or the Healthy Texas Women (HTW) program can be transferred to another Medicaid or HTW client. If feasible and cost effective, HHSC, with prior written approval from the Legislative Budget Board and Governor, may implement the process.

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143. **Study Relating to Cost Drivers in STAR Kids.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall study the cost impact of STAR Kids members with high utilization and cost drivers, including private duty nursing, and other services as appropriate, in each participating managed care organization (MCO) to determine if adjustments to the current rate-setting methodology would more appropriately align capitation rates with relative acuity without reducing the incentive for MCOs to manage utilization, while providing the most cost-effective care in the most appropriate setting. If adjustments are deemed appropriate, HHSC may make such adjustments to the STAR Kids capitation rate-setting methodology if the adjustments will not result in increased expenditures.

144. **Rural Labor and Delivery Medicaid Add-on Payment.** Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in Strategy A.1.3, Pregnant Women, is $3,146,400 in General Revenue and $4,853,600 in Federal Funds in fiscal year 2020 and $3,050,400 in General Revenue and $4,949,600 in Federal Funds in fiscal year 2021 for HHSC to provide a $500 Medicaid add-on payment for labor and delivery services provided by rural hospitals. For purposes of this rider, rural hospitals are defined as (1) hospitals located in a county with 60,000 or fewer persons according to the 2010 U.S. Census; or (2) a hospital designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA); or

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(3) a hospital that has 100 or fewer beds, is designated by Medicare as a CAH, a SCH, or a RRC, and is located in an MSA.

144. Long-Acting Reversible Contraception Bulk Purchasing.

(a) Out of funds appropriated above in Strategy D.1.1, Women's Health Programs, the Health and Human Services Commission (HHSC) may expend up to $4,000,000 in General Revenue for the Healthy Texas Women (HTW) program and $4,000,000 in General Revenue for the Family Planning Program (FPP) during the 2020-21 biennium for contracts with program providers for the purpose of allowing providers to purchase and maintain a supply of long-acting reversible contraception (LARCs) devices and related supplies within their office or clinic.

(b) HHSC shall construct a tiered funding methodology and disperse funding in the following order: providers serving clients in rural and medically underserved areas or serving populations with historical underutilization; providers who demonstrate historical barriers to purchasing LARCs; and providers generally seeking to increase LARC utilization. HHSC shall base all funding allocations for this purpose on historical utilization and overall clients served.

(c) HHSC shall develop a mechanism to properly account for utilization of stocked LARC devices and supplies purchased with funds identified in subsection (a).

(d) HHSC shall place a set percentage of contracted funds used for the purpose described in subsection (a) at risk for each contracted HTW and FPP provider. Funds placed at risk are subject to recoupment. Unexpended or recouped funds and unused devices shall be redistributed, to the extent allowable and feasible, to other contractors for the purpose described in subsection (a) according to a methodology developed by HHSC.

(e) Contingent upon approval by the Centers for Medicare and Medicaid Services (CMS) of the HTW Section 1115 Demonstration Waiver, HHSC shall work with CMS to determine if LARC bulk purchasing can be added to the waiver and receive federal matching funds.

(f) Amounts identified in subsection (a) related to the HTW program are a portion of, not in addition to, appropriations for the HTW Cost Reimbursement program identified in HHSC Rider XX, Healthy Texas Women Cost Reimbursement Program, and are subject to the

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provisions of that rider.

145. **Mobile Stroke Unit Funding.** Included in amounts appropriated above in Strategy D.1.10, Additional Specialty Care, is $500,000 in General Revenue in fiscal year 2020 and $500,000 in General Revenue in fiscal year 2021 for the Health and Human Services Commission to provide funding for services provided by mobile stroke units.

146. **Unexpended Balances within the Biennium: Family Violence Services.** Any unexpended and unobligated balances remaining as of August 31, 2020, from appropriations made to the Health and Human Services Commission (HHSC) in Strategy F.3.1, Family Violence Services, are appropriated to HHSC for the fiscal year beginning September 1, 2020, for the same purposes relating to the provision of family violence services.

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145. **Medicaid Fraud Enforcement.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission shall allocate an amount not to exceed $330,000 in General Revenue in fiscal year 2020 and $70,000 in General Revenue in fiscal year 2021 to create an automated database for the Texas Drug Code Index Certification of Information.

147. **Managed Care Organization Services for Adults with Serious Mental Illness.** Out of funds appropriated above in Strategy B.1.1, Medicaid Client Services, the Health and Human Services Commission (HHSC) shall identify claims and expenditures, by managed care organization (MCO), for Medicaid recipients in STAR+PLUS with a serious mental illness (SMI) to evaluate any inappropriate variation in delivery of service to individuals with SMI by MCO. For the purposes of the evaluation, individuals with SMI are individuals who have: (1) a qualifying

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148. Hepatitis C Treatment Access. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC), in cooperation with the Texas Department of Criminal Justice, Employees Retirement System, and Teachers Retirement System, shall explore the feasibility of implementing a model allowing the state to pay a flat monthly rate for unlimited access to medications or other bulk purchasing or negotiating opportunities to treat individuals with Hepatitis C who are eligible to have prescription drugs provided with state funds. HHSC shall prepare and submit a report on the cost-effectiveness and projected savings of implementing such a model to the Governor, Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services no later than July 1, 2020. If feasible and cost effective, HHSC, with prior written approval from the Legislative Budget Board and the Governor, may implement this model.

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diagnosis; and (2) functional impairment if a local mental health authority has performed an assessment on the recipient. HHSC shall identify performance measures to better hold MCOs accountable for outcomes and Medicaid spending for individuals with SMI, evaluate the delivery of services to individuals with SMI by MCOs against standards of care, and develop recommendations to improve quality of care. HHSC shall submit a report, including findings and recommendations, to the Governor, Legislative Budget Board, Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor not later than August 31, 2020.

148. Coordination with Diabetes Council. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission shall coordinate with the Texas Diabetes Council to develop strategies to reduce or contain diabetes-related costs in the Medicaid program using best practices to improve quality of care. HHSC shall submit a report including findings and recommendations to the Legislative Budget Board, the Governor, and the permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services by August 31, 2020.

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149. **Regional Advisory Council Diversion Evaluation.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission (HHSC) shall evaluate the feasibility of requiring trauma service area regional advisory councils to implement a program to allow emergency medical services providers to navigate medically stable psychiatric emergency detention patients to the most appropriate setting. As part of the evaluation, HHSC shall consider the potential for Medicaid cost savings and options for providing reimbursement to the regional advisory councils or emergency medical services providers with those savings. If determined feasible and cost-effective, HHSC, with prior written approval from the Legislative Budget Board and the Governor, may implement the program. HHSC shall report to the Governor and the Legislative Budget Board on the results of the evaluation, including any recommendations or implementation plans, no later than October 31, 2020.

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149. **Evaluation of Opioid Drug Prescribing Practices Under Medicaid.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC) shall evaluate the prescribing practices for opioid drugs in the state under Medicaid and assess to what extent those practices align with the guidelines for prescribing opioid drugs adopted by the Centers for Disease Control and Prevention. No later than September 1, 2020, HHSC shall submit a report to the Legislature, Legislative Budget Board, and the Governor, that includes findings of the evaluation and recommendations for next steps to take to better align the prescribing practices for opioid drugs in this state under Medicaid with the guidelines for prescribing opioid drugs adopted by the Centers for Disease Control and Prevention.

150. **Study on Cost Savings for Medicaid Prescription Drugs.** Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC) shall evaluate strategies to achieve cost savings for Medicaid prescription drugs, including the direct dispensing of prescription drugs by physicians. HHSC shall submit a report with findings and recommendations for achieving cost savings to the Senate Finance Committee, the House Committee on Appropriations, the Legislative Budget Board, the Governor,

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	and permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services by September 1, 2020.
150. Emergency Medical Services Enhanced Payment Model. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission (HHSC) shall conduct a study on the feasibility and cost-effectiveness of establishing an enhanced payment model for nonstate government-operated public providers of ground emergency medical transportation services, which includes Medicaid fee-for-service supplemental payments and an enhanced Medicaid Managed Care fee schedule for public ambulance providers. If HHSC determines that an enhanced payment model is feasible and necessary, and receives federal approval to operate such a payment model, HHSC may receive and expend any inter-governmental transfer funds that may be required to support the enhanced payments.	
	151. Pharmacy Services at State Supported Living Centers. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall evaluate the feasibility and cost-effectiveness of alternative models for providing pharmacy services for state supported living centers. The evaluation should include consideration of entering into a contract with an organization to provide off-site pharmacy services, partnering with an institution of higher education to obtain more favorable pricing, and any other option identified by HHSC. The evaluation must consider any potential issues with compliance with the Department of Justice Settlement Agreement. HHSC shall report its findings and recommendations to the Governor, the Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services or finance by December 1, 2020.
152. Study on Substance Abuse Treatment Services. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall evaluate the reimbursement methodology and payment rate for substance use treatment services provided under Strategy D.2.4, Substance Abuse Services. In its evaluation, HHSC shall consider best practices for each level of care. HHSC shall report its initial findings to the Governor, the	

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Legislative Budget Board, and permanent committees in the House of Representatives and the Senate with jurisdiction over health and human services by November 1, 2020, and include in the report recommendations to improve current payment rates for substance use treatment services.	
	153. Report on Medicaid Coverage for Former Foster Children. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts & Administration, the Health and Human Services Commission shall evaluate the number of former foster children who do not renew Medicaid coverage to maintain continuous health coverage until their 26th birthday. HHSC shall develop recommendations to improve the rate of youth formerly in foster care who maintain continuous health coverage and shall submit a report including findings and recommendations to the Governor, Legislative Budget Board, Speaker of the House, Lieutenant Governor, and members of the Senate Finance Committee and House Appropriations Committee no later than November 1 of each fiscal year.
153. Texas Human Trafficking Resource Center. Out of funds appropriated above in Strategy D.1.1, Women's Health Programs, the Health and Human Services Commission shall allocate a minimum of $50,000 each state fiscal year to the Texas Human Trafficking Resource Center.	
154. Women's Health Funding. Out of funds appropriated above in strategy D.1.1., Women's Health Programs, $750,000 must be used in each year of the state fiscal biennium ending August 31, 2021, to increase oversight of women's health contracts under the Healthy Texas Women Program and $750,000 must be used in each of those years by the Health and Human Services Commission to implement a pilot program for women enrolled in Medicaid who need more comprehensive services to improve maternal and infant health outcomes.	

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154. **Quality-based Enrollment Incentive Program.** Pursuant to Government Code § 533.00511, the Health and Human Services Commission (HHSC) shall create an incentive program that automatically enrolls a greater percentage of Medicaid recipients who have not selected a managed care plan into a plan based on quality of care, efficiency and effectiveness of service provision, and performance. Appropriations in Strategy B.1.1, Medicaid Contracts & Administration, for fiscal year 2021 are contingent on HHSC implementing the required program by September 1, 2020.

155. **Consolidated Reporting of Opioid-Related Expenditures.** No later than October 1 of each year, the Executive Commissioner of the Health and Human Services Commission (HHSC) shall submit to the Legislature, Legislative Budget Board, and the Governor a report that provides information about actual annual expenditures from the previous fiscal year for all opioid abuse and misuse-related programs at HHSC, the Department of Family and Protective Services, and the Department of State Health Services, including but not limited to prevention, treatment, recovery, intervention, and detoxification services. The report shall include expenditure data by program at the method of finance level. The report shall include the amount distributed by Article II agencies to institutions of higher education for each program at the method of finance level.

155. **Contingency for HB 1110.** Contingent on the passage and becoming law of House Bill No. 1110 or similar legislation of the 86th Legislature, Regular Session, 2019, relating to the Medicaid eligibility of certain women after a pregnancy, the amount of $15 million is appropriated to the Health and Human Services Commission for use to implement the changes in law provided by that legislation during the state fiscal biennium ending August 31, 2021.

156. **Veterans Recovery Pilot Program.** Included in amounts appropriated above in Strategy F.3.3., Additional Advocacy Programs, is $1,000,000 in General Revenue in fiscal year 2020 to establish

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and operate a veterans recovery pilot program to provide certain veterans with hyperbaric oxygen treatment pursuant to Chapter 49 of the Health and Safety Code. Any unexpended balances in the Veterans Recovery Pilot Program as of August 31, 2020 are appropriated for the same purposes for the fiscal year beginning September 1, 2020.

157. Contingency for HB 1110. Contingent on the passage and becoming law of House Bill No. 1110 or similar legislation of the 86th Legislature, Regular Session, 2019, relating to the Medicaid eligibility of certain women after a pregnancy, the amount of $5 million is appropriated to the Health and Human Services Commission for use to implement the changes in law provided by that legislation during the state fiscal biennium ending August 31, 2021.

158. Alternatives to Abortion.

(a) Method of Financing. Notwithstanding any contrary provision of this Article, reduce the appropriations from the Temporary Assistance for Needy Families (TANF) program allocated to Strategy D.1.2, Alternatives to Abortion, for the state fiscal biennium ending August 31, 2021, to zero and increase the appropriations from the general revenue fund for Strategy D.1.2 by an amount equal to the amount reduced.

(b) Unexpended Balances: Between Years within the State Fiscal Biennium. Notwithstanding any other provision of this Act, any unobligated and unexpended balances as of August 31, 2020, in appropriations made to the Health and Human Services Commission for Strategy D.1.2, Alternatives to Abortion, are appropriated for the same purpose for the state fiscal year beginning September 1, 2020.

159. Services for Individuals with Disabilities Aging Out of Certain Medicaid Services. Out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health

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and Human Services Commission shall use existing resources to conduct an analysis to determine if it is cost effective to continue to provide private duty nursing services to disabled children in Medicaid past the age of 21 when this population ages out of these services as adults. As part of the cost benefit analysis, the Commission shall consider a functional needs-based eligibility requirement placed on applicants in order for private duty nursing services to continue. The Commission may recommend other utilization controls as appropriate.

HHSC shall issue a report with findings and recommendations to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and Legislative Budget Board no later than November 1, 2020.

160. Suicide Prevention.

(a) Notwithstanding other provisions of this Act, the general revenue appropriations made to each of the following agencies or entities are reduced by the amount of $125,000 for the state fiscal year ending August 31, 2020, and by the amount of $125,000 for the state fiscal year ending August 31, 2021:

(1) the Department of Family and Protective Services;

(2) the Department of State Health Services;

(3) the Department of Criminal Justice;

(4) the Texas Education Agency;

(5) the Juvenile Justice Department;

(6) the Veterans Commission; and

(7) Trusteed Programs Within the Office of the Governor.

(b) Each agency or entity whose general revenue appropriations are reduced by Subsection (a)

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of this rider may reallocate the general revenue appropriated to it for any strategy as necessary to accommodate the reductions.

(c) Notwithstanding other provisions of this Article, the appropriations made to the Health and Human Services Commission for Strategy D.2.3, Community Mental Health Crisis Services, are increased by the amount of $875,000 for the state fiscal year ending August 31, 2020, and by the amount of $875,000 for the state fiscal year ending August 31, 2021.

(d) Out of money appropriated to the Health and Human Services Commission for Strategy D.2.3, Community Mental Health Crisis Services, the commission shall allocate not less than $1,000,000 in each year of the fiscal biennium ending August 31, 2021, to:

(1) provide grants to nonprofit organizations to coordinate a network of state and community-based suicide prevention groups; and

(2) assist the Health and Human Services Commission with the development, implementation, and monitoring of a statewide and community-based suicide prevention plan.

161. Increased Access to Community Mental Health Services. Out of funds appropriated above in Strategy D.2.1, Community Mental Health Services-Adults, and Strategy D.2.2, Community Mental Health Services-Children, the Health and Human Services Commission shall allocate for the state fiscal biennium beginning September 1, 2019, the amount of $31,104,450 from Strategy D.2.1 and the amount of $11,800,000 from Strategy D.2.2 for the purpose of:

(1) eliminating waiting lists for community mental health services for adults and children;

(2) increasing capacity to avoid future waiting lists for community mental health services for adults and children;

(3) addressing population growth in local mental health authority and local behavioral health authority service areas; and

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35. Increased Access to Community Mental Health Services. Included in amounts appropriated above is $23,416,350 in General Revenue and $1,667,735 in Federal Funds for each fiscal year for the 2020-21 biennium in Strategy D.2.1, Community Mental Health Svcs-Adults, and $4,026,866 in General Revenue and $416,934 in Federal Funds for each fiscal year of the 2020-21 biennium in Strategy D.2.2, Community Mental Hlth Svcs-Children, to avoid future waitlists and increase outpatient mental health treatment capacity at the local mental health authorities and local behavioral health authorities.

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(4) increasing equity in funding allocations to local mental health authorities and local behavioral health authorities.

162. Statewide Bed Capacity Review and Reallocation. The Health and Human Services Commission shall use funds appropriated above in Strategy H.1.1, Facility/Community-based Regulation, to review the statewide bed capacity of community ICF-IID facilities for individuals with an intellectual disability or a related condition and, based on the review, to develop a process to reallocate beds held in suspension by the commission. The process may include:

(1) criteria by which ICF-IID providers may apply to receive reallocated beds and remain within appropriated amounts; and

(2) a means to reallocate the beds across service regions.

163. Delivery System Reform Incentive Payment (DSRIP) Program: Transition Plan to Sustain Services for Adults with Serious Mental Illness; Report Required.

(a) It is the intent of the legislature that the Health and Human Services Commission, in negotiations with the Centers for Medicare and Medicaid Services under the Texas Health Care Transformation and Quality Improvement Program Waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to establish a transition plan for the delivery system that will succeed the Delivery System Reform Incentive Payment (DSRIP) program, consider implementing approaches in the state fiscal biennium beginning September 1, 2022, that:

(1) to the extent possible, use money from the general revenue fund to draw down federal matching money in a manner that at least sustains services provided to the target population of adults with serious mental illness, as defined by Section 1355.001, Insurance Code, who meet appropriate diagnostic and functional eligibility criteria and have incomes at or below the federal poverty level; and

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(2) use alternate payment strategies and initiatives for providers who meet certain quality metrics that support positive treatment outcomes for the target population described by Subdivision (1) of this subsection, including the provision of integrated care, use of appropriate data systems, the provision of criminal justice interface, and assistance in securing stable housing.

(b) Not later than December 1 of each state fiscal year of the state fiscal biennium beginning September 1, 2019, the Health and Human Services Commission shall submit a report to the Legislative Budget Board and the governor on the status of negotiations with the Centers for Medicare and Medicaid Services described by Subsection (a) of this section.

164. Information Technology and Data Services Modernization Plan. It is the intent of the legislature that, not later than August 31, 2021, the Health and Human Services Commission, using money appropriated to the commission by this Act, prepare and submit to the legislature a 10-year system-wide plan outlining the manner in which the commission intends to transition its information technology and data-related services and capabilities into a more modern, integrated, secure, and effective environment. The plan must:

(1) describe the commission's project management processes;

(2) identify the resources required to implement the plan;

(3) define the desired outcomes of the plan;

(4) include:

(A) legacy system modernization or replacement;

(B) efforts toward server consolidation through the Department of Information Resources data center services program;

(C) a description of cloud computing service options; and

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(D) an analysis of the commission's technical and data architecture that is necessary to provide enhanced data analytics, reporting, and performance management needs; and	
(5) describe the commission's approach to creating an automated, interoperable system-wide data analytics and performance management system that transforms data into meaningful information to support data-driven decision making, quality improvement initiatives, efficient service delivery, and effective regulation and oversight of programs administered by the commission.	

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Sec. 4. Federal Match Assumptions and Limitations on Use of Available General Revenue Funds.

a. **Federal Match Assumptions.** The following percentages reflect federal match assumptions used in Article II of this Act. The Enhanced Federal Medical Assistance Percentage includes the 11.5 percentage point increase for federal fiscal year 2020 pursuant to Federal Law, which is only available for certain expenditures.

Federal Medical Assistance Percentage (FMAP)

	2020	2021
Federal Fiscal Year	60.89%	61.96%
State Fiscal Year	60.67%	61.87%

Enhanced Federal Medical Assistance Percentage (EFMAP)

	2020	2021
Federal Fiscal Year	84.12%	73.37%
State Fiscal Year	84.92%	74.27%

b. **Enhanced Match Assumptions and Reporting.** Health and human services agencies listed in Article II of this Act shall submit to the Legislative Budget Board and the Governor the monthly number of clients receiving services eligible for any enhanced federal match as well as the amount of eligible expenditures subject to an enhanced match, by strategy. The data shall be submitted on a monthly basis in a format specified by the Legislative Budget Board. For purposes of this section, enhanced federal matches are defined as an increase to the usual matching rate (regardless of what the usual match is) that are, or become, available under Medicaid or another federally-matched program. Enhanced federal matches include, but are not limited to, those made available through the Money Follows the Person demonstration and the Community First Choice Program. Whether or not a match meets the definition of enhanced federal match for purposes of this section will be at the discretion of the Legislative Budget Board.

Appropriations to the Health and Human Services Commission in Article II of this Act have been adjusted to reflect $149,863,297 increased Federal Funds and reduced General Revenue Funds due to enhanced matches under the Community First Choice program.

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Appropriations to the Health and Human Services Commission in Article II of this Act have been adjusted to reflect $149,863,297 increased Federal Funds and reduced General Revenue Funds due to enhanced matches under the Community First Choice program.

Any other Article II agency is still subject to the requirements of subsections (b) and (c) of

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Any other Article II agency is still subject to the requirements of subsections (b) and (c) of this provision if any agency expenditures receive an enhanced federal match.

c. **Limitations on Use of Available General Revenue Funds.** In the event the actual FMAP and EFMAP should be greater than shown in subsection (a), or the amount of increased Federal Funds and reduced General Revenue Funds due to enhanced matches should be greater than shown in subsection (b), or if any other matching rate becomes more favorable than the rate assumed in the General Appropriations Act, the health and human services agencies in Article II of this Act are authorized to expend the General Revenue Funds thereby made available only upon authorization from the Legislative Budget Board and Governor.

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

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

(2) the amount available by strategy;

(3) the strategy(ies) in which the funds will be expended and the associated amounts, including any matching Federal Funds;

(4) an estimate of performance levels and, where relevant, a comparison to targets included in this Act; and

(5) the capital budget and/or full-time equivalent impact.

Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board.

The request shall be considered to be approved unless the Legislative Budget Board or the

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this provision if any agency expenditures receive an enhanced federal match.

c. **Limitations on Use of Available General Revenue Funds.** In the event the actual FMAP and EFMAP should be greater than shown in subsection (a), or the amount of increased Federal Funds and reduced General Revenue Funds due to enhanced matches should be greater than shown in subsection (b), or if any other matching rate becomes more favorable than the rate assumed in the General Appropriations Act, the health and human services agencies in Article II of this Act are authorized to expend the General Revenue Funds thereby made available only upon authorization from the Legislative Budget Board and Governor.

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

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

(2) the amount available by strategy;

(3) the strategy(ies) in which the funds will be expended and the associated amounts, including any matching Federal Funds;

(4) an estimate of performance levels and, where relevant, a comparison to targets included in this Act; and

(5) the capital budget and/or full-time equivalent impact.

Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner. The request and information provided subsequently shall be prepared in a format specified by the Legislative Budget Board.

The request shall be considered to be approved unless the Legislative Budget Board or the Governor issue a written disapproval within 30 business days of the date on which the staff

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Governor issue a written disapproval within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to expend the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House, and Lieutenant Governor. Any requests for additional information made by the Legislative Budget Board shall interrupt the counting of the 30 business days.

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.

Sec. 32. Foster Care Rate Methodology. Out of funds appropriated above to the Health and Human Services Commission (HHSC) in Strategy L.1.1, Enterprise Oversight and Policy, and in consultation with the Department of Family and Protective Services (DFPS) HHSC shall evaluate the methodology for establishing foster care rates to determine whether there is an alternative methodology that would increase provider capacity capable of delivering appropriate and evidence-based services, incentivize quality improvements, and maximize the use of federal funds.

If an alternative is identified, HHSC and DFPS may implement the revised methodology if doing so would not increase General Revenue expenditures for foster care payments in Strategies B.1.9, Foster Care Payments and B.1.12, Community-based Care Payments.

Sec. 33. Waiver Program Cost Limits.

(a) **Individual Cost Limits for Waiver Programs.** It is the intent of the Legislature that the Health and Human Services Commission comply with the cost-effectiveness requirements of the Centers for Medicare and Medicaid Services and set the individual cost limit for each waiver program as follows:

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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. Any requests for additional information made by the Legislative Budget Board shall interrupt the counting of the 30 business days.

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.

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

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

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

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

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

(b) **Use of General Revenue Funds for Services.**

(1) Out of funds appropriated for the waiver programs identified above, and subject to the terms of subsection (3) below, the commission is authorized to use General Revenue Funds to pay for services if:

(A) the cost of such services exceeds the individual cost limit specified in a medical assistance waiver program listed above;

(B) federal financial participation is not available to pay for such services; and

(C) the commission determines that:

(i) the person's health and safety cannot be protected by the services provided within the individual cost limit established for the program; and

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(ii) there is no other available community living arrangement in which the person's health and safety can be protected at that time, as evidenced by:

1. an assessment conducted by clinical staff of the commission; and
2. supporting documentation, including the person's medical and service records.

(2) Out of funds appropriated under this Article for the waiver programs identified above, and subject to the terms of subsection (3) below, the commission is authorized to use General Revenue Funds to continue to provide services to a person who was receiving medical assistance waiver program services on September 1, 2005, at a cost that exceeded the individual cost limit specified in the medical assistance waiver program if:

(A) federal financial participation is not available to pay for such services; and

(B) continuation of those services is necessary for the person to live in the most integrated setting appropriate to the needs of the person.

(3) Authority provided in subsections (b)(1) and (b)(2) above is contingent upon the agency submitting a report in writing to the Legislative Budget Board and Governor on October 1 of each year of the biennium. The report shall include the number of clients by program which exceeds cost limits and the unmatched General Revenue associated with each by fiscal year.

(c) HHSC shall evaluate the possible incorporation of the limitations described in section (a) above into the Texas Administrative Code.