Rider Comparison Packet

Conference Committee on Senate Bill 1

2026-27 General Appropriations Bill

Article II – Health and Human Services

DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

Differences Only - Excludes Capital

Senate

10. Limitation on Transfers: CPS and APS Direct Delivery Staff.

(a) **Funding.** Notwithstanding Article IX, Section 14.01, Appropriation Transfers, and Article IX, Section 14.03, Transfers - Capital Budget, in this Act, the Department of Family and Protective Services (DFPS) shall not transfer funds out of Strategy B.1.1, CPS Direct Delivery Staff, or Strategy C.1.1, APS Direct Delivery Staff, without the prior written approval of the Legislative Budget Board and the Governor. DFPS may transfer funds into Strategy B.1.1, CPS Direct Delivery Staff, or Strategy C.1.1, APS Direct Delivery Staff, with prior written notification to the Legislative Budget Board and the Governor 30 business days prior to the transfer. The Legislative Budget Board and the Governor may disapprove the transfer during the 30 business day period.

(b) **Full-time-equivalent (FTE) Positions.** Out of the FTE positions identified above for DFPS, 8,335.3 positions in fiscal year 2026 and 8,177.3 positions in fiscal year 2027 are allocated to Strategy B.1.1, CPS Direct Delivery Staff, and 868.3 positions in each fiscal year are allocated to Strategy C.1.1, APS Direct Delivery Staff.

None of the FTEs allocated by this rider may be transferred out to any other item of appropriation or utilized for any purpose other than the specific purpose for which the FTEs are allocated without the prior written approval of the Legislative Budget Board and the Governor. DFPS may transfer FTEs in with prior written notification to the Legislative Budget Board and the Governor 30 business days prior to the transfer. The Legislative Budget Board and the Governor may disapprove the transfer during the 30 business day period.

(c) **Limitations on Transfers: Request for Approval.** To request approval for the transfer of funds and/or FTEs, DFPS shall submit at least 60 business days prior to when the funds or FTEs are intended to be expended or reallocated for a different purpose a written request to the Legislative Budget Board and the Governor that includes the following information:

(1) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing;

(2) the name of the strategy or strategies affected by the transfer, and the method of finance and FTEs for each program by fiscal year;

(3) an estimate of performance levels and, where relevant, a comparison to targets

House

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(b) **Full-time-equivalent (FTE) Positions.** Out of the FTE positions identified above for DFPS, 8,335.3 positions in each fiscal year 2026 and 8,167.3 in fiscal year 2027 are allocated to Strategy B.1.1, CPS Direct Delivery Staff, and 868.3 positions in each fiscal year are allocated to Strategy C.1.1, APS Direct Delivery Staff.

None of the FTEs allocated by this rider may be transferred out to any other item of appropriation or utilized for any purpose other than the specific purpose for which the FTEs are allocated without the prior written approval of the Legislative Budget Board and the Governor. DFPS may transfer FTEs in with prior written notification to the Legislative Budget Board and the Governor 30 business days prior to the transfer. The Legislative Budget Board and the Governor may disapprove the transfer during the 30 business day period.

(c) **Limitations on Transfers: Request for Approval.** To request approval for the transfer of funds and/or FTEs, DFPS shall submit at least 60 business days prior to when the funds or FTEs are intended to be expended or reallocated for a different purpose a written request to the Legislative Budget Board and the Governor that includes the following information:

(1) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing;

(2) the name of the strategy or strategies affected by the transfer, and the method of finance and FTEs for each program by fiscal year;

(3) an estimate of performance levels and, where relevant, a comparison to targets

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included in this Act for both the originating and the receiving programs; and

(4) the capital budget impact.

Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner.

The transfer request shall be considered disapproved unless the Legislative Budget Board and the Governor issue written approvals within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the 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.

The Comptroller of Public Accounts shall not allow the transfer of funds if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.

25. Limitations: Community-based Care Payments.

(a) Included in amounts appropriated above is $462,052,391 in All Funds ($350,526,284 from the General Revenue Fund) in fiscal year 2026 and $564,259,968 in All Funds ($437,141,961 from the General Revenue Fund) in fiscal year 2027 in Strategy B.1.1, CPS Direct Delivery Staff, for resource transfers, Stage II network support payments, and Child and Adolescent Needs and Strengths (CANS) assessments and Strategy B.1.9, Foster Care

House

included in this Act for both the originating and the receiving programs; and

(4) the capital budget impact.

Additional information requested by the Legislative Budget Board or the Governor should be provided in a timely manner.

The transfer request shall be considered disapproved unless the Legislative Budget Board and the Governor issue written approvals within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the 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.

The Comptroller of Public Accounts shall not allow the transfer of funds if the Legislative Budget Board provides notification to the Comptroller of Public Accounts that the requirements of this provision have not been satisfied.

(d) **Transferability of Resources to A.1.1, Statewide Intake Services.** Notwithstanding the above limitations, DFPS may transfer FTE and associated funding from B.1.1, CPS Direct Delivery Staff, to A.1.1, Statewide Intake Services, for the purpose of process efficiency as identified through business process reviews with prior notification to the Legislative Budget Board and the Governor 30 business days prior to the transfer. The Legislative Budget Board and the Governor may disapprove the transfer during the 30 business day period.

25. Limitations: Community-based Care Payments.

(a) Included in amounts appropriated above is $459,571,638 in All Funds ($347,895,241 from the General Revenue Fund) in fiscal year 2026 and $561,383,196 in All Funds ($434,062,597 from the General Revenue Fund) in fiscal year 2027 in Strategy B.1.1, CPS Direct Delivery Staff, for resource transfers, Stage II network support payments, and Child and Adolescent Needs and Strengths (CANS) assessments and Strategy B.1.9, Foster Care

Senate

Payments, for Stage I network support payments and foster care payments for Community-based Care (CBC) in Stages I and II in Catchment Areas 3W, 2, 1, 8B, 3E, 4, 5, 8A, 6B, 6A, and 7A, and Stage I in Catchment Areas 8A, 6A, 6B, 7B, 11A, and 11B, as authorized by Family Code, Chapter 264.

(b) Included in amounts identified in Subsection (a) is $222,844,860 in All Funds ($206,756,631 from the General Revenue Fund) in fiscal year 2026 and $302,656,525 in All Funds ($279,913,811 from the General Revenue Fund) in fiscal year 2027 in Strategy B.1.1, CPS Direct Delivery Staff, which DFPS may not exceed or expend for any purpose not identified in Subsection (a) without the prior written approval of the Legislative Budget Board and the Governor.

(c) DFPS in conjunction with the Office of CBC Transition, shall continue the use of an independent evaluation to complete process and outcome evaluations throughout the entire rollout and implementation of CBC 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.

39. **Kinship Family Support.** No later than November 1, 2026, the Department of Family and Protective Services (DFPS) shall report on the utilization of funding provided for kinship family support for children with behavioral health needs in the three new Community-based Care Regions, 3E, 4, and 5. DFPS shall also include outcomes of the children who received the kinship family support services including but not limited to, the number of children and families who received services, and the types of services they received.

The report shall be provided 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, Lieutenant Governor, and the permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services.

House

Payments, for Stage I network support payments and foster care payments for Community-based Care (CBC) in Stages I and II in Catchment Areas 3W, 2, 1, 8B, 3E, 4, 5, 8A, 6B, 6A, and 7A and Stage I in Catchment Areas 8A, 6A, 6B, 7B, and 11B as authorized by Family Code, Chapter 264.

(b) Included in amounts identified in Subsection (a) is $222,749,945 in All Funds ($206,511,426 from the General Revenue Fund) in fiscal year 2026 and $302,756,232 in All Funds ($279,810,926 from the General Revenue Fund) in fiscal year 2027 in Strategy B.1.1, CPS Direct Delivery Staff, which DFPS may not exceed or expend for any purpose not identified in Subsection (a) without the prior written approval of the Legislative Budget Board and the Governor.

Senate

House

39. **Caseworker Incentive Pay.** Notwithstanding Article IX, Section 3.03, Salary Limits, and Article IX, Section 3.06, Recruitment and Retention Bonuses, in this Act, the Department of Family and Protective Services may grant one-time merit payments as incentive pay for employees transitioning from State employment to the Community-based Care contractor.

40. **Comprehensive Quality Assurance Program.** Out of funds appropriated above, the Department of Family and Protective Services (DFPS) shall establish a comprehensive quality assurance program to assess the quality and consistency of services delivered through its Statewide Intake, Adult Protective Services, and Child Protective Services programs, including quality assurance processes designed to ensure the consistency and accuracy of investigation dispositions and the quality of services delivered through the Community Based Care model. DFPS shall publish on its website the results of its quality assurance monitoring quarterly beginning with the quarter ended November 30, 2026.

40. **Lease Site Replacement.** Included in amounts appropriated above to the Department of Family and Protective Services (DFPS) in Strategies D.1.1, Central Administration, and D.1.4, IT Program Support, is one-time funding of $9,600,000 from the General Revenue Fund ($10,240,765 from All Funds) in fiscal year 2026 and $2,400,000 from the General Revenue Fund ($2,560,191 from All Funds) in fiscal year 2027, contingent upon DFPS securing a new office site to replace the San Antonio Pickwell office.

41. **Kinship Funds Awareness Campaign.** Out of funds appropriated above to the Department of Family and Protective Services, is $300,000 from the General Revenue Fund in each fiscal year of the biennium to establish and promote a statewide campaign on kinship care funds.

    The public awareness campaign shall begin no later than September 1, 2025. The public awareness

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	campaign may include online materials, printed materials, public service announcements, or other advertising media. The public awareness campaign may not convey a message that it is unlawful or misleading regarding funds that are available to qualifying kinship care homes under Temporary Assistance for Needy Families (TANF) and other Health and Human Services Commission programs.

Senate

19. Maternal Mortality and Morbidity. Amounts appropriated above to the Department of State Health Services (DSHS) in Strategy B.1.1, Maternal and Child Health, include $3,500,000 in All Funds and 8.0 FTEs in each fiscal year for the following items:

(a) to implement and operate maternal safety initiatives statewide;

(b) to expand a high-risk maternal care coordination services pilot for women of childbearing age, which may include the following:

(1) Implementing a statewide assessment of training courses;

(2) Sharing existing models of high-risk maternal care coordination services;

(3) Implementing a risk assessment tool to identify pregnant women who are at a higher risk for poor pregnancy, birth, or postpartum outcomes and train providers on use of the risk assessment tools; and

(4) Creating educational materials for promotoras or community health workers; and

(c) to increase public awareness and prevention activities related to maternal mortality and morbidity.

Additionally, out of funds appropriated above, DSHS in coordination with the Maternal Mortality and Morbidity Review Committee shall annually collect information relating to postpartum depression screening and treatment under state health programs administered by the Health and Human Services Commission, including Medicaid and Healthy Texas Women.

23. Emergency Medical Task Force.

(a) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, the Department of State Health Services (DSHS) shall provide $1,000,000 in each fiscal year of the biennium out of General Revenue Fund appropriations to fund ongoing programs, exercises, and readiness for the Emergency Medical Task Force (EMTF).

House

19. Maternal Mortality and Morbidity. Amounts appropriated above to the Department of State Health Services (DSHS) in Strategy B.1.1, Maternal and Child Health, include $7,000,000 in All Funds and 16.0 FTEs in each fiscal year for the following items:

(a) to implement and operate maternal safety initiatives statewide;

(b) to continue and expand the high-risk maternal care coordination services pilot for women of childbearing age, which may include the following:

(1) Implementing a statewide assessment of training courses;

(2) Sharing existing models of high-risk maternal care coordination services;

(3) Implementing a risk assessment tool to identify pregnant women who are at a higher risk for poor pregnancy, birth, or postpartum outcomes and train providers on use of the risk assessment tools; and

(4) Creating educational materials for promotors or community health workers; and

(c) to increase public awareness and prevention activities related to maternal mortality and morbidity.

Additionally, out of funds appropriated above, DSHS in coordination with the Maternal Mortality and Morbidity Review Committee shall annually collect information relating to postpartum depression screening and treatment under state health programs administered by the Health and Human Services Commission, including Medicaid and Healthy Texas Women.

23. Emergency Medical Task Force.

(a) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, the Department of State Health Services (DSHS) shall provide $2,000,000 in each fiscal year of the biennium out of General Revenue Fund appropriations to fund ongoing programs, exercises, and readiness for the Emergency Medical Task Force (EMTF).

Senate

(b) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, DSHS shall provide $250,000 in each fiscal year of the biennium out of General Revenue Fund appropriations to fund the management of the EMTF program.

(c) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, DSHS shall provide $1,250,000 in each fiscal year of the biennium out of General Revenue Fund appropriations for the replacement of critical emergency medical response equipment statewide, including specialized emergency medical vehicles, trailers, inflatable equipment, and durable medical equipment.

(d) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, DSHS shall utilize $1,000,000 in each fiscal year of the biennium out of General Revenue Fund appropriations for any purpose stated above in Sections (a), (b), and (c) except for the purchase or replacement of ambulance buses (AMBUSes).

31. **HIV Medication Cabenuva.** It is the intent of the Legislature that to the extent federal funding is available, the Department of State Health Services shall utilize existing or future federal funding to purchase Cabenuva (HIV long-acting treatment), or any other similar HIV long-acting treatment medication, for Texas HIV Medication Program (THMP) participants for inclusion in the THMP formulary.

House

(b) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, DSHS shall provide $500,000 in each fiscal year of the biennium out of General Revenue Fund appropriations to fund the management of the EMTF program.

(c) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, DSHS shall provide $1,500,000 in each fiscal year of the biennium out of General Revenue Fund appropriations for the replacement of critical emergency medical response equipment statewide, including specialized emergency medical vehicles, trailers, inflatable equipment, and durable medical equipment.

(d) Out of the amounts appropriated above in Strategy A.1.1, Public Health Preparedness and Coordinated Services, DSHS shall utilize $1,000,000 in each fiscal year of the biennium out of General Revenue Fund appropriations for any purpose stated above in Sections (a), (b), and (c) except for the purchase or replacement of ambulance buses (AMBUSes).

31. **HIV Long-acting Injectable Treatment.** Included in the amounts appropriated above in Strategy A.2.2, HIV/STD Prevention, the Department of State Health Services shall allocate $7,700,000 from the General Revenue Fund in fiscal year 2026 and $7,700,000 from the General Revenue Fund in fiscal year 2027 to purchase HIV long-acting injectable treatment for Texas HIV Medication (THMP) participants for inclusion in the THMP formulary. It is the intent of the Legislature that to the extent federal funding is available, the Department of State Health Services shall utilize existing or future federal funding for that purpose.

Any unexpended and unobligated balances of these funds remaining at the end of the first fiscal year of the biennium are appropriated for the same purposes in the second fiscal year of the biennium.

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32. **Spay and Neuter Pilot Program - Public Health Focus.** Out of funds appropriated above in Strategy A.2.3, Infectious Disease Prevention, Epidemiology, and Surveillance are $6,500,000 in General Revenue Fund appropriations in fiscal year 2026 and $6,500,000 in General Revenue Fund appropriations in fiscal year 2027 designated for the Department of State Health Services (DSHS) to implement a pilot program focused on protecting human health by reducing the population of cats and dogs at risk for unplanned breeding that may carry infectious diseases. The agency will oversee spay and neuter procedures.

    The agency is also authorized to outsource sterilization efforts to qualified entities to ensure the most effective and humane methods are employed for the sterilization of dogs and cats. Such entities must have a long-standing history of providing cost effective large-scale spay and neuter services and demonstrate proven experience in successfully managing high quality, high volume spay and neuter services.

    Additionally, licensed veterinarians may utilize nonsurgical methods and technologies approved by the United States Food and Drug Administration or the United States Department of Agriculture to humanely and permanently render a dog or cat unable to reproduce, in accordance with Health and Safety Code, Section 828.0045, as part of the overall public health strategy.

    Any unexpended and unobligated balances of these funds remaining at the end of the first fiscal year of the biennium are appropriated for the same purposes in the second fiscal year of the biennium.

    Reporting Requirements:

    (a) **Quarterly Performance Reporting.** The outsourcing entity shall report quarterly to DSHS the number of procedures completed per quarter to maintain the agreement for continued outsourcing funding.

    (b) **Annual Reporting and Metrics.** DSHS shall submit an annual report by September 1 of each fiscal year beginning September 1, 2026, detailing the following:

        (1) number of animals treated and location;

        (2) health outcomes, including disease prevention and control efforts;

House

32. **Spay and Neuter Pilot Program - Public Health Focus.** Out of funds appropriated above in Strategy A.2.3, Infectious Disease Prevention, Epidemiology, and Surveillance, are $2,000,000 in General Revenue Fund appropriations in fiscal year 2026 and $2,000,000 in General Revenue Fund appropriations in fiscal year 2027 designated for the Department of State Health Services (DSHS) to implement a pilot program focused on protecting human health by reducing the population of cats and dogs at risk for unplanned breeding that may carry infectious diseases. The agency will oversee spay and neuter procedures.

    The agency is also authorized to outsource sterilization efforts to qualified entities to ensure the most effective and humane methods are employed for the sterilization of dogs and cats. Such entities must have a long-standing history of providing cost effective large-scale spay and neuter services and demonstrate proven experience in successfully managing high quality, high volume spay and neuter services.

    Additionally, licensed veterinarians may utilize nonsurgical methods and technologies approved by the United States Food and Drug Administration or the United States Department of Agriculture to humanely and permanently render a dog or cat unable to reproduce, in accordance with Health and Safety Code Section 828.0045 of the Health and Safety Code, as part of the overall public health strategy.

    Any unexpended and unobligated balances of these funds remaining at the end of the first fiscal year of the biennium are appropriated for the same purposes in the second fiscal year of the biennium.

    Reporting Requirements:

    (a) **Quarterly Performance Reporting.** The outsourcing entity shall report quarterly to DSHS the number of procedures completed per quarter to maintain the agreement for continued outsourcing funding.

    (b) **Annual Reporting and Metrics.** DSHS shall submit an annual report by September 1 of each fiscal year beginning September 1, 2026, detailing the following:

        (1) number of animals treated and location;

        (2) health outcomes, including disease prevention and control efforts;

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(3) a budget report outlining the expenditure of allocated funds; and

(4) strategies for program expansion and improvement.

33. Texas Center for Infectious Disease Reimbursements. It is the intent of the Legislature that the Texas Center for Infectious Disease (TCID) maximize insurance reimbursements for services provided. The Department of State Health Services shall provide a report to the Legislative Budget Board no later than September 30, 2026. The report shall include the following information:

(a) TCID reimbursement amounts across all categories, including but not limited to, private pay and health insurance, Medicaid reimbursements, or any other method of payment; and the accounts that those funds are deposited into;

(b) the number of out-of-state patients that TCID serves, and explanation of how out-of-state patient expenditures are reimbursed at TCID; and

(c) utilization of reimbursements for services rendered which details activities and expenditures reimbursements pay for across TCID.

House

(3) a budget report outlining the expenditure of allocated funds; and

(4) strategies for program expansion and improvement.

33. Unexpended Balances: Emergency Medical Services Extraordinary Emergencies Allocation. In accordance with Health and Safety Code Section 780.004(b), any unexpended balances from the $500,000 reserved for extraordinary emergencies from the General Revenue-Dedicated Designated Trauma Facility and EMS Account No. 5111 remaining as of August 31, 2025, are appropriated to the Department of State Health Services for the fiscal year beginning September 1, 2025, for the same purpose.

In accordance with Health and Safety Code Section 780.004(b), any unexpended balances from the $500,000 reserved for extraordinary emergencies from the General Revenue-Dedicated Designated Trauma Facility and EMS Account No. 5111 remaining as of August 31, 2026, are

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appropriated to the Department of State Health Services for the fiscal year beginning September 1, 2026, for the same purpose.

Any unexpended balances from the $500,000 reserve for extraordinary emergencies from General Revenue-Dedicated Designated Trauma Facility and EMS Account No. 5111 from prior appropriations years (estimated to be $0), are appropriated to the Department of State Health Services for the fiscal year beginning September 1, 2025, for the same purpose.

34. Unexpended Balance Authority. Any unexpended balances as of August 31, 2026, in appropriations made to the Department of State Health Services are appropriated for the same purposes for the fiscal year beginning September 1, 2026.

34. Texas Center for Infectious Disease Deferred Maintenance. It is the intent of the Legislature that the Department of State Health Services shall utilize any available federal funding including, but not limited to, COVID-19 related federal funding, for deferred maintenance needs at the Texas Center for Infectious Disease.

36. Future Healthcare Workforce Apprenticeship Support. Included in the amounts appropriated above to the Department of State Health Services (DSHS) in Strategy A.1.1, Public Health Preparedness and Coordinated Services, is $500,000 from the General Revenue Fund in fiscal year 2026 and $500,000 from the General Revenue Fund in fiscal year 2027, to provide grants to hospitals to develop and implement on-site healthcare workforce apprenticeship programs. Eligible hospitals must participate in the Disproportionate Share Hospital Program.

Any unexpended and unobligated balances of these funds remaining at the end of the first fiscal year of the biennium are appropriated for the same purposes in the second fiscal year of the biennium.

Senate

House

Participating hospitals must submit any program data requested by DSHS. DSHS shall prepare a summary report identifying hospitals, the amount granted to each hospital, the number of apprentices, and the specialty area of each apprentice, to be posted on the agency's website no later than October 1, 2026.

36. Sickle Cell Guidance for Public Schools. Out of funds appropriated to the Department of State Health Services (DSHS) in Strategy B.1.2, Children with Special Needs, the Sickle Cell Task Force shall develop guidelines for public schools regarding the administration of health care services to students with sickle cell disease by December 31, 2026. The guidelines shall include:

(a) Procedures for educating clinical and non-clinical school personnel and individuals who work with students who are participating in school-related activities about symptoms of distress related to sickle cell disease;

(b) Protocols to ensure students with sickle cell disease receive care as determined by orders from the student's provider and school nurse's assessment during school and school-sponsored after-school activities; and

(c) Any other issue pertaining to the administration of health care services to students with sickle cell disease.

DSHS shall work with the Texas Education Agency to implement the guidelines created by the Sickle Cell Task Force at independent school districts and charter schools in Texas.

37. HIV Vendor Drug Rebate Funding Loss Replacement. Included in the amounts appropriated above in Strategy A.2.2, HIV/STD Prevention, is $2,300,000 from the General Revenue Fund in fiscal year 2026 and $2,300,000 from the General Revenue Fund in fiscal year 2027 to replace funding from the loss of HIV Vendor Drug Rebates and to maintain funding for the HIV Medication program at the 2024-25 biennium level.

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Any unexpended and unobligated balances of these funds remaining at the end of the first fiscal year of the biennium are appropriated for the same purposes in the second fiscal year of the biennium.

37. **Paternity Registry Upgrade.** Out of funds appropriated above in Strategy A.1.2, Vital Statistics, the Department of State Health Services shall allocate $200,000 in All Funds in fiscal year 2026 for system upgrades to the Texas Paternity Registry to allow for electronic search requests and processing.

    Any unexpended and unobligated balances of these funds remaining at the end of the first fiscal year of the biennium are appropriated for the same purposes in the second year of the biennium.

38. **Cost Analysis of Measles Outbreak.** Out of the funds appropriated above, the Department of State Health Services shall study and assess the direct and indirect economic costs incurred by the department and local public health organizations in responding to measles outbreaks that occurred in 2025. Not later than September 1, 2026, the department shall: (1) prepare all findings from the study; and (2) submit the findings to the relevant House and Senate committees.

39. **Strategic National Stockpile for Health Emergency Preparedness and Response.** Out of the amounts appropriated above to the Department of State Health Services and to the extent federal funding is available for that purpose, the department, in coordination with the Task Force on Infectious Disease Preparedness and Response created under Subchapter J, Chapter 81, Health and Safety Code, may prepare and submit to the United States Department of Health and Human Services an application for a grant award under Section 319F-2, Public Health Service Act (42 U.S.C. Section 247d-6b), to establish, expand, or maintain a stockpile of appropriate medicines, medical devices, protective equipment, and other supplies determined necessary by this state to

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	respond to a disaster declared by the governor or public health disaster or emergency declared by the commissioner of state health services under state law or a major disaster or emergency declared by the President of the United States under federal law.

Senate

6. **Medicaid Enterprise Systems (MES).** Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission shall maintain an Executive Steering Committee for the contracts supporting the Texas Medicaid Management Information System (MMIS) and MMIS Modernization capital projects. The Medicaid Enterprise Systems (MES) Executive Steering Committee shall provide executive-level strategic direction and commitment to the MES contracts and MMIS projects. Strategic direction includes, but is not limited to, review of contract terms prior to execution of a new contract or amendment and reports from third-party quality assurance and independent verification and validation vendors. The Executive Commissioner or his or her designee shall chair the MES Executive Steering Committee. Membership of the MES Executive Steering Committee shall include similar executive level representatives, including the Chief Financial Officer, Information Resource Manager, technology sponsors, project managers, project contractors, staff of the Legislative Budget Board, and members of the Quality Assurance Team or their designee.

   In addition, the MES Executive Steering Committee shall report any anticipated contract or project cost over-runs or delays to the Legislative Budget Board.

   Notwithstanding the limitations of Article IX, Section 14.03, Transfers - Capital Budget, and any other transfer provisions of this Act, funds appropriated by this Act to the Health and Human Services Commission may not be expended in excess of the amounts identified in Rider 2, Capital Budget, for the MMIS and MMIS Modernization capital budget projects without prior written approval from the Legislative Budget Board. 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 Legislative Budget Board shall interrupt the counting of the 30 business days.

House

6. **Medicaid Enterprise Systems (MES).** Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission shall maintain an Executive Steering Committee for the contracts supporting the Texas Medicaid Management Information System (MMIS) and MMIS Modernization capital projects. The Medicaid Enterprise Systems (MES) Executive Steering Committee shall provide executive-level strategic direction and commitment to the MES contracts and MMIS projects. Strategic direction includes, but is not limited to, review of contract terms prior to execution of a new contract or amendment and reports from third-party quality assurance and independent verification and validation vendors. The Executive Commissioner or his or her designee shall chair the MES Executive Steering Committee. Membership of the MES Executive Steering Committee shall include similar executive level representatives, including the Chief Financial Officer, Information Resource Manager, technology sponsors, project managers, project contractors, staff of the Legislative Budget Board, and members of the Quality Assurance Team or their designee.

   In addition, the MES Executive Steering Committee shall report any anticipated contract or project cost over-runs or delays to the Legislative Budget Board.

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8. **Hospital Payments.** Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in Strategy A.1.1, Medicaid Client Services, is $148,223,452 from the General Revenue Fund, $80,127,880 from Interagency Contracts, and $334,691,465 from Federal Funds ($563,042,797 from All Funds) in fiscal year 2026 and $151,177,280 from the General Revenue Fund, $80,127,880 from Interagency Contracts, and $338,350,362 from Federal Funds ($569,655,522 from All Funds) in fiscal year 2027 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) $73,044,000 from Interagency Contracts and $106,956,000 from Federal Funds ($180,000,000 from All Funds) in fiscal year 2026 and $73,134,000 from Interagency Contracts and $106,866,000 from Federal Funds ($180,000,000 from All Funds) in fiscal year 2027 for trauma care;

(b) $53,786,120 from the General Revenue Fund, $7,083,880 from Interagency Contracts, and $89,130,000 from Federal Funds ($150,000,000 from All Funds) in fiscal year 2026 and $53,951,120 from the General Revenue Fund, $6,993,880 from Interagency Contracts, and $89,055,000 from Federal Funds ($150,000,000 from All Funds) in fiscal year 2027 for safety-net hospitals;

(c) $26,945,120 from the General Revenue Fund and $39,454,880 from Federal Funds ($66,400,000 from All Funds) in fiscal year 2026 and $26,978,320 from the General Revenue Fund and $39,421,680 from Federal Funds ($66,400,000 from All Funds) in fiscal year 2027 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) $11,849,360 from the General Revenue Fund and $17,350,640 from Federal Funds ($29,200,000 from All Funds) in fiscal year 2026 and $13,611,050 from the General Revenue Fund and $19,888,950 from Federal Funds ($33,500,000 from All Funds) in fiscal year 2027 for rural hospitals to maintain inpatient rates trended forward from 2013 to 2020 using an inflationary factor;

(e) $5,541,749 from the General Revenue Fund and $8,114,607 from Federal Funds ($13,656,356 from All Funds) in fiscal year 2026 and $5,723,199 from the General Revenue

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8. **Hospital Payments.** Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in Strategy A.1.1, Medicaid Client Services, is $132,496,793 from the General Revenue Fund, $83,286,919 from Interagency Contracts, and $315,965,210 from Federal Funds ($531,748,922 from All Funds) in fiscal year 2026 and $135,279,199 from the General Revenue Fund, $83,286,918 from Interagency Contracts, and $319,376,577 from Federal Funds ($537,942,694 from All Funds) in fiscal year 2027 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) $73,044,000 from Interagency Contracts and $106,956,000 from Federal Funds ($180,000,000 from All Funds) in fiscal year 2026 and $73,134,000 from Interagency Contracts and $106,866,000 from Federal Funds ($180,000,000 from All Funds) in fiscal year 2027 for trauma care;

(b) $53,786,120 from the General Revenue Fund, $7,083,880 from Interagency Contracts, and $89,130,000 from Federal Funds ($150,000,000 from All Funds) in fiscal year 2026 and $53,951,120 from the General Revenue Fund, $6,993,880 from Interagency Contracts, and $89,055,000 from Federal Funds ($150,000,000 from All Funds) in fiscal year 2027 for safety-net hospitals;

(c) $26,945,120 from the General Revenue Fund and $39,454,880 from Federal Funds ($66,400,000 from All Funds) in fiscal year 2026 and $26,978,320 from the General Revenue Fund and $39,421,680 from Federal Funds ($66,400,000 from All Funds) in fiscal year 2027 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) $11,849,360 from the General Revenue Fund and $17,350,640 from Federal Funds ($29,200,000 from All Funds) in fiscal year 2026 and $13,611,050 from the General Revenue Fund and $19,888,950 from Federal Funds ($33,500,000 from All Funds) in fiscal year 2027 for rural hospitals to maintain inpatient rates trended forward from 2013 to 2020 using an inflationary factor;

(e) $5,541,749 from the General Revenue Fund and $8,114,607 from Federal Funds ($13,656,356 from All Funds) in fiscal year 2026 and $5,723,199 from the General Revenue

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Fund and $8,362,941 from Federal Funds ($14,086,140 from All Funds) in fiscal year 2027 for rural hospitals to maintain increases to inpatient rates in addition to those identified in Subsection (d);

(f) $24,753,594 from the General Revenue Fund and $36,245,899 from Federal Funds ($60,999,493 from All Funds) in fiscal year 2026 and $25,378,912 from the General Revenue Fund and $37,084,569 from Federal Funds ($62,463,481 from All Funds) in fiscal year 2027 to maintain increases in reimbursement for Medicaid services provided by rural hospitals;

(g) $12,779,889 from the General Revenue Fund and $18,713,184 from Federal Funds ($31,493,073 from All Funds) in fiscal year 2026 and $12,795,636 from the General Revenue Fund and $18,697,437 from Federal Funds ($31,493,073 from All Funds) in fiscal year 2027 for HHSC to maintain a $1,500 Medicaid add-on payment for labor and delivery services provided by rural hospitals; and

(h) $12,567,620 from the General Revenue Fund and $18,726,255 from Federal Funds ($31,293,875 from All Funds) in fiscal year 2026 and $12,739,043 from the General Revenue Fund and $18,973,785 from Federal Funds ($31,712,828 from All Funds) in fiscal year 2027 for HHSC to increase reimbursement for Medicaid inpatient and outpatient services provided by 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 this provision, rural hospitals are defined as (1) hospitals located in a county with 68,750 or fewer persons according to the 2020 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.

House

Fund and $8,362,941 from Federal Funds ($14,086,140 from All Funds) in fiscal year 2027 for rural hospitals to maintain increases to inpatient rates in addition to those identified in Subsection (d);

(f) $24,753,594 from the General Revenue Fund and $36,245,899 from Federal Funds ($60,999,493 from All Funds) in fiscal year 2026 and $25,378,912 from the General Revenue Fund and $37,084,569 from Federal Funds ($62,463,481 from All Funds) in fiscal year 2027 to maintain increases in reimbursement for Medicaid services provided by rural hospitals; and

(g) $12,779,889 from the General Revenue Fund and $18,713,184 from Federal Funds ($31,493,073 from All Funds) in fiscal year 2026 and $12,795,636 from the General Revenue Fund and $18,697,437 from Federal Funds ($31,493,073 from All Funds) in fiscal year 2027 for HHSC to maintain a $1,500 Medicaid add-on payment for labor and delivery services provided by 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 Subsections (c), (d), (e), (f), and (g), rural hospitals are defined as (1) hospitals located in a county with 68,750 or fewer persons according to the 2020 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.

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10. Medicaid Therapy Services Reporting. Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall report on an annual basis to the Legislative Budget Board and the Office of the Governor, in a format specified by the Legislative Budget Board, 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, and resolution of the appeals;

(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 ensure standardized collection of data to obtain all data used in the report. HHSC shall develop a process for pediatric therapy providers to submit data directly to HHSC for items (f) and (g), using feedback obtained from relevant stakeholders.

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10. Medicaid Therapy Services Reporting. Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall report on an annual basis to the Legislative Budget Board and the Office of the Governor, in a format specified by the Legislative Budget Board, 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, and resolution of the appeals;

(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 ensure standardized collection of data to obtain all data used in the report. HHSC shall develop a process for pediatric therapy providers to submit data directly to HHSC for items (f) and (g), using feedback obtained from relevant stakeholders. HHSC shall post quarterly the

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pediatric therapy waitlist data under subsection (f) on their website in a location that is easily accessible to the public.

23. Base Wage Increase for Personal Attendant Services.

(a) Included in the amounts appropriated above in Goal A, Medicaid Client Services, Strategy D.2.3, Behavioral Health Waiver & Amendment, and Strategy F.1.2, Non-Medicaid Services, is $364,158,414 from the General Revenue Fund and $559,032,046 from Federal Funds ($923,190,460 from All Funds) in fiscal year 2026 and $382,969,439 from the General Revenue Fund and $587,721,687 from Federal Funds ($970,691,126 from All Funds) in fiscal year 2027 to increase the base wage for personal attendant services to $12.44 per hour, increase the associated payroll costs, taxes, and benefits percentage to 14 percent, and increase the associated administrative rate by $0.24 per hour in fiscal years 2026 and 2027.

(b) The Health and Human Services Commission (HHSC) shall utilize any funds that were previously expended for the attendant compensation rate enhancement programs for the base wage increase described in subsection (a) and shall discontinue the attendant compensation rate enhancement programs for community care services, intermediate care facility services, and intellectual and developmental disability services.

(c) Out of funds appropriated in Strategy B.1.1, Medicaid & CHIP Contracts and Administration, HHSC shall continue to collect biennial cost reports from providers to monitor the average hourly wage and associated payroll costs, taxes, and benefits. HHSC shall calculate for each provider the total amount that was paid to the provider that is attributable to the direct care wages, payroll costs, taxes, and benefits, the amount expended by the provider for that purpose, and the ratio of expenses to revenue to determine a direct care wage and benefits expense ratio. HHSC shall report to the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House of Representatives, and the Office of the

23. Base Wage Increase for Personal Attendant Services.

(a) Included in the amounts appropriated above in Goal A, Medicaid Client Services, Strategy D.2.3, Behavioral Hlth Waiver & Amendment, and Strategy F.1.2, Non-Medicaid Services, are the following:

(1) $653,342,819 from the General Revenue Fund and $955,481,745 from Federal Funds ($1,648,824,564 from All Funds) in fiscal year 2026 and $685,729,992 from the General Revenue Fund and $1,044,698,132 from Federal Funds ($1,730,428,124 from All Funds) in fiscal year 2027;

(2) $61,193,965 from the General Revenue Fund and $92,072,335 from Federal Funds ($153,266,300 from All Funds) in fiscal year 2026 and $61,365,335 from the General Revenue Fund and $92,134,134 from Federal Funds ($153,499,470 from All Funds) in fiscal year 2027; and

(3) $80,558,343 from the General Revenue Fund and $122,901,912 from Federal Funds ($203,460,255 from All Funds) in fiscal year 2026 and $84,040,662 from the General Revenue Fund and $128,156,242 from Federal Funds ($212,196,904 from All Funds) in fiscal year 2027.

(b) The Health and Human Services Commission (HHSC) shall only expend the funds appropriated in subsection (a)(1) to increase the base wage for personal attendant services to $14.28 per hour and to increase the associated payroll costs, taxes, and benefits percentage to 14 percent; the funds appropriated in subsection (a)(2) to further increase the base wage for personal attendant services in the Home and Community-based Services waiver, the Texas

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Governor on an annual basis by November 1 of each year on the findings, including a list of providers whose calculated direct care staff wage and benefits expense ratio is less than 0.95.

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Home Living waiver, and intermediate care facilities to $17.50 per hour; and the funds appropriated in subsection (a)(3) to increase the administrative subcomponent of the reimbursement rate for personal attendant services by $0.48 per attendant hour assumed in the billing unit.

(c) Out of funds appropriated in Strategy B.1.1, Medicaid & CHIP Contracts and Administration, HHSC shall continue to collect biennial cost reports from providers to monitor the average hourly wage and associated payroll costs, taxes, and benefits. HHSC shall calculate for each provider the total amount that was paid to the provider that is attributable to the direct care wages, payroll costs, taxes, and benefits, the amount expended by the provider for that purpose, and the ratio of expenses to revenue to determine a direct care wage and benefits expense ratio. HHSC shall report to the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House of Representatives, and the Office of the Governor on an annual basis by November 1 of each year on the findings, including a list of providers whose calculated direct care staff wage and benefits expense ratio is less than 0.90.

25. Rate Increase for Nursing Facilities.

(a) Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, are the following amounts:

(1) $78,359,051 from the General Revenue Fund and $116,758,109 from Federal Funds ($195,117,160 from All Funds) in fiscal year 2026 and $82,477,647 from the General Revenue Fund and $122,843,855 from Federal Funds ($205,321,502 from All Funds) in fiscal year 2027 to increase the dietary rate for nursing facilities; and

(2) $26,119,684 from the General Revenue Fund and $38,919,370 from Federal Funds ($65,039,054 from All Funds) in fiscal year 2026 and $27,492,549 from the General Revenue Fund and $40,947,952 from Federal Funds ($68,440,501 from All Funds) in fiscal year 2027 to increase the administrative rate for nursing facilities.

(b) The Health and Human Services Commission (HHSC) shall only expend the funds in subsection (a)(1) to provide reimbursement rate increases that will increase the dietary

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subcomponent and subsection (a)(2) to provide reimbursement rate increases that will increase the facility and operations subcomponents.

HHSC shall implement the rate increases in a manner that will enable HHSC to ensure that at least 90 percent of the funds appropriated in subsection (a)(1) are expended for dietary and nutrition expenses and 90 percent of the facility and operations funds appropriated in subsection (a)(2) are expended for facility and operational costs. For purposes of these funds, "facility and operational costs" means costs related to fixed capital and general and administrative costs, but does not include:

(1) professional and facility malpractice or liability insurance expenses;

(2) advertising expenses;

(3) travel and seminar expenses;

(4) association and other dues;

(5) facility owner, partner, or stockholder salaries, wages, and/or benefits;

(6) professional service fees;

(7) management consultant fees;

(8) management fees; or

(9) total central office overhead expenses or individual central office line items.

(c) HHSC shall return to the Comptroller of Public Accounts any amount recouped from a provider who does not utilize the funds in accordance with the stated purpose. HHSC may not expend funds appropriated for nursing facility services in Medicaid managed care in lieu of payments that are currently authorized by the Centers for Medicare and Medicaid Services for the Quality Improvement Payment Program; and HHSC may not expend funds appropriated for nursing facility services in Medicaid fee-for-service that would not result in receipt of Federal Funds.

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To receive reimbursement rate increases appropriated under subsection (a), nursing facilities must report to HHSC on their cost report, as specified by HHSC, to demonstrate that at least 90 percent of the funds were expended for the purpose of dietary and nutrition expenses and facility and operational costs, as defined above.

39. Informational Listing: Community Mental Health Hospital Beds.

(a) Included in amounts appropriated above in Strategy G.2.2, Community Mental Health Hospitals, is $47,216,400 from the General Revenue Fund in each fiscal year of the biennium for operation of 168 beds at the John S. Dunn Center, and $43,508,000 from the General Revenue Fund in each fiscal year of the biennium for operation of 149 beds at the Harris County Psychiatric Center.

(b) Included in amounts appropriated above in Strategy G.2.2, Community Mental Health Hospitals, is $10,883,799 from the General Revenue Fund in fiscal year 2026 for operation of 44 beds and $18,143,482 from the General Revenue Fund for operation of 88 beds under contract with the University of Texas Health Science Center at Tyler.

38. Informational Listing: Community Mental Health Hospital Beds. Included in amounts appropriated above in Strategy G.2.2, Community Mental Health Hospitals, is $47,952,240 from the General Revenue Fund in each fiscal year of the biennium for operation of 168 beds at the John S. Dunn Center, and $43,508,000 from the General Revenue Fund in each fiscal year of the biennium for operation of 149 beds at the Harris County Psychiatric Center.

41. Youth Mobile Crisis Outreach Teams. Included in amounts appropriated above in Strategy D.2.1, Community Mental Health Services, is $27,000,000 from the General Revenue Fund in each fiscal year of the biennium for youth mobile crisis outreach teams (YCOTs), including funding to establish at least eight new YCOTs.

It is the intent of the Legislature that the Health and Human Services Commission (HHSC) prioritize establishment of the new YCOTs in urban areas of the state.

HHSC may establish three coverage tiers for YCOTs with minimum coverage consisting of YCOT staff available for eight hours each weekday for crisis response, stabilization, follow-up care, and community outreach and engagement activities and maximum coverage to include

40. Youth Mobile Crisis Outreach Teams. Included in amounts appropriated above in Strategy D.2.1, Community Mental Health Services, is $36,379,460 from the General Revenue Fund in each fiscal year of the biennium for youth mobile crisis outreach teams.

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weekday and weekend on-call coverage available 24 hours for crisis response. HHSC shall establish YCOT standards and reporting requirements to ensure program integrity and financial accountability.

51. Informational Listing: Women's Health Funding. This rider is informational only and does not make any appropriations. Appropriations above in Strategy D.1.1, Women's Health Programs, include the following:

(a) **Healthy Texas Women (HTW) Program**: $47,381,311 from the General Revenue Fund and $81,757,986 from Federal Funds ($129,139,297 from All Funds) in fiscal year 2026 and $50,622,862 from the General Revenue Fund and $88,856,750 from Federal Funds ($139,479,611 from All Funds) in fiscal year 2027;

(b) **Family Planning Program (FPP)**: $75,749,255 from the General Revenue Fund and $2,630,728 from Federal Funds ($78,379,983 from All Funds) in fiscal year 2026 and $71,354,630 from the General Revenue Fund and $2,630,728 from Federal Funds ($73,985,358 from All Funds) in fiscal year 2027;

(c) **Breast and Cervical Cancer Services (BCCS)**: $3,429,381 from the General Revenue Fund and $8,877,538 from Federal Funds ($12,306,919 from All Funds) in each fiscal year; and

(d) **Additional Funding for Caseload Growth**:

(1) In the amounts appropriated above in Strategy D.1.1, Women's Health Programs, is $10,000,000 from the General Revenue Fund in fiscal year 2026 that can only be utilized to address an increase in caseloads for Women's Health Programs.

(2) The Health and Human Services Commission (HHSC) may not access the amount specified in subsection (d)(1) of this rider prior to providing notification to the Legislative Budget Board and the Governor's Office at least 30 business days prior to utilizing these funds. A notification must include the following information:

50. Informational Listing: Women's Health Funding. This rider is informational only and does not make any appropriations. Appropriations above in Strategy D.1.1, Women's Health Programs, include the following:

(a) **Healthy Texas Women (HTW) Program:** Healthy Texas Women (HTW) Program: $47,381,311 from the General Revenue Fund and $81,757,986 from Federal Funds ($129,139,297 from All Funds) in fiscal year 2026 and $50,622,862 from the General Revenue Fund and $88,856,750 from Federal Funds ($139,479,611 from All Funds) in fiscal year 2027;

(b) **Family Planning Program (FPP):** $75,749,255 from the General Revenue Fund and $2,630,728 from Federal Funds ($78,379,983 from All Funds) in fiscal year 2026 and $71,354,630 from the General Revenue Fund and $2,630,728 from Federal Funds ($73,985,358 from All Funds) in fiscal year 2027;

(c) **Breast and Cervical Cancer Services (BCCS):** $3,429,381 from the General Revenue Fund and $8,877,538 from Federal Funds ($12,306,919 from All Funds) in each fiscal year; and

(d) **Additional Funding for Caseload Growth**. It is the intent of the Legislature that the Health and Human Services Commission (HHSC) distributes funding to providers in Women's Health Programs in a manner that allows for the uninterrupted care of clients served throughout the state.

(1) Included in amounts appropriated above in Strategy D.1.1, Women's Health Programs, is $10,000,000 from the General Revenue Fund in fiscal year 2026 that can only be utilized to address an increase in caseloads for Women's Health Programs, including an increase in enrollments for HTW, growth from Women's Preventative Mobile Health Units (MHUs), or contract utilization.

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(A) Caseload projections that support the need for additional General Revenue Funds; and

(B) The effect on performance measures.

(3) Any unexpended balances from the General Revenue Fund described in subsection (d) of this rider remaining as of August 31, 2026, are appropriated to HHSC for the fiscal year beginning September 1, 2026, for the same purpose.

(e) Nothing in subsections (a) - (d) shall be construed to limit HHSC's authority to transfer appropriations within Strategy D.1.1, Women's Health Programs.

(f) In the event federal funds identified above are available in a lesser amount, HHSC shall seek approval to transfer funds from other sources prior to making any reductions to service levels.

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(2) The Health and Human Services Commission (HHSC) may not access the amount specified in subsection (d)(1) of this rider prior to providing notification to the Legislative Budget Board and the Governor's Office at least 30 business days prior to utilizing these funds. A notification must include the following information:

(A) Caseload projections, MHU expansion, HTW enrollment, or contract utilization that support the need for additional General Revenue Funds; and

(B) The effect on performance measures.

(3) Any unexpended balances of the $10,000,000 from the General Revenue Fund described in Subsection (d) of this rider remaining as of August 31, 2026, are appropriated to HHSC for the fiscal year beginning September 1, 2026, for the same purpose.

(e) Nothing in this provision shall be construed to limit HHSC's authority to transfer appropriations within Strategy D.1.1, Women's Health Programs.

(f) In the amounts appropriated above in Strategy, D.1.1, Women's Health Programs, and listed in Subsection (b) of this rider, is $20,000,000 from the General Revenue Fund for the purposes of maintaining existing Women's Preventative Mobile Health Units (MHUs) and expanding the number of MHUs prioritizing rural areas including unserved and underserved regions of the state.

(g) In the event federal funds identified above are available in a lesser amount, HHSC shall seek approval to transfer funds from other sources prior to making any reductions to service levels.

Senate

60. Funding for Child Advocacy Center Programs and Court Appointed Special Advocate Programs.

(a) Included in appropriations above in Strategy F.3.2, Child Advocacy Programs, is $32,327,834 from the General Revenue Fund, $5,000,000 from the General Revenue - Dedicated Sexual Assault Program Account No. 5010, and $6,948,063 from Federal Funds ($44,275,897 from All Funds) in each fiscal year for the purpose of entering into a contract with a statewide organization that shall provide training, technical assistance, evaluation services, and funds administration to support contractual requirements for local children's advocacy center programs. The statewide organization must be exempt from federal income taxation and be composed of individuals or groups of individuals who have expertise in the establishment and operation of children's advocacy center programs.

(b) Included in appropriations above in Strategy F.3.2, Child Advocacy Programs, is $15,950,500 from the General Revenue Fund and $13,500 from the License Plate Trust Fund Account No. 0802 ($15,964,000 from All Funds) in each fiscal year of the biennium for the purpose of entering into a contract with a statewide organization that shall provide training, technical assistance, and evaluation services for the benefit of local volunteer advocate programs. The statewide organization must be exempt from federal income taxation and be composed of individuals or groups of individuals who have expertise in the dynamics of child abuse and neglect and experience in operating volunteer advocate programs.

(c) Unexpended balances in Strategy F.3.2, Child Advocacy Programs, remaining at the end of the first fiscal year of the biennium, are appropriated for the same purposes for the second fiscal year of the biennium.

(d) No later than December 1 of each fiscal year, the Health and Human Services Commission shall submit a report detailing the expenditures of funds appropriated in Strategy F.3.2, Child Advocacy Programs. The report shall include information demonstrating continuity of service from the previous fiscal year, services provided and the number of children for whom the services were provided, the amount of grants awarded in each of the categories listed above, the amount of expenditures for administration, the amount of expenditures from General Revenue - Dedicated Sexual Assault Program Account No. 5010, oversight activities conducted relating to the child advocacy programs, and an analysis of the effectiveness of the contracts awarded in subsections (a) and (b). The report shall be submitted to the Legislative Budget Board, the Governor's Office, the Senate Finance

House

59. Funding for Child Advocacy Center Programs and Court Appointed Special Advocate Programs.

(a) Included in appropriations above in Strategy F.3.2, Child Advocacy Programs, is $40,384,652 from the General Revenue Fund, $5,000,000 from the General Revenue - Dedicated Sexual Assault Program Account No. 5010, and $6,948,063 from Federal Funds ($52,332,715 from All Funds) in each fiscal year for the purpose of entering into a contract with a statewide organization that shall provide training, technical assistance, evaluation services, and funds administration to support contractual requirements for local children's advocacy center programs. The statewide organization must be exempt from federal income taxation and be composed of individuals or groups of individuals who have expertise in the establishment and operation of children's advocacy center programs. Included in appropriations above in Strategy F.3.2, Child Advocacy Programs, is $1,500,000 in General Revenue each fiscal year, not subject to Texas Family Code 264.409(b), to implement a regional support initiative to support the execution of Texas Family Code 264, Subchapter E.

(b) Included in appropriations above in Strategy F.3.2, Child Advocacy Programs, is $16,700,500 from the General Revenue Fund and $13,500 from the License Plate Trust Fund Account No. 0802 ($16,714,000 from All Funds) in each fiscal year of the biennium for the purpose of entering into a contract with a statewide organization that shall provide training, technical assistance, and evaluation services for the benefit of local volunteer advocate programs. The statewide organization must be exempt from federal income taxation and be composed of individuals or groups of individuals who have expertise in the dynamics of child abuse and neglect and experience in operating volunteer advocate programs.

(c) Unexpended balances in Strategy F.3.2, Child Advocacy Programs, remaining at the end of the first fiscal year of the biennium, are appropriated for the same purposes for the second fiscal year of the biennium.

(d) No later than December 1 of each fiscal year, the Health and Human Services Commission shall submit a report detailing the expenditures of funds appropriated in Strategy F.3.2, Child Advocacy Programs. The report shall include information demonstrating continuity of service from the previous fiscal year, services provided and the number of children for whom the services were provided, the amount of grants awarded in each of the categories listed above, the amount of expenditures for administration, the amount of expenditures from General Revenue - Dedicated Sexual Assault Program Account No. 5010, oversight

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Committee, and the House Appropriations Committee.

67. Rural Hospital Grant Program.

(a) **Informational Listing**. Included in amounts appropriated above to the Health and Human Services Commission (HHSC) is $25,000,000 from the General Revenue Fund in each fiscal year in Strategy F.3.3, Additional Advocacy Programs, to provide grants for purposes described in Subsection (b); $12,500,000 from the General Revenue Fund in each fiscal year in Strategy F.3.3, Additional Advocacy Programs, to provide grants for purposes described in Subsection (c); and $500,000 from the General Revenue Fund in each fiscal year in Strategy L.1.1, HHS System Supports, to administer the program.

(b) Grants awarded under this section shall be expended for the following purposes:

(1) Recruitment, retention, and development of physician workforce, including Obstetricians-Gynecologists and Emergency Physicians, and nursing workforce in underserved areas;

(2) Financial stabilization for rural hospitals;

(3) Improving maternal health outcomes and increasing access to maternal care services;

(4) Financing innovative methods to deliver care in rural areas, including using technology to expand access to care; and

(5) Enhancing critical care transport.

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activities conducted relating to the child advocacy programs, and an analysis of the effectiveness of the contracts awarded in subsections (a) and (b). The report shall be submitted to the Legislative Budget Board, the Governor's Office, the Senate Finance Committee, and the House Appropriations Committee.

66. Rural Hospital Grant Program.

(a) **Informational Listing.** Included in amounts appropriated above to the Health and Human Services Commission (HHSC) is $25,000,000 from the General Revenue Fund in each fiscal year in Strategy F.3.3, Additional Advocacy Programs, to provide grants for financial stabilization of rural hospitals, for maternal care operations in rural hospitals, for trauma, maternal, and neonatal designation-related expenses in rural hospitals, and for alternative payment model readiness for rural hospitals; and $500,000 from the General Revenue Fund in each fiscal year in Strategy L.1.1, HHS System Supports, to administer the program.

(b) **Unexpended Balance Authority within the Biennium.** Any unexpended balances remaining at the end of August 31, 2026, are appropriated for the same purposes for the fiscal year beginning September 1, 2026.

(c) **Reporting Requirement.** By November 1 of each fiscal year of the biennium, HHSC shall submit a report detailing the expenditure of funds appropriated in Strategy F.3.3, Additional Advocacy Programs, for the Rural Hospital Grant Program. The report shall include the following: the number of grants awarded, amount awarded per entity, effectiveness of the grants, the number of hospitals served by each grant program, and any other information requested by the Legislative Budget Board. The report shall be submitted to the Legislative Budget Board, the Governor’s Office, the Senate Finance Committee, and the House Appropriations Committee.

(d) Notwithstanding the limitations in Article IX, Sec. 6.10, Limitations on State Employment Levels, of this Act, HHSC may increase the “number of full-time-equivalents (FTEs)”

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(6) HHSC shall ensure that at least 50 percent of the funds awarded for financial stabilization for rural hospitals are made to hospitals paid using a prospective payment system by Medicare.

(c) **Essential Access Grants**. HHSC shall award grants under this subsection to a hospital that meets one of the following criteria: (1) a hospitals located in a county with 68,750 or fewer persons according to the 2020 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.

Grants may be expended for the following purposes:

(1) Recruitment, retention, and development of physician workforce, including Obstetricians-Gynecologists and Emergency Physicians, and nursing workforce in underserved areas;

(2) Financial stabilization, including for a hospital that has recently experienced a change in federal designation that is anticipated to negatively impact access to care, including loss of Critical Access Hospital designation; and

(3) Rural hospitals eligible for funding under this subsection shall not be limited from applying for funds available in Subsection (a).

(d) **Application Process**: In making awards under the Rural Hospital Grant Program, HHSC must reduce any unnecessary or overly burdensome requirements on rural hospital grant applicants, or the internal processes required to post a solicitation for applications for the Rural Hospital Grant Program. HHSC shall, at a minimum, review and revise current grant policies, procedures, and templates in a manner that expedites the solicitation process and reduces the administrative burden to rural hospital grant applicants and grantees. The review must include a determination of the applicability to grants of required terms, conditions, requirements, and clauses in the Texas Procurement and Contract Management Guide and eliminate any that are not expressly statutorily required and applicable.

(e) **Unexpended Balance Authority within the Biennium**. Any unexpended balances

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appropriated above by 6.0 FTEs in each fiscal year to address staffing needs related to providing grants under this provision.

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remaining at the end of August 31, 2026, are appropriated for the same purposes for the fiscal year beginning September 1, 2026.

(f) **Grant Deadline**: All funds shall be awarded by August 31, 2027

(g) **Reporting Requirement.** By November 1 of each fiscal year of the biennium, HHSC shall submit a report detailing the expenditure of funds appropriated in Strategy F.3.3, Additional Advocacy Programs, for the Rural Hospital Grant Program. The report shall include the following: the number of grants awarded, amount awarded per entity, effectiveness of the grants, the number of hospitals served by each grant program, and any other information requested by the Legislative Budget Board. The report shall be submitted to the Legislative Budget Board, the Governor's Office, the Senate Finance Committee, and the House Appropriations Committee.

(h) Notwithstanding the limitations in Article IX, Sec. 6.10, Limitations on State Employment Levels, of this Act, HHSC may increase the "number of full-time-equivalents (FTEs)" appropriated above by 6.0 FTEs in each fiscal year to address staffing needs related to providing grants under this provision.

77. Maximum Security Salaries.

(a) As a specific exception to the General Provisions of this Act governing salary rates of classified positions, funds are included above for the Health and Human Services Commission to pay employees working in designated Maximum Security Units of state hospitals up to a 6.8 percent increase over those salary rates provided by Article IX, Section 3.01, Salary Rates.

(b) As a specific exception to the General Provisions of this Act governing salary rates of classified positions, funds are included above for the Health and Human Services Commission to pay employees working in designated specialized Behavioral Management Units of state supported living centers up to a 10.0 percent increase over those salary rates provided by Article IX, Section 3.01, Salary Rates. It is the intent of the Legislature that the increase is also applied to direct support professionals, nurses, social workers, and physicians who interact

76. Maximum Security Salaries. As a specific exception to the General Provisions of this Act governing salary rates of classified positions, funds are included above for the Health and Human Services Commission to pay employees working in designated Maximum Security Units or designated specialized Behavioral Management Units of state hospitals and state supported living centers up to a 6.8 percent increase over those salary rates provided by Article IX, Section 3.01, Salary Rates.

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with the residents of Behavioral Management Units regardless of the amount of time of the interaction.

TEXAS PHARMACEUTICAL INITIATIVE

93. Texas Pharmaceutical Initiative (TPI).

(a) **Full Time Equivalents (FTEs).** The number of FTEs for Goal N, Texas Pharmaceutical Initiative, is 25.6 in each year of the biennium.

(b) **Unexpended Balances**.

(1) Any unexpended balances remaining on August 31, 2025, in Strategy N.1.1, Texas Pharmaceutical Initiative, in the 2024-25 biennium (estimated to be $0) are appropriated for the same purpose for the fiscal year beginning September 1, 2025, in Strategy N.1.1, Texas Pharmaceutical Initiative.

(2) Any unexpended balances remaining on August 31, 2026, in Strategy N.1.1, Texas Pharmaceutical Initiative, are appropriated for the same purpose for the fiscal year beginning September 1, 2026, contingent upon TPI providing written notification to the Legislative Budget Board and the Office of the Governor at least 30 calendar days prior to making the transfer.

(c) **Texas Pharmaceutical Initiative Report.** Out of funds appropriated above in Strategy N.1.1, Texas Pharmaceutical Initiative, TPI shall submit on a quarterly basis, within 30 calendar days of the end of each fiscal quarter, the following information to the Legislative Budget Board and the Office of the Governor:

(1) Information on appropriated, budgeted, expended, and projected funds and FTEs, by strategy and method of finance from the previous fiscal quarter;

TEXAS PHARMACEUTICAL INITIATIVE

92. Texas Pharmaceutical Initiative (TPI).

(a) **Full Time Equivalents (FTEs).** The number of FTEs for Goal N, Texas Pharmaceutical Initiative, is 25.6 in each year of the biennium.

(b) **Unexpended Balances**.

(1) Any unexpended balances remaining on August 31, 2025, in Strategy O.1.1, Texas Pharmaceutical Initiative, in the 2024-25 biennium (estimated to be $0) are appropriated for the same purpose for the fiscal year beginning September 1, 2025, in Strategy N.1.1, Texas Pharmaceutical Initiative.

(2) Any unexpended balances remaining on August 31, 2026, in Strategy N.1.1, Texas Pharmaceutical Initiative, are appropriated for the same purpose for the fiscal year beginning September 1, 2026, contingent upon TPI providing written notification to the Legislative Budget Board and the Office of the Governor at least 30 calendar days prior to making the transfer.

(c) **Texas Pharmaceutical Initiative Report.** Out of funds appropriated above in Strategy N.1.1, Texas Pharmaceutical Initiative, TPI shall submit on a quarterly basis, within 30 calendar days of the end of each fiscal quarter, the following information to the Legislative Budget Board and the Office of the Governor:

(1) Information on appropriated, budgeted, expended, and projected funds and FTEs, by strategy and method of finance from the previous fiscal quarter;

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(2) Narrative explanations of significant budget adjustments, ongoing budget issues, progress on active business plan operations, and other items as appropriate from the previous fiscal quarter; and

(3) Any additional information requested by the Legislative Budget Board or the Office of the Governor.

TPI shall submit the above information in an individual report prepared in a format specified by the Legislative Budget Board.

(d) **Sunset Contingency**. Funds appropriated above for fiscal years 2026 and 2027 for TPI are made contingent on the continuation of TPI by the Eighty-ninth Legislature, 2025. In the event that the agency is not continued, the funds appropriated for fiscal years 2026 and 2027, or as much thereof as may be necessary, are to be used to provide for the phase out of agency operations.

TRANSFERS

108. Limitations on Transfer Authority.

(a) **Limitations on Transfers for Goal A, Medicaid Client Services, and Goal C, CHIP Client Services.**

(1) Notwithstanding Article IX, Section 14.01, Appropriation Transfers, Article IX, Section 14.03, Transfers - Capital Budget, and Article II, Special Provisions Section 6, Limitations on Transfer Authority, funds appropriated by this Act to the Health and Human Services Commission (HHSC) for the following goals shall be governed by the specific limitations included in this subsection.

(A) **Goal A, Medicaid Client Services.** Transfers may not be made to strategies in Goal A, Medicaid Client Services, from strategies in other goals nor from

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(2) Narrative explanations of significant budget adjustments, ongoing budget issues, progress on active business plan operations, and other items as appropriate from the previous fiscal quarter; and

(3) Any additional information requested by the Legislative Budget Board or the Office of the Governor.

TPI shall submit the above information in an individual report prepared in a format specified by the Legislative Budget Board.

(d) **Sunset Contingency**. Funds appropriated above for fiscal years 2026 and 2027 for TPI are made contingent on the continuation of TPI by the Eighty-ninth Legislature, 2025. In the event that the agency is not continued, the funds appropriated for fiscal years 2026 and 2027, or as much thereof as may be necessary, are to be used to provide for the phase out of agency operations.

TRANSFERS

107. Limitations on Transfer Authority.

(a) **Transfer Limitations.** Notwithstanding Article IX, Section 14.01, Appropriation Transfers, Section 14.03, Transfers - Capital Budget, and Article II, Special Provisions Section 6, Limitations on Transfer Authority, transfers between strategies of funds and full-time equivalents (FTEs) appropriated by this Act to the Health and Human Services Commission (HHSC) shall be governed by the specific limitations included in this rider.

(b) **Notification and Request Requirements**. Authority granted by this rider to transfer funding or FTEs without written approval is contingent upon a written notification from HHSC to the Legislative Budget Board and the Governor's Office at least 30 business days prior to the transfer. To request a transfer requiring written approval, HHSC shall submit a written request to the Legislative Budget Board and the Governor's Office and provide a copy of the request

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strategies in Goal A, Medicaid Client Services, to strategies in other goals without prior written approval from the Legislative Budget Board and the Office of the Governor pursuant to subsection (a)(3) of this rider.

(B) **Community Care Waivers and Other Medicaid Non-Entitlement Services (Goal A).** Without prior written approval from the Legislative Budget Board and the Office of the Governor pursuant to subsection (a)(3) of this rider, transfers may not be made:

(i) between strategies listed below in this subdivision (B); or

(ii) to or from strategies listed below in this subdivision (B).

A.2.1, Home and Community-based Services;
A.2.2, Community Living Assistance (CLASS);
A.2.3, Deaf-Blind Multiple Disabilities;
A.2.4, Texas Home Living Waiver; and
A.2.5, All-Inclusive Care-Elderly.

(C) **Goal C, CHIP Client Services.** Transfers may not be made to Goal C, CHIP Client Services, from strategies in other goals nor from Goal C, CHIP Client Services, to strategies in other goals without prior written approval from the Legislative Budget Board and the Office of the Governor pursuant to Subsection (a)(3) of this rider.

(2) **Notification Requirements.** Authority granted by this subsection to transfer funds without written approval is contingent upon a written notification from HHSC to the Legislative Budget Board and the Office of the Governor at least 30 business days prior to the transfer, and shall include the following information:

(A) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing;

(B) the names of the originating and receiving strategies and the method of financing for each strategy by fiscal year; and

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to the Comptroller of Public Accounts (CPA).

Written notifications and requests for approval shall include the following information:

(1) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing;

(2) the names of the originating and receiving strategies and the method of financing and FTEs for each strategy by fiscal year;

(3) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and receiving strategies; and

(4) the capital budget impact, if relevant.

(c) **Strategies Requiring Approval.** Transfers of any amount may not be made into or out of the following strategies without prior written approval from the Legislative Budget Board and the Governor's Office:

(1) Strategies in Goal A, Medicaid;
(2) Strategy B.1.1, Medicaid & CHIP Contracts & Administration;
(3) Strategy C.1.1, CHIP;
(4) Strategy D.1.1, Women's Health Programs;
(5) Strategy D.1.3, ECI Services;
(6) Strategy G.1.1, State Supported Living Centers;
(7) Strategy G.2.1, Mental Health State Hospitals; and
(8) Strategies in Goal L, System Oversight & Program Support.

(d) **Thriving Texas Families Transfer Limitation.** HHSC may not make any transfers out of Strategy D.1.2, Thriving Texas Families.

(e) **Transfer Limitations for Other Strategies.** For transfers between strategies not limited by Sections (c) or (d), HHSC may not make any transfers that exceed the lesser of $1,000,000 or 20.0 percent of the originating strategy and FTE adjustments of more than 10.0 FTEs in total for either fiscal year or transfers of capital budget authority that exceed $500,000 without

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(C) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and the receiving strategies.

(3) **Requests for Transfers that Require Approval.** To request a transfer, HHSC shall submit a written request to the Legislative Budget Board and the Office of the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts (CPA). The request shall include the following information:

(A) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing;

(B) the names of the originating and receiving strategies and the method of financing for each strategy by fiscal year; and

(C) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and the receiving strategies.

(4) **Cash Management.** Notwithstanding the above limitations, HHSC may temporarily utilize funds appropriated in Goals A, Medicaid Client Services, and C, CHIP Client Services, for cash flow purposes. All funding used in this manner shall be promptly returned to the originating strategy. This authorization is subject to limitations established by the CPA.

The CPA shall not allow the transfer of funds authorized by any of the above subsections if the Legislative Budget Board provides notification to the CPA that the requirements of this provision have not been satisfied.

(b) **Limitations on Transfers within/between Other Goals.** Notwithstanding Article IX, Section 14.01, Appropriation Transfers, and Article IX, Section 14.03, Transfers - Capital Budget, HHSC is authorized to make transfers of funding, full-time equivalents (FTEs), and capital budget authority between strategies, subject to the following requirements:

(1) Authority granted by this subsection to transfer funding, FTEs, or capital budget authority is contingent upon a written notification from HHSC to the Legislative Budget Board and the Office of the Governor at least 30 business days prior to the transfer.

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written approval from the Legislative Budget Board and the Governor's Office.

(f) **Additional Authority.** Notwithstanding the above limitations, transfers described in this Section shall be governed by the specific limitations described below.

(1) **Contingency Fees.** Contingent on revenues generated from certain contingency or Recovery Audit Contractor based contracts in the Medicaid program exceeding the amounts assumed in appropriations above as Medicaid Subrogation Receipts Account No. 8044 in Strategy A.1.1, Medicaid Client Services, transfers may be made from Strategy A.1.1, Medicaid Client Services, to Strategy B.1.1, Medicaid & CHIP Contracts & Administration, solely to provide for an increase in contingency fees for a contract resulting from higher than anticipated revenue collections. This authority is limited to contracts that result in revenue collections that are deposited as Medicaid Subrogation Receipts Account No. 8044 and shall not be used to increase the percentage of revenue collections retained by a contractor pursuant to existing contracts and applicable state and federal law. HHSC shall provide written notification of all transfers to the Legislative Budget Board and the Governor's Office within 30 calendar days of making a transfer.

(2) **Internal Transfer Authority for Goal L, System Oversight & Program Support.** Transfers may be made between the following strategies in Goal L, System Oversight & Program Support with prior written notification pursuant to Subsection (b) of this rider.

(3) **Cash Management.** HHSC may temporarily utilize funds appropriated in Goals A, Medicaid Client Services, and C, CHIP Client Services, for cash flow purposes. All funding used in this manner shall be promptly returned to the originating strategy. This authorization is subject to limitations established by the CPA.

The CPA shall not allow the transfer of funds authorized by any of the above subsections if the Legislative Budget Board provides notification to the CPA that the requirements of this provision have not been satisfied.

(g) **Transfer Authority for Medicaid Waiver Programs.** Notwithstanding Article IX, Section 14.01, Appropriation Transfers; Article II, Special Provisions, Section 6, Limitations on Transfer Authority; and limitations elsewhere in this provision; HHSC may transfer funds from Strategy A.1.1, Medicaid Client Services, to meet the targeted number of end-of-year waiver slots identified in Rider 21, Informational Listing: End-of-Year Waiver Slots Funding,

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Notification provided under this subsection must include the following information:

(A) a detailed explanation of the purpose(s) of the transfer and whether the expenditure will be one-time or ongoing;

(B) the names of the originating and receiving strategies and the method of financing and FTEs for each strategy by fiscal year;

(C) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and receiving strategies; and

(D) the capital budget impact.

(2) Notwithstanding Article II, Special Provisions, Section 6, Limitations on Transfer Authority; Article IX, Section 14.01, Appropriation Transfers; and subsection (b)(1) of this rider, HHSC may not make any transfers out of Strategy D.1.2, Thriving Texas Families.

(3) Notwithstanding Article II, Special Provisions, Section 6, Limitations on Transfer Authority; Article IX, Section 14.01, Appropriations Transfers; Article IX, Section 14.03, Transfers - Capital Budget; and subsection (b)(1) of this rider, any transfers that exceed the lesser of $1,000,000 or 20.0 percent of the originating strategy in either fiscal year; FTE adjustments of more than 10.0 FTEs in either fiscal year; capital budget authority that exceeds $500,000; or transfers in any amount into or out of: (1) Strategy B.1.1, Medicaid & CHIP Contracts & Administration; (2) Strategy D.1.1, Women's Health Programs; (3) Strategy D.1.3, ECI Services; (4) Strategy G.1.1, State Supported Living Centers; (5) Strategy G.2.1, Mental Health State Hospitals; and (6) Strategies in Goal L, System Oversight & Program Support, are subject to the prior written approval of the Legislative Budget Board and the Office of the Governor.

(A) To request a transfer, HHSC shall submit a written request to the Legislative Budget Board and the Office of 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:

(i) a detailed explanation of the purpose(s) of the transfer and whether the

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for each waiver program subject to the specific limitations included in this subsection.

(1) Transfers may be made from Strategy A.1.1, Medicaid Client Services, to the following strategies, solely to cover costs that exceed appropriations identified in Rider 21, Informational Listing: End-of-Year Waiver Slots Funding, to meet the targeted number of end-of-year waiver slots for each waiver program:

(A) A.2.1, Home and Community-based Services (HCS);
(B) A.2.2, Community Living Assistance (CLASS);
(C) A.2.3, Deaf-Blind Multiple Disabilities; and
(D) A.2.4, Texas Home Living Waiver.

(2) Notwithstanding Rider 11, Medically Dependent Children Program and Youth Empowerment Services Waivers, and any other provision of this act that may limit reallocation of funds within Strategy A.1.1, Medicaid Client Services, for the Medically Dependent Children and STAR+PLUS Home and Community-based Services Program, HHSC may use funds appropriated in Strategy A.1.1 to cover costs that exceed appropriations to meet the targeted number of end-of-year waiver slots for the subset of the waiver population that is subject to an interest list.

(3) Authority granted by Subsection (b) to transfer funds is contingent upon a written notification from HHSC to the Legislative Budget Board and Office of the Governor within 30 business days of the transfer and shall include the following information about the transfer:

(A) The names of the originating and receiving strategies and the method of financing for each strategy by fiscal year; and

(B) A comparison to targets included in this Act for the receiving strategy related to average monthly cost per individual served.

(h) **Disaster Transfers.** In the case of disaster or other emergency, this provision is superseded by the emergency-related transfer authority in Article IX of this Act.

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expenditure will be one-time or ongoing;

(ii) the name of the originating and receiving strategies and the method of financing and FTEs for each strategy by fiscal year;

(iii) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and receiving strategies; and

(iv) the capital budget impact.

(4) Notwithstanding subsection (b)(3) of this rider, transfers may be made between strategies in Goal L, System Oversight & Program Support. HHSC shall provide notification of all transfers pursuant to subsection (b)(1) of this rider.

(5) Notwithstanding subsection (a)(1)(A) and subsection (b)(3) of this rider, and contingent on revenues generated from certain contingency or Recovery Audit Contractor based contracts in the Medicaid program exceeding the amounts assumed in appropriations above as Medicaid Subrogation Receipts Account No. 8044 in Strategy A.1.1, Medicaid Client Services, transfers may be made from Strategy A.1.1, Medicaid Client Services, to Strategy B.1.1, Medicaid & CHIP Contracts & Administration, solely to provide for an increase in contingency fees for a contract resulting from higher than anticipated revenue collections. This authority is limited to contracts that result in revenue collections that are deposited as Medicaid Subrogation Receipts Account No. 8044 and shall not be used to increase the percentage of revenue collections retained by a contractor pursuant to existing contracts and applicable state and federal law. HHSC shall provide written notification of all transfers to the Legislative Budget Board and the Office of the Governor within 30 calendar days of making a transfer.

(6) In addition to the notice required by this subsection, the total of all transfers from a strategy may not exceed the lesser of $1,000,000 or 20.0 percent of the originating item of appropriation for funding for the fiscal year without prior written approval of the Legislative Budget Board and the Office of the Governor. The approval requirement contained in this subsection does not apply to transfers to which subsection (b)(5) also applies.

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(c) In the case of disaster or other emergency, this provision is superseded by the emergency-related transfer authority in Article IX of this Act.

115. Disposition of Appropriation Transfers from State-owned Hospitals.

(a) The Health and Human Services Commission (HHSC) shall use the sums transferred from state owned hospitals as provided elsewhere in the Act as necessary to apply for appropriate matching Federal Funds and to provide the state's share of disproportionate share payments and uncompensated care payments 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.

(b) If a state owned hospital is eligible and chooses to participate in a hospital directed payment program authorized under the federal Healthcare Transformation and Quality Improvement Waiver, and the amount of funds deposited by HHSC under paragraph (a) of this provision is not equivalent to the amount deposited in the second fiscal year of the previous biennium based on the non-enhanced Federal Medical Assistance Percentages, HHSC shall calculate the difference and provide notice to the state-owned hospital, the Legislative Budget Board, the Comptroller of Public Accounts, and the Office of the Governor.

(c) Payments for physicians, pharmacies, and clinics are governed by Special Provisions Relating Only to Agencies of Higher Education, Section 50, Transfer of Appropriations for Participation in the Healthcare Transformation and Quality Improvement Waiver.

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

(e) The Comptroller of Public Accounts shall process all payments and transfers, unless disapproved or modified by the Legislative Budget Board or the Office of the Governor.

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114. Disposition of Appropriation Transfers from State-owned Hospitals.

(a) The Health and Human Services Commission (HHSC) shall use the sums transferred from state owned hospitals as provided elsewhere in this Article 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. Any amounts of such transferred funds not required for these payments shall be deposited by HHSC to the General Revenue Fund as unappropriated revenue.

(b) If a state owned hospital as provided elsewhere in this Article is eligible and chooses to participate in a hospital directed payment program authorized under the federal Healthcare Transformation and Quality Improvement Waiver, and the amount of funds deposited by HHSC under paragraph (a) of this provision is not equivalent to the amount deposited in the second fiscal year of the previous biennium based on the non-enhanced Federal Medical Assistance Percentages, HHSC shall calculate the difference and provide notice to the state-owned hospital, the Legislative Budget Board, the Comptroller of Public Accounts, and the Office of the Governor.

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

(d) The Comptroller of Public Accounts shall process all payments and transfers, unless disapproved or modified by the Legislative Budget Board or the Office of the Governor

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SENATE COMMITTEE SUBSTITUTE FOR SENATE BILL 1: NEW RIDERS

129. **Enhanced Capacity for Family Violence Services.** Included in amounts appropriated above for the Health and Human Services Commission in Strategy F.3.1, Family Violence Services, is $2,000,000 from the General Revenue Fund in fiscal year 2026 and $2,000,000 from the General Revenue Fund in fiscal year 2027 to be distributed to existing family violence centers and special nonresidential projects to provide housing support and enhanced capacity for services to victims of family violence and their children.

130. **Vision Screenings for Children Plan.** Out of funds appropriated above, the Health and Human Services Commission in Strategy D.1.5, Children's Blindness Services, shall develop recommendations on ways to implement birth through four years old vision screenings. The agency shall report the recommendations to the Legislature, including the Legislative Budget Board, Senate Finance Committee, House Appropriations Committee, the Speaker of the House, the Lieutenant Governor, and the Office of the Governor no later than December 1, 2027.

131. **Summer EBT Administrative Costs.** Included in the amounts appropriated above in Strategy I.1.1, Integrated Eligibility & Enrollment, is $55,000,000 from the General Revenue Fund in each fiscal year of the biennium for the State's share of administrative costs associated with implementing the Summer Electronic Benefit Transfer (Summer EBT) program in 2026. The Health and Human Services Commission shall, in consultation with the Department of Agriculture and the Texas Education Agency, work with and submit a plan to the Food and Nutrition Services of the U.S. Department of Agriculture to administer Summer EBT in 2026 and shall seek any federal waivers necessary to administer the program.

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131. Colorectal Cancer Feasibility Study. Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts and Administration, the Health and Human Services Commission (HHSC) shall conduct a study to determine the feasibility of a Section 1115 Demonstration Waiver, or similar federal funding opportunity, for the purpose of early screening and treatment of colorectal cancer for uninsured or underinsured Texas residents. HHSC shall make recommendations and report on the feasibility of a Section 1115 Demonstration Waiver, or similar federal funding opportunity, by September 1, 2026, and submit the report to the Legislative Budget Board and the Office of the Governor.

132. Fatherhood EFFECT Program. Included in amounts appropriated above for the Health and Human Services Commission in Strategy O.1.4, Other At-risk Prevention Programs, is $1,400,000 from the General Revenue Fund in fiscal year 2026 and $1,400,000 from the General Revenue Fund in fiscal year 2027 to provide grants to organizations that provide parent education and resources to fathers through the Fatherhood EFFECT Program.

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133. Intensive Outpatient Services and Partial Hospitalization Services.

(a) Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, is $3,028,397 from the General Revenue Fund and $4,519,009 from Federal Funds ($7,547,406 from All Funds) in fiscal year 2026 and $3,138,990 from the General Revenue Fund and $4,679,167 from Federal Funds ($7,818,157 from All Funds) in fiscal year 2027 for intensive outpatient services and partial hospitalization services.

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(b) For the purpose of this provision, "intensive outpatient services" means outpatient treatment services, including treatment services for substance use disorders, depression, eating disorders, and other mental health conditions that do not require detoxification or 24-hour supervision, provided to patients who require a time-limited, multifaceted array of services, structures, and supports by a team of clinical staff capable of providing, at a minimum, the following services:

(1) Individual counseling;

(2) Group counseling;

(3) Family counseling;

(4) Motivational enhancement training; and

(5) Relapse prevention, drug refusal, and coping skills training.

(c) For the purpose of this provision, "partial hospitalization services" means distinct and organized intensive ambulatory treatment services provided for periods of not more than 24 hours at a location other than a patient's home or in an inpatient or a residential care setting. The term includes the services described by 42 C.F.R. Section 410.43(a)(4).

134. STAR Health Services Coordination. Not later than August 31, 2026, the Health and Human Services Commission shall, in collaboration with the STAR Health Contractor and the Department of Family and Protective Services, develop written protocols to operationalize the service coordination requirements in the STAR Health Medicaid managed care contract. The written protocols should, at a minimum, define a process through which a STAR Health service coordinator participates in the development of the Child's Plan of Service and defines the service coordinator's role in facilitating access to all STAR Health covered services identified in the plan.

Senate

134. Cost Comparison Report. Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall develop a report analyzing state and federally funded residential and nonresidential services in the Home and Community-based Services (HCS) waiver program, the Texas Home Living waiver program, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

(a) The report must include the following:

(1) The monthly average cost to the state per person for individuals residing in state-operated and non-state-operated ICFs/IID, HCS waiver program, and Texas Home Living waiver program by Level of Need (LON) and facility size (private ICFs/IID only);

(2) A comparison of severity across settings; and

(3) The total number of persons, by LON, who transitioned from state-operated ICFs/IID to the HCS residential waiver program for the previous biennium, and their average monthly cost of service in the HCS waiver program.

(b) With respect to the cost to the state per person residing in a state-operated ICF/IID, HHSC shall include all costs, such as Statewide Cost Allocation Plan (SWCAP), maintenance and construction costs, employee benefit costs and other federally allowable administrative, medical, and overhead costs. With respect to the cost to the state per person in state-operated ICFs/IID, non-state-operated ICFs/IID, and the HCS and Texas Home Living waivers, HHSC shall include all Medicaid costs including acute care costs that are not included in the waiver rates for those programs and all costs to administer and license those programs. For state-operated ICFs/IID, the average monthly administrative and overhead costs shall be reported separately from the average monthly client care costs. HHSC shall identify the types of costs included in each category.

(c) Cost for waiver recipients will cover the time a person enrolled in the waiver through the time they are terminated from waiver services. The cost for ICF/IID services will cover the time a person is admitted to the facility to the time of discharge unless the person is admitted to an ICF/IID or waiver within 60 days of discharge. In that case, the Medicaid costs incurred during discharge will be counted toward the ICF/IID costs.

House

150. Cost Comparison Report. Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall develop a report analyzing state and federally-funded residential and nonresidential services in the Home and Community-based Services (HCS) waiver program, the Texas Home Living waiver program, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID).

(a) The report shall include the following:

(1) The monthly average cost to the state per person for individuals residing in state-operated and non-state-operated ICFs/IID, HCS waiver program, and Texas Home Living waiver program by Level of Need (LON) and facility size (private ICFs/IID only);

(2) A comparison of severity across settings; and

(3) The total number of persons, by LON, who transitioned from state-operated ICFs/IID to the HCS residential waiver program for the previous biennium, and their average monthly cost of service in the HCS waiver program.

(b) With respect to the cost to the state per person residing in a state-operated ICF/IID, HHSC shall include all costs, such as Statewide Cost Allocation Plan (SWCAP), maintenance and construction costs, employee benefit costs and other federally allowable administrative, medical, and overhead costs. With respect to the cost to the state per person in state-operated ICFs/IID, non-state-operated ICFs/IID, and the HCS and Texas Home Living waivers, HHSC shall include all Medicaid costs including acute care costs that are not included in the waiver rates for those programs and all costs to administer and license those programs. For state-operated ICFs/IID, the average monthly administrative and overhead costs shall be reported separately from the average monthly client care costs. HHSC shall identify the types of costs included in each category.

(c) Cost for waiver recipients will cover the time a person enrolled in the waiver through the time they are terminated from waiver services. The cost for ICF/IID services will cover the time a person is admitted to the facility to the time of discharge unless the person is admitted to an ICF/IID or waiver within 60 days of discharge. In that case, the Medicaid costs incurred during discharge will be counted toward the ICF/IID costs.

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(d) The report must be submitted to the Legislative Budget Board and the Office of the Governor and shall be posted on the Commission's website no later than August 31 of the first fiscal year of the biennium.

House

The report shall be submitted to the Legislative Budget Board and the Office of the Governor, and shall be posted on the Commission's website no later than August 31 of the first fiscal year of the biennium.

136. Maternal Health Outcome Program. Included in the amounts appropriated above in Strategy D.1.1, Women's Health Programs, is $10,000,000 from the General Revenue Fund in fiscal year 2026 and $10,000,000 from the General Revenue Fund in fiscal year 2027 for grants to organizations implementing maternal health outcome programs. Any organization selected for grant funding must design and implement successful health outcome programs that reduce severe obstetric complications, offer administrative and technological support, enhance participation in the program, and operate in a geography with a contiguous population of at least five million.

Any unexpended balances of these funds remaining at the end of the first fiscal year of the biennium are appropriated to the agency for the same purpose in the second year of the biennium.

137. Credentialing for Providers within the STAR Health Managed Care Program. Out of funds appropriated above in Strategy B.1.1. Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall, directly or through contract, analyze and make all necessary improvements to the process for credentialing health care providers, particularly those health care providers that provide and bill for mental and behavioral health services, within the STAR Health managed care program. Specifically, HHSC shall implement any changes needed to accomplish the expeditious credentialing and enrollment of health care providers, including:

(a) Authority for an individual health care provider to bill under the National Provider Identifier Standard of their employer organization, so long as the organization is in good standing. HHSC shall prioritize allowing billing from the date of employment. However, if HHSC determines that such billing is disallowed by law, HHSC shall facilitate the retroactive billing of individual health care providers who become fully credentialed after beginning employment;

Senate

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(b) A single process to permit credentialing across managed care organizations; and

(c) Any other process, policy, or other efficiencies to streamline access to qualified health care providers.

HHSC shall make all changes within its legal authority not later than December 31, 2025. HHSC shall report to the Senate Finance Committee and the House Appropriations Committee on its overall findings, the actions taken in response, any actions HHSC has determined require state or federal legal changes, and any additional recommendations for the Legislature's consideration no later than March 31, 2026.

137. Long-Term Care Ombudsman. Included in the amounts appropriated above in Strategy I.2.1, Community Services Admin & Access, is $1,500,000 from the General Revenue Fund and 1.0 full-time-equivalent (FTE) in fiscal year 2026 and $1,500,000 in General Revenue and 1.0 FTE in fiscal year 2027, to support services provided by the Long-Term Care Ombudsman. Any unexpended balances remaining at the end of the first fiscal year of the biennium are appropriated for the same purpose for the second fiscal year of the biennium.

138. Electronic Visit Verification Fraud Prevention Criteria. Out of funds appropriated above in Strategy B.1.1. Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall establish clear, specific, and restricted criteria for when the use of compliance grace periods and match bypasses is permitted in the electronic visit verification process in order to prevent fraud, waste, and abuse. These exceptions shall only be permitted when not explicitly required by federal law or tied to a federal action.

No later than September 1, 2025, HHSC shall develop and implement these criteria and submit a report to the Legislative Budget Board, Governor, Chair of the Senate Finance Committee, and Chair of the House Appropriations Committees. The report must include:

139. Electronic Visit Verification Fraud Prevention Criteria. Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall establish clear, specific, and restricted criteria for when the use of compliance grace periods and match bypasses is permitted in the electronic visit verification process in order to prevent fraud, waste, and abuse. These exceptions shall only be permitted when not explicitly required by federal law or tied to a federal action.

No later than September 1, 2026, HHSC shall develop and implement these criteria and submit a report to the Legislative Budget Board, Governor, Chair of the Senate Finance Committee, and Chair of the House Appropriations Committees. The report must include:

Senate

(a) The established fraud prevention criteria for compliance grace periods and match bypasses; and

(b) The frequency and circumstances under which these exceptions can be applied.

HHSC shall ensure that compliance grace periods and match bypasses are applied consistently and do not undermine accountability or responsible use of funds.

House

(a) The established fraud prevention criteria for compliance grace periods and match bypasses; and

(b) The frequency and circumstances under which these exceptions can be applied.

HHSC shall ensure that compliance grace periods and match bypasses are applied consistently and do not undermine accountability or responsible use of funds.

138. **Maximize Federal Funds for Maternal Home Visiting Services.** Out of funds appropriated above in Strategy O.1.5, Home Visiting Programs, the Health and Human Services Commission (HHSC) shall conduct a study to determine the cost-effectiveness and feasibility of obtaining federal funds for home visiting services for pregnant women and children in the Medicaid program. If HHSC determines that nurse home visiting services utilizing nurses or licensed professionals would improve maternal and child health outcomes and lower Medicaid costs, HHSC shall seek prior approval from the Legislative Budget Board (LBB) before implementing the benefit.

HHSC shall provide a report by September 1, 2026, to the Legislature that includes the findings from the study and the determination of the LBB.

In conducting the cost-effectiveness and feasibility study, HHSC shall consider:

(a) The impact of services on maternal and child health outcomes and the cost offsets associated with improved health outcomes;

(b) The potential impact of the nurse home visiting programs on maternal mortality and morbidity rates;

(c) The ability of nurse home visiting programs on access to maternal health in rural areas;

(d) The effect on waitlists for nurse home visiting services for women seeking services through Thriving Texas Families and Family Support Services;

Senate

House

(e) The impact of services on maternal and child health outcomes and the cost offsets associated with improved health outcomes; and

(f) The potential impact of the nurse home visiting.

139. Rate Increase for Applied Behavior Analysis Services and Report on Autism Services. Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, is $5,549,400 from the General Revenue Fund and $8,268,826 from Federal Funds ($13,818,226 from All Funds) in fiscal year 2026 and $6,947,212 from the General Revenue Fund and $10,347,316 from Federal Funds ($17,294,528 from All Funds) in fiscal year 2027 to increase the Medicaid reimbursement rate for certain applied behavior analysis services to $14.50 per unit in both Medicaid fee-for-service and managed care models. To the extent allowable by federal and state law, HHSC shall implement an age cap for autism services only allowing services for children aged 10 and younger.

HHSC shall report to the Legislative Budget Board and Governor by September 1, 2026, the following:

(a) The compliance by managed care organizations in increasing reimbursement rates pursuant to this rider;

(b) The number of monthly utilizers of pediatric autism services in Medicaid; and

(c) An analysis on whether the utilization of autism services aligns with the actual need for services, considering the incidence rates of autism within the general population and the projected rates of individuals potentially eligible for autism services in Medicaid.

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140. Rate Increase for Intellectual Developmental Disability Nursing Facilities.

(a) Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, is $519,870 from the General Revenue Fund ($1,299,675 from All Funds) in fiscal year 2026 and $540,665 from the General Revenue Fund ($1,351,662 from All Funds) in fiscal year 2027 to revise the reimbursement methodology for an Intellectual Developmental Disability (IDD) nursing facility special reimbursement class, in which 90% percent of residents have a Preadmission Screening and Resident Review positive screen for IDD, to match that of the allowable Medicare equivalent.

(b) It is the intent of the Legislature that, out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission conduct an annual review, by August 31 of each year, of reimbursement rates for Intellectual Developmental Disability nursing facility services delivered under Medicaid.

House

129. Rate Increase for Intellectual Developmental Disability Nursing Facilities.

(a) Included in the amounts appropriated above in Strategy A.1.1, Medicaid Client Services, is $779,805 from the General Revenue Fund and $1,169,708 from Federal Funds ($1,949,513 from All Funds) in fiscal year 2026 and $810,997 from the General Revenue Fund and $1,216,496 from Federal Funds ($2,027,493 from All Funds) in fiscal year 2027 to revise the reimbursement methodology for an Intellectual Developmental Disability (IDD) nursing facility special reimbursement class, in which 90 percent of residents have a Preadmission Screening and Resident Review positive screen for IDD, to match that of the allowable Medicare equivalent.

(b) It is the intent of the Legislature that, out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission conduct an annual review, by August 31 of each year, of reimbursement rates for Intellectual Developmental Disability nursing facility services delivered under Medicaid.

140. Implementation of Eligibility Policy Options. The Texas Health and Human Services Commission (HHSC) may implement eligibility policy options authorized under federal law related to Supplemental Nutrition Assistance Program (SNAP), Medicaid, Children's Health Insurance Program (CHIP) or Temporary Assistance for Needy Families (TANF) that will streamline eligibility determination processes, create efficiencies that improve timeliness, and strengthen program integrity.

141. Nutritional Support Services. Out of funds appropriated above, the Health and Human Services Commission (HHSC) shall permit a managed care organization to offer nutritional support services in lieu of a service or setting covered under the state plan. The nutritional support services must be clinically appropriate, evidence-based, and a cost-effective substitute for a covered Medicaid service.

In determining nutritional support services to include in the contract with managed care

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organizations, the commission shall take into consideration the following services, tailored to health risk or demonstrated outcome improvement:

(a) Nutrition counseling and instruction;

(b) Home delivered meals or pantry stocking;

(c) Nutrition prescriptions;

(d) Grocery provisions, for high-risk individuals to avoid unnecessary acute care admission or institutionalization; and

(e) Additional federally allowable nutritional support services HHSC determines to be appropriate, evidence-based, and cost-effective.

141. Reporting Requirement: Data Collection to Assess Financial Stability of Certain Medicaid Long-Term Care Providers. Out of funds appropriated above, the Health and Human Services Commission (HHSC) shall collect information from each Medicaid long-term care provider that provides residential or facility-based services for the purpose of submitting a cost report to determine the profits and losses incurred by each provider, including any non-Medicaid revenues and costs.

(a) The data collected shall include, at a minimum:

(1) A listing of all land and buildings or improvements located in Texas and owned by the provider's corporation or a related business entity; and

(2) The fair market value of items described in Subsection (a)(1) as they existed on January 1.

(b) HHSC shall report on the data described above, including the aggregate totals by provider type, the profit and losses reported, and a summary of the real property and assets valuation. HHSC shall submit the report with findings to the Senate Committee on Finance, the House

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Committee on Appropriations, the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House, and the Office of the Governor by December 1 of each even-numbered year.

142. Childcare Development Center. Notwithstanding the limitations of Rider 16, Use of Certain Additional Medicaid Revenues, Section (b); Rider 108, Limitations on Transfer Authority; Article II, Special Provisions Section 6, Limitations on Transfer Authority; Article IX, Section 14.01, Appropriations Transfers; and Article IX, Section 14.03, Transfers - Capital Budget, the Health and Human Services Commission (HHSC) may transfer funds from Strategy A.1.1, Medicaid Client Services, to Strategy L.2.2, Regional Program Support, subject to the following limitations:

(a) HHSC may only transfer up to $20,000,000 for the 2026-27 biennium in Medicaid Program Income No. 705 as defined in Rider 16, Use of Certain Additional Medicaid Revenues, Subsection (a)(1);

(b) Transferred funds shall only be used to contract with the Texas Facilities Commission (TFC) to build and equip a Childcare Development Center (CDC) in the HHSC John H. Winters Building parking lot to support the HHSC North Austin Complex, and to separately contract with an expert in project management and childcare consulting services;

(c) Transferred funds may be transferred to a new capital budget item not present in the agency's bill pattern to implement the CDC project;

(d) Once complete, the CDC shall be operated by the University of Texas with oversight provided by HHSC in collaboration with TFC; and

(e) HHSC shall provide written notification of any transfer to the Legislative Budget Board and the Governor’s Office within 30 calendar days of making a transfer.

Once the CDC is in operations, is the intent of the Legislature that the CDC’s services will be available for state employees regardless of employment at health and human services agencies.

154. Childcare Development Center. Notwithstanding the limitations of Rider 16, Use of Certain Additional Medicaid Revenues, Section (b); Rider 107, Limitations on Transfer Authority; Article II, Special Provisions Section 6, Limitations on Transfer Authority; Article IX, Section 14.01, Appropriations Transfers; and Article IX, Section 14.03, Transfers - Capital Budget, the Health and Human Services Commission (HHSC) may transfer funds from Strategy A.1.1, Medicaid Client Services, to Strategy L.2.2, Regional Program Support, subject to the following limitations:

(a) HHSC may only transfer up to $20,000,000 for the 2026-27 biennium in Medicaid Program Income No. 705 as defined in Rider 16, Use of Certain Additional Medicaid Revenues, Subsection (a)(1);

(b) Transferred funds shall only be used to contract with the Texas Facilities Commission (TFC) to build and equip a Childcare Development Center (CDC) in the HHSC John H. Winters Building parking lot to support the HHSC North Austin Complex, and to separately contract with an expert in project management and childcare consulting services;

(c) Transferred funds may be transferred to a new capital budget item not present in the agency's bill pattern to implement the CDC project;

(d) Once complete, the CDC shall be operated by the University of Texas with oversight provided by HHSC in collaboration with TFC; and

(e) HHSC shall provide written notification of any transfer to the Legislative Budget Board and the Governor’s Office within 30 calendar days of making a transfer.

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142. Prescribed Pediatric Extended Care Centers (PPECC). Included in the amounts appropriated above to the Health and Human Services Commission (HHSC) in Strategy H.1.1, Facility/Community-based Regulation is $423,182 from the General Revenue Fund and 2.0 "full-time-equivalents (FTEs)" in fiscal year 2026 and $406,715 from the General Revenue Fund and 2.0 FTEs in fiscal year 2027 for salaries, travel, and operating expenses for HHSC's Regulatory Services Division to perform timely reviews of the architectural requirements for PPECC.

143. Out-Stationed Eligibility Staff. Notwithstanding the limitations of Article IX, Section 6.10, Limitations on State Employment Levels, limitations on full-time equivalents do not apply to instances of employment for out-stationed eligibility staff in which the state does not pay a portion of the salary or benefits.

144. Montgomery County Mental Health Treatment Facility. Appropriations made in this Act for the Health and Human Services Commission to contract for competency restoration beds at Montgomery County Mental Health Treatment Facility not otherwise restricted in use may also be expended by Montgomery County to pay necessary administrative fees, including the cost of bond debt accrued for the original construction of the facility.

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144. External Evaluation of Child Care Rules and Minimum Standards.

(a) Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in Strategy H.2.1, Child Care Regulation, is $1,025,000 from the General Revenue Fund in fiscal year 2026 to contract with an independent entity with expertise in child welfare and child care regulation to evaluate HHSC's rules and minimum standards for licensed day care centers, licensed day care homes, registered family homes, licensed before and after school programs, and licensed school-age programs to evaluate the following:

(1) The relevance of the requirement to child health, safety, and welfare;

(2) Whether the requirement aligns with federal and/or state laws; and

(3) Whether the requirement is aligned with best practices in regulated child care.

(b) Before September 1, 2026, the independent entity must issue a report to HHSC that includes the findings of the assessment and recommendations to simplify and adjust the agency's rules and minimum standards for the purpose of:

(1) Prioritizing the health, safety and well-being of children attending licensed day care centers, licensed day care homes, registered family homes, licensed before and after school programs, and licensed school-age programs; and

(2) Reducing any licensing, training or oversight requirements that present a barrier to opening or operating licensed day care centers, licensed day care homes, registered family homes, licensed before and after school programs, and licensed school-age programs, including barriers to the hiring and retention of high-quality leadership, administrators, and staff at licensed day care centers, licensed day care homes, registered family homes, licensed before and after school programs, and licensed school-age programs.

(c) The independent entity conducting the assessment under this section shall make recommendations for required legislative action, including recommendations for retaining, repealing, or modifying existing state laws. In conducting the assessment, the independent entity shall solicit and consider the input of relevant stakeholders, including licensed child care providers and families with children in licensed child care as well as families who

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cannot currently afford licensed child care.

(d) Before the 90th day after HHSC receives the independent entity's assessment, the agency shall submit a report on the independent assessment to the Office of the Governor, Lieutenant Governor, Speaker of the House, and the standing committee of each chamber of the Legislature with jurisdiction over HHSC including the following:

(1) HHSC's plan to implement the independent entity's assessment recommendations; and

(2) Any recommendation the agency decides not to implement and a written justification for not implementing the recommendation.

145. Interest List Reduction Workgroup.

(a) Out of funds appropriated to the Health and Human Services Commission (HHSC) for the biennium beginning September 1, 2025, HHSC shall establish a workgroup as a subcommittee of the Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee, created by Government Code, Chapter 534. The subcommittee shall study and provide recommendations on the feasibility, impact, and implementation of the following approaches to both decrease the number of individuals waiting on the IDD Waiver interest lists, and ensure timely access to supports, including:

(1) Implementing changes to interest list management, including eligibility screenings, prioritization criteria, and automation to improve efficiency and accuracy;

(2) Evaluating the feasibility of implementing the Tax Equity and Fiscal Responsibility Act (TEFRA) option to extend Medicaid eligibility for children with significant disabilities, potentially reducing demand for waiver services;

(3) Examining options for restructuring the Texas Home Living (TxHmL) waiver as the lowest-cost waiver to provide basic services to more individuals currently on the interest list;

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(4) Establishing a dedicated fund or endowment to ensure sustainable financing for Medicaid waiver slots and interest list reduction; and

(5) Studying interest list reduction strategies implemented in other states to identify best practices and potential models for Texas.

(b) The subcommittee shall include representatives from state agencies, advocacy organizations, service providers, individuals with intellectual and developmental disabilities, and fiscal policy experts, as well as other stakeholders deemed appropriate by the executive commissioner.

(c) HHSC shall convene the subcommittee no later than December 1, 2025. The subcommittee shall conduct research, gather stakeholder input, and analyze data on current and potential interest list reduction strategies. HHSC shall provide quarterly updates to the Legislative Budget Board and relevant legislative committees on the progress of the study. A report detailing findings, cost-benefit analyses, and recommendations shall be submitted to the Governor, Lieutenant Governor, Speaker of the House, Senate Finance Committee, and House Appropriations Committee no later than September 1, 2026. The final report shall include legislative and budgetary recommendations for the 90th Legislature's consideration to both reduce the number of individuals waiting for services and ensure timely access to supports for people with IDD.

145. Unexpended Balance Authority for Certain Capital Projects. Unexpended balances for certain capital budget projects remaining as of August 31, 2025, (estimated to be $0) are appropriated for the same purpose for the fiscal year beginning September 1, 2025. This Section applies to each project requiring capital expenditures for:

(a) one-time construction of buildings and facilities as described in Article IX, Section 14.03, Subsection (a)(1)(B); and

(b) repairs and rehabilitations of buildings or other facilities as described in Article IX, Section 14.03, Subsection (a)(1)(C), exceeding $5,000,000.

Senate

146. Offsite Healthcare Study. Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Health and Human Services Commission (HHSC) shall identify strategies and recommendations to reduce costs related to health care not covered under contract provided to civilly committed residents of a housing facility either operated by or contracted for by the Texas Civil Commitment Office (TCCO). HHSC shall:

(a) Evaluate whether civilly committed residents could be eligible for state or federally provided health coverage or other insurance coverage options;

(b) Examine whether TCCO could partner with a health-related institution to provide health care to civilly committed residents; and

(c) Partner with TCCO to develop the strategies and recommendations.

No later than December 1, 2026, HHSC shall submit findings and recommendations to the Senate Finance Committee, the House Appropriations Committee, the Legislative Budget Board, the Office of the Governor, and permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services.

House

146. Search Engine Multi-Agency Reportable Conduct (SEMARC). Included in the amounts appropriated above at the Health and Human Services Commission in Strategy L.1.2, IT Oversight & Program Support, is $500,381 from the General Revenue Fund in fiscal year 2026 and $500,381 from the General Revenue Fund in fiscal year 2027 for the SEMARC system to support the safety and oversight of individuals working with vulnerable populations, as required by Senate Bill 1849, 88th Legislature, Regular Session, 2023. The funds shall provide additional Tier 1 IT Help Desk contracted resources to support the implementation and operation of SEMARC, including triaging technical issues encountered by users at schools, child care facilities, long-term care providers, and juvenile detention centers.

Senate

House

147. Mobile and School-Based Dental Services. Medicaid appropriations for direct fee-for-service programs or transfers to Medicaid managed care organizations under contract with the State of Texas may not be used in a way that restricts or prohibits mobile or school-based dental services to Medicaid beneficiaries 18 years old and under, whether the provider has a primary physical location to provide services or not, provided the provider:

(a) Ensures a parent, legal guardian, or another adult who is authorized by the parent or guardian accompanies a child who is 14 years of age or younger or, if school-based care, receives parental consent in accordance with Human Resources Code, Section 32.024(s-1);

(b) Complies with all state and federal solicitation and Medicaid provider enrollment requirements;

(c) Is able to safely provide all elements of a dental checkup or treatment to be completed;

(d) Has the capacity to coordinate emergency follow-up care in accordance with 22 Texas Administrative Code, Section 108.42; and

(e) Sends notification to the child's main dental home to support coordination of care, if the provider is not the main dental home.

This provision does not apply to appropriations for Medicaid services provided by school districts in Texas to Medicaid-eligible students through the School Health and Related Services (SHARS) program.

Senate

147. **Cost Containment.** The Health and Human Services Commission (HHSC) shall develop and implement cost containment initiatives to achieve savings of at least $550,000,000 in General Revenue Funds for the 2026-27 biennium throughout the health and human services system. These initiatives shall include:

(a) increasing fraud, waste, and abuse prevention and detection;

(b) seeking to maximize federal flexibility under the Medicaid program;

(c) achieving other programmatic and administrative efficiencies; and

(d) savings from services that include emergency telemedicine services for individuals with intellectual and developmental disabilities.

HHSC shall provide an annual report on the implementation of cost containment initiatives to the Legislative Budget Board by December 1. It is the intent of the legislature that HHSC shall achieve savings without 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. This rider shall not be construed as limiting HHSC's ability to maximize federal flexibility under the Medicaid program, including federal flexibility that may impact amount, scope, or duration of services.

148. **Appropriate Care Settings for Individuals with Severe and Persistent Mental Illness and Co-Occurring Conditions Study.** Out of funds appropriated in Strategy D.2.5, Community Behavioral Health Administration, the Health and Human Services Commission (HHSC) shall study and develop a proposal to implement a pilot program that provides residential intermediate care services for individuals with severe and persistent mental illness who may have co-occurring conditions, including traumatic brain injury, and intellectual or developmental disabilities, who,

House

158. **Cost Containment.** The Health and Human Services Commission (HHSC) shall develop and implement cost containment initiatives to achieve savings of at least $550,000,000 in General Revenue Funds for the 2026-27 biennium throughout the health and human services system. These initiatives shall include:

(a) increasing fraud, waste, and abuse prevention and detection;

(b) seeking to maximize federal flexibility under the Medicaid program;

(c) achieving other programmatic and administrative efficiencies;

(d) savings from services that include emergency telemedicine services for individuals with intellectual and developmental disabilities; and

(e) identifying underpayments and overpayments under the Medicaid managed care program and recovering the overpayments in accordance with Subchapter K, Chapter 544, Government Code.

HHSC shall provide an annual report on the implementation of cost containment initiatives to the Legislative Budget Board by December 1. It is the intent of the legislature that HHSC shall achieve savings without 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. This rider shall not be construed as limiting HHSC's ability to maximize federal flexibility under the Medicaid program, including federal flexibility that may impact amount, scope, or duration of services.

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due to the acuity of their conditions, are inappropriate for community placement but no longer meet criteria for inpatient psychiatric care.

For the purposes of the developing the study and proposal:

(1) An individual must meet the following eligibility criteria to qualify for the pilot program:

i. Have a diagnosis of severe and persistent mental illness with a co-occurring condition, such as a traumatic brain injury or intellectual and developmental disability;

ii. Have been incarcerated at least three times; and

iii. Voluntarily agree to participate in the program.

The study and proposal shall:

(1) Assess the existing unmet needs in the service continuum for the target population;

(2) Assess the need for nursing-level care and other specialized services for the target population;

(3) Identify opportunities to modify or expand eligibility criteria for existing programs and services;

(4) Scalable options for implementing the program at residential care facilities and nursing facilities;

(5) Evaluate whether vacated buildings on state hospital campuses or other state facilities could be rehabilitated and used to provide intensive residential services for the target population; and

(6) Evaluate statutory changes and funding needed to establish the pilot program to serve the target population, including the estimated cost to provide intensive residential services for the eligible population and the estimated cost to rehabilitate vacated buildings on state facility campuses to serve as the location of the pilot program.

Senate

No later than October 15, 2026, HHSC shall submit findings and recommendations from the study to the Senate Finance Committee, the House Appropriations Committee, the Legislative Budget Board, the Office of the Governor, and permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services.

House

148. Medicaid Reimbursement Rates for Rapid Testing. It is the intent of the Legislature that the Health and Human Services Commission (HHSC) shall evaluate the rate for reimbursement for services related to syphilis testing and treatment to include accurate reimbursement for both point of care rapid testing and best practices for most effective treatment of syphilis no later than October 1, 2025. HHSC shall consider clinical expertise, public comments, the characteristics of the populations served, and financial sustainability of reimbursement rates prior to adopting final rates.

149. Rate Review for Pediatric Care Center Services. It is the intent of the Legislature that, out of funds appropriated above in Strategy B.1.1, Medicaid Contracts and Administration, the Health and Human Services Commission shall, not later than August 31 of each year, conduct a review of reimbursement rates for pediatric care center services delivered to children under Medicaid.

149. Federal Reimbursement for Certain Substance Use Services. Included in amounts appropriated above in Strategy L.1.1, HHS System Supports, is $533,356 from the General Revenue Fund in fiscal year 2026 and $652,239 from the General Revenue Fund in fiscal year 2027 for Health and Human Services Commission (HHSC) one-time administrative and salary costs related to developing a rate setting methodology and associated cost reporting for certain services reimbursable to grant recipients of the Federal Substance Use Prevention, Treatment, and Recovery Services block grant for up to three children accompanying the child or children's mother in a residential treatment setting.

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HHSC shall propose reimbursement rates for these services no later than January 1, 2026, in a format that will enable HHSC to receive public comments on the proposed rates. HHSC shall consider public comments as well as characteristics of the population served and financial sustainability for the rates prior to adoption of the final rates.

150. Appropriation of Unexpended Balances for Alternative Therapy Studies. Notwithstanding any other provision of this Act, any unexpended and unobligated balances remaining as of August 31, 2025, out of funds originally appropriated by the Eighty-seventh Legislature to the Health and Human Services Commission (HHSC) for the purpose of implementing the provisions of House Bill 1802, Eighty-seventh Legislature, Regular Session, 2021, or similar legislation, are appropriated to HHSC for the biennium beginning September 1, 2025, for the same purpose. These funds shall be allocated withing Strategy D.2.1, Community Mental Health Services, to continue the implementation of alternative therapy studies for the treatment of post-traumatic stress disorder in accordance with the provisions of the enabling legislation.

151. Guardianship Service Provider Rates. Included in the amounts appropriated above to the Health and Human Services Commission in Strategy F.1.1, Guardianship, is $662,400 from the General Revenue Fund in each fiscal year of the biennium to increase the contracted rates for guardianship services to a maximum of $425 per client per month.

151. Report on the Development of Hospital Inpatient Rates. Out of funds appropriated above in Strategy B.1.1. Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall submit a report to the Legislature by November 1, 2026, on HHSC's proposal to rebase Medicaid inpatient hospital base rates. The report shall include:

(a) Financial models demonstrating the impact of the updated Medicaid inpatient rates by

Senate

152. Regulatory Services Division. Out of amounts appropriated above, the Health and Human Services is appropriated, as one-time costs, in Strategy H.1.1, Facility/Community-Based Regulation, $3,561,204 from the General Revenue Fund ($3,561,204 from All Funds) and 31.6 full-time-equivalents (FTEs) in fiscal year 2026 and $3,561,204 from the General Revenue Fund ($3,561,204 from All Funds) and 31.6 FTEs in fiscal year 2027; Strategy L.1.2, IT Oversight &

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hospital based on data from fiscal year 2025;

(b) The amount of general revenue needed to stabilize revenue levels that may otherwise be impacted by revisions to inpatient hospital rates, in total and by hospital class; and

(c) Recommendations developed by the agency and temporary advisory committee on a process and implementation timeline for hospital inpatient rate rebasing.

In developing the recommendations and financial models, HHSC shall solicit input from stakeholders and may establish a temporary advisory committee pursuant to the authority provided under Chapter 2110, Government Code. In establishing a temporary advisory committee, HHSC shall include representatives that reflect each hospital class participating in the Medicaid program. No later than July 15, 2026, HHSC shall make public, including through distribution to and discussion with the Hospital Payment Advisory Committee, any agency and advisory committee recommendations and draft financial models.

152. Streamlining Managed Care Enrollment. Out of funds appropriated above in Strategy B.1.1. Medicaid & CHIP Contracts & Administration, the Health and Human Services Commission (HHSC) shall develop and implement a plan to align Medicaid enrollment into managed care with the automatic enrollment process used by the Children's Health Insurance Program (CHIP). Implementation of this plan is contingent upon HHSC developing strategies to mitigate any impact to state supplemental funding and Graduate Medical Education (GME) funding, including the potential transition of the state's supplemental payment program from fee-for-service claims to managed care claims.

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Program Support, $115,370 from the General Revenue Fund ($126,419 from All Funds) in fiscal year 2026 and $115,370 from the General Revenue Fund ($126,419 from All Funds) in fiscal year 2027; Strategy L.2.1, Central Program Support, $110,771 from the General Revenue Fund ($164,282 from All Funds) in fiscal year 2026 and $110,771 from the General Revenue Fund ($164,282 from All Funds) in fiscal year 2027; and Strategy L.2.2, Regional Program Support, $31,613 from the General Revenue Fund ($38,830 from All Funds) and 3.0 FTEs in fiscal year 2026 and $31,613 from the General Revenue Fund ($38,830 from All Funds) and 3.0 FTEs in fiscal year 2027 to address backlogs relating to abuse, neglect, and exploitation investigations in the Regulatory Services Division.

House

156. Establishment of Additional PACE Sites.

(a) The Health and Human Services Commission (HHSC) is authorized to procure and implement contracts to establish three additional Program of All-Inclusive Care for the Elderly (PACE sites) in geographical areas not currently served by the program. Prior to finalizing a contractual agreement, HHSC shall determine that any entity to be contracted with satisfies procurement and contracting requirements established by HHSC and is approved by the Centers for Medicare and Medicaid Services (as described in 42 CFR, Part 460, Subpart B of the Code of Federal Regulations) to be a provider agency.

(b) HHSC is authorized to transfer General Revenue Funds appropriated to Strategy A.1.1, Medicaid Client Services, along with qualifying federal matching funds, to support up to 300 slots in each of the three additional PACE sites during the 2026-27 biennium. The total General Revenue Funds amount transferred for this purpose may be used to fund start-up and operational costs and may not exceed $X in any fiscal year. The capitation rate to be paid for each site shall be determined pursuant to agency rate methodology for the PACE program without application of the budget reduction factor.

(c) This transfer shall be executed notwithstanding any other provision relating to limitations on transfer authority. Further, this authorization fulfills the requirements of Special Provisions Relating to All Health and Human Services Agencies, Section 12, Rate Limitations and Reporting Requirements.

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(d) HHSC shall provide written notification to the Legislative Budget Board (LBB) and the Governor's Office of the certification and the transfer of amounts within 30 business days of the date on which any transfer occurs.

(e) On the request of LBB or the Governor's Office, HHSC shall provide any requested information from PACE providers on actual cost, caseload, and services.

157. Psychiatric Residential Youth Treatment Facility. Included in amounts appropriated above in Strategy G.4.2, Facility Capital Repairs and Renov, is $6,000,000 from the General Revenue Fund in each fiscal year of the biennium to purchase and repurpose a building in Southeast Texas to serve as a psychiatric residential youth treatment facility and youth mental health facility.

159. Study on Including Psychiatric Residential Treatment Facility as a Medicaid State Plan Benefit. A Psychiatric Residential Treatment Facility (PRTF) is a facility, other than a hospital, which provides inpatient behavioral health treatment to Medicaid-eligible individuals under the age of 21. A PRTF must provide the inpatient psychiatric services under the direction of a physician, must be accredited, and must comply with all the requirements of applicable state and federal regulations. Out of funds appropriated above, HHSC shall conduct a study to determine the feasibility of including Psychiatric Residential Treatment Facilities as a Medicaid state plan benefit for a specialized population of youth between the ages of 13-17 with high acuity behavioral health conditions and report the findings of the study to the Legislative Budget Board and the Governor by December 1, 2026.

The study shall include:

(a) The experiences of other states that include PRTFs as a Medicaid benefit, including specific populations eligible for services through this benefit and any outcomes for youth who have received Medicaid covered PRTF services;

(b) Information and data from the Texas Department of Family and Protective Services and the

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Texas Juvenile Justice Department including but not limited to specific populations that may benefit from the service, gaps in services that may be filled if PRTFs were included in the State Medicaid Plan and other relevant information;

(c) Licensure requirements, including the need for any new licensure types needed to meet these requirements;

(d) Service expectations, standards, and definitions as required by the Centers for Medicare and Medicaid Services (CMS) 42 CFR Part 441 Subpart D §441.150 through §441.184;

(e) Determination of specialized population of Medicaid-eligible youth between the ages of 13-17 who would be eligible for admission into the PRTF including specificity of high acuity behavioral health conditions and symptoms/severe functional impairments;

(f) Recommendations, fiscal impact and projected timelines for potential inclusion of benefit in the State Medicaid Plan.

160. McLennan County Crisis Stabilization and Inpatient Services. Included in amounts appropriated above in Strategy D.2.1, Community Mental Health Services, is $5,000,000 from the General Revenue Fund in each fiscal year of the biennium to support mental health screening and assessment, crisis services, and expanded inpatient bed capacity in McLennan County. The Health and Human Services Commission shall enter into a memorandum of understanding with the McLennan County Commissioners Court for the transfer of funds.

161. Pediatric Child Care Facility Developmentally Appropriate Care.

(a) Included in amounts appropriated above to the Health and Human Services Commission (HHSC) is $500,000 from the General Revenue Fund in each fiscal year of the biennium in Strategy F.3.3, Additional Advocacy Programs, for a grant to a pediatric care center located in Texas to support developmentally appropriate care for pediatric nursing facility residents.

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The grant funds may be used by the grantee for costs related to ensuring accessibility and developmentally appropriate environments and supports, and other costs identified by HHSC as necessary for the pediatric patients.

(b) Notwithstanding any other limitations within Article II or Article IX, should HHSC determine the amounts in Subsection (a) are eligible for federal funds through the Medicaid program, HHSC shall transfer these amounts to Strategy A.1.1, Medicaid Client Services for the same purpose, and shall notify the Legislative Budget Board and the Office of the Governor within 30 business days of initiating the transfer.

(c) Any unexpended balances of these funds remaining on August 31, 2026, are appropriated to HHSC for the same purpose for the fiscal year beginning on September 1, 2026.

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162. Uvalde Behavioral Health Campus. Out of amounts appropriated above to the Health and Human Services Commission for Strategy G.2.2, Mental Health Community Hospitals, the commission shall allocate $2,500,000 of general revenue appropriations for the state fiscal year ending August 31, 2026, and $10,000,000 of general revenue appropriations for the state fiscal year ending August 31, 2027, to fund the start-up and operations of the Uvalde Behavioral Health Campus.

163. Connecting Technology Services. Included in amounts appropriated above to the Health and Human Services Commission (HHSC) in Strategy O.1.3, Child Abuse Prevention Grants, is $2,000,000 from the General Revenue Fund in fiscal year 2026 and $2,000,000 from the General Revenue Fund in fiscal year 2027. HHSC shall contract with an organization that provides connecting technology for children and families in Texas. The technology services include providing community partners the opportunity to address the needs of children and families in their community.

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164. Medicaid and CHIP Residency Verification. Out of funds appropriated above in Strategy B.1.1, Medicaid & CHIP Contracts & Admin (page II-34), the Health and Human Services Commission:

(1) on at least a monthly basis shall, in accordance with applicable state and federal law, verify the residency status of clients under Medicaid and the child health plan program to ensure that only clients who are eligible residents of this state receive benefits under those programs; and

(2) may use a private third-party vendor to identify and recover improper capitation payments made to a managed care organization with respect to individuals the commission determines were not eligible for benefits under those programs because the individuals were not residents of this state.

165. Diabetes Prevention Program.

(a) Out of amounts appropriated above to the Health and Human Services Commission that are available for that purpose, the commission shall conduct a study, in consultation with the Department of State Health Services, to evaluate the cost-effectiveness and feasibility of implementing and administering a diabetes prevention program for Medicaid recipients, including alternative interventions for Medicaid recipients at risk of developing Type 2 diabetes.

(b) The Health and Human Services Commission may implement the diabetes prevention program if they determine it will improve health outcomes for Medicaid recipients and lower Medicaid costs.

(c) Not later than November 1, 2026, the commission shall submit to the governor, the Legislative Budget Board, the Senate Finance Committee, the House Appropriations Committee, and each standing committee of the Legislature with jurisdiction over health and human services a written report containing the findings of the study conducted under this

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rider and any recommendations for legislative or other action based on those findings.

166. Study on Language Accessibility.

(a) Out of the funds appropriated above, the Health and Human Services Commission shall employ a language access coordinator to conduct an assessment of and identify gaps in non-English speakers' access to the health and human services programs administered by the commission and 2-1-1 services provided by the Texas Information and Referral Network.

(b) Not later than the first anniversary of the date the commission employs a language access coordinator, the coordinator shall conduct the assessment described by that subsection and submit to the executive commissioner a written report that:

(1) summarizes the findings of the assessment; and

(2) provides recommendations for increasing non-English speakers' access to health and human services programs and 2-1-1 services provided by the Texas Information and Referral Network throughout this state.

167. Evaluation of Federal Medicaid Funding or Policy Changes. Out of funds above, the Health and Human Services Commission is directed to evaluate the impact of any federal changes to Medicaid funding or policy within 30 days of announcement, to determine the extent of any increase or decrease to programs, eligibility, federal matching assistance percentage (FMAP), provider payments, and any other changes which may impact the operation of programs supporting Medicaid and uninsured patient care in Texas. The evaluation should quantify funding reductions that result from federal changes to the Medicaid program and recommend alternative funding considerations as may be needed through carryover, balance transfer, or Budget Execution authority. Results of this evaluation should be provided to the Governor, Lieutenant Governor, Speaker of the House, Legislative Budget Board, Senate Committee on Finance, and House Committee on Appropriations.

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168. Medicaid Dental Reimbursement Rate Reallocation.

(a) Out of amounts appropriated above to the Health and Human Services Commission for Strategy A.1.1, Medicaid Client Services, the commission shall:

(1) for each procedure code under which a dental service provided to a Medicaid recipient is billed:

(A) other than a procedure code described by Paragraph (B) of this subdivision, reduce the reimbursement rate for the dental service to the amount in effect for the dental service on February 28, 2025; and

(B) if the procedure code was impacted by policy changes resulting from the commission's biennial review of dental services reimbursement rates that took effect March 1, 2025, maintain the reimbursement rate implemented under the policy; and

(2) subject to Subsection (b) of this rider, after adjusting the reimbursement rates as prescribed by Subdivision (1), implement a uniform reimbursement rate increase for the following procedure codes: D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1206, D1208, D1351, D1510, D1515, D2140, D2150, D2160, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2751, D2930, D3120, D3220, D3310, D3320, D3330, D7140, D7240, D9248, D2931, D7111, D7210, D7220, D7230, D2750, D2752, D2790, D2933, D2934, D2940, and D9243.

(b) In implementing the uniform reimbursement rate increase described by Subsection (a)(2) of this rider, the Health and Human Services Commission shall limit the percentage of the rate increases as necessary to ensure any overall increase in the amount of estimated expenditures on an annual basis is equivalent to the overall increase in amount of estimated expenditures that would have resulted from implementation of policy changes that took effect March 1, 2025, including changes in reimbursement rates, following the commission's biennial review of dental services reimbursement rates.

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169. Report on Medicaid Eligibility Determinations.

(a) Using funds appropriated above, the commission shall produce a report and provide detailed data on Medicaid eligibility determinations for each state fiscal year starting with the year ending August 31, 2018, including the total number of Medicaid applications submitted, approved, or denied within the required time frames. It should specify the number of applications approved or denied on time, those exceeding the time frame, and those denied due to failure to meet the time frame, along with reasons for each denial. Additionally, the report should include the average and median number of days from submission to decision, the total number of pending applications and the days elapsed for each, and the highest number of days for any application in each fiscal year.

(b) Not later than September 1, 2026, the Health and Human Services Commission shall prepare and submit to the legislature a written report.

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Sec. 6. Limitations on Transfer Authority. Notwithstanding the limitations of Article IX, Section 14.01, Appropriation Transfers, of this Act, the Executive Commissioner of the Health and Human Services Commission is authorized to make transfers of funding and full-time equivalents (FTEs) between all health and human services agencies listed in Article II of this Act, subject to the following requirements. Transfers that exceed $1,000,000 from the General Revenue Fund or FTE adjustments of more than 10.0 FTEs are subject to the prior written approval of the Legislative Budget Board and the Governor.

Transfers below these thresholds require written notification to the Legislative Budget Board and Governor at least 30 business days prior to the transfer. The total of all transfers from a strategy may not exceed $1,000,000 without the prior written approval of the Legislative Budget Board and the Governor.

To request a transfer, the Executive Commissioner of HHSC shall submit a written request to the Legislative Budget Board and the Governor. At the same time, the agency shall provide a copy of the request to the Comptroller of Public Accounts. The request shall include the following information:

(a) a detailed explanation of the purpose(s) of the transfer, including the following:

(1) a description of each initiative with funding and FTE information by fiscal year; and

(2) an indication of whether the expenditure will be one-time or ongoing;

(b) the names of the originating and receiving agencies and/or strategies and the method of financing and FTEs for each strategy by fiscal year;

(c) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and the receiving agencies and/or strategies; and

(d) the capital budget impact.

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

House

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(2) an indication of whether the expenditure will be one-time or ongoing;

(b) the names of the originating and receiving agencies and/or strategies and the method of financing and FTEs for each strategy by fiscal year;

(c) an estimate of performance levels and, where relevant, a comparison to targets included in this Act for both the originating and the receiving agencies and/or strategies; and

(d) the capital budget impact.

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

The request shall be considered to be approved unless the Legislative Budget Board issues a written

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In the case of disaster or other emergency, this provision is superseded by the emergency-related transfer authority in Article IX of this Act.

Sec. 24. Federal Funds Requirements.

(a) **Reporting Requirements.** All agencies listed in Article II of this Act 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 any federal grant requiring a state plan, which shall also be provided to the permanent standing committees of the House and Senate with jurisdiction over health and human services; and

(2) Reports associated with Maintenance of Effort (MOE) for federal grants.

(b) **Loss of Federal Funds.** All agencies listed in Article II of this Act 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 $1,000,000 in federal funds assumed in this Act.

(c) **General Revenue Fund Appropriations Associated with MOE.** The agencies listed in Article II of this Act shall not increase the state's MOE requirement for any federal grant without prior written approval of the Legislative Budget Board and the Governor. To request approval, the agency shall submit a written request to the Legislative Budget Board and the Governor that

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disapproval within 30 business days of the date on which the staff of the Legislative Budget Board concludes its review of the proposal to transfer the funds and forwards its review to the Chair of the House Appropriations Committee, Chair of the Senate Finance Committee, Speaker of the House of Representatives, and Lieutenant Governor. Any request for additional information from the Legislative Budget Board shall interrupt the counting of the 30 business days.

In the case of disaster or other emergency, this provision is superseded by the emergency-related transfer authority in Article IX of this Act.

Sec. 24. Federal Funds Requirements.

(a) **Reporting Requirements.** All agencies listed in Article II of this Act 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 any federal grant requiring a state plan, which shall also be provided to the permanent standing committees of the House and Senate with jurisdiction over health and human services; and

(2) Reports associated with Maintenance of Effort (MOE) for federal grants.

(b) **Loss of Federal Funds.** All agencies listed in Article II of this Act 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 $1,000,000 in federal funds assumed in this Act.

(c) **General Revenue Fund Appropriations Associated with MOE.** The agencies listed in Article II of this Act shall not increase the state's MOE requirement for any federal grant without prior written approval of the Legislative Budget Board and the Governor. To request approval, the agency shall submit a written request to the Legislative Budget Board and the Governor that

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includes the following information:

(1) a detailed explanation of the need to increase the state's MOE requirement; and

(2) the impact the increase will have on future MOE requirements.

(d) **Reporting of MOE for Federal Grants.** All agencies listed in Article II of this Act shall submit the following information to the Legislative Budget Board by October 1 and April 1 of each year for each federal grant received by the agency that has a MOE requirement:

(1) the current amount of the MOE requirement for the grant;

(2) the time period of which the current MOE requirement applies;

(3) total expenditures made towards meeting the current MOE requirement;

(4) the time period for which current expenditures will impact future MOE requirements;

(5) projection of future MOE requirements based on current spending; and

(6) if the agency projects the current MOE requirement will not be fulfilled, a narrative explanation of why and the impact of not doing so, including any projected loss of federal funding.

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includes the following information:

(1) a detailed explanation of the need to increase the state's MOE requirement; and

(2) the impact the increase will have on future MOE requirements.

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 increase the MOE 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 Legislative Budget Board shall interrupt the counting of the 30 business days.

(d) **Reporting of MOE for Federal Grants.** All agencies listed in Article II of this Act shall submit the following information to the Legislative Budget Board by October 1 and April 1 of each year for each federal grant received by the agency that has a MOE requirement:

(1) the current amount of the MOE requirement for the grant;

(2) the time period of which the current MOE requirement applies;

(3) total expenditures made towards meeting the current MOE requirement;

(4) the time period for which current expenditures will impact future MOE requirements;

(5) projection of future MOE requirements based on current spending; and

(6) if the agency projects the current MOE requirement will not be fulfilled, a narrative explanation of why and the impact of not doing so, including any projected loss of federal funding.

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Sec. 28. Residential Services for High Acuity Youth in Department of Family and Protective Services Conservatorship.

(a) Included in amounts appropriated above to the Health and Human Services Commission (HHSC) are the following amounts to establish a residential treatment facility for the purpose of providing dedicated bed capacity for youth in Department of Family and Protective Services (DFPS) conservatorship:

(1) $5,366,461 in General Revenue in fiscal year 2026 and $24,563,129 in General Revenue in fiscal year 2027 and 255.0 FTEs in each fiscal year in Strategy G.2.1, Mental Health State Hospitals;

(2) $235,767 in General Revenue in fiscal year 2026 and $1,261,813 in General Revenue in fiscal year 2027 and 7.0 FTEs in each fiscal year in Strategy H.1.1, Facility/Community-based Regulation;

(3) $247,925 in General Revenue in fiscal year 2026 and $729,460 in General Revenue in fiscal year 2027 and 6.4 FTEs in each fiscal year in Strategy L.1.2, IT Oversight and Program Support; and

(4) $451,400 in General Revenue in fiscal year 2026 and $1,445,598 in General Revenue in fiscal year 2027 and 11.6 FTEs in each fiscal year in Strategy L.2.1, Central Program Support.

(b) The capacity shall accommodate a daily census of up to 30 youth in DFPS conservatorship, including both boys and girls, between the ages of 13-17 with the following conditions:

(1) Behavioral Health Conditions (mental health or substance use) or co-occurring mental health and substance use conditions; and/or

(2) Intellectual and Developmental Disabilities (IDD); or

(3) co-occurring behavioral health and IDD.

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(c) The residential treatment facility shall establish programming to meet the immediate needs of youth in DFPS conservatorship with high acuity behavioral health and/or IDD conditions who require placement in a residential facility, and shall provide a stable treatment environment for DFPS youth, and programming shall prepare youth for transition by DFPS to a longer term DFPS licensed or kinship placement following the provision of mental health services by HHSC with the consent of DFPS.

(d) DFPS will refer youth and HHSC may transfer youth to a higher level of care if clinically indicated with DFPS's consent. Admission to the state-operated residential facility shall be voluntary and eligibility criteria shall address the needs of high-acuity youth in DFPS conservatorship and shall be defined jointly by DFPS and HHSC.

(1) The residential treatment facility must allow for admission within 24 hours if a bed is available for youth referred by DFPS for immediate mental health services.

DFPS shall ensure at least one staff person is available onsite during normal working hours (and available after hours) to participate in and collaboratively coordinate discharge planning with all parties, including the facility and the potential future placement, to help secure services for child and family supports in accordance with relevant state continuity of care standards throughout the course of placement in the residential facility and prior to discharge.

House

Sec. 28. Transparency in Child Care Regulatory Activities.

(a) The Health and Human Services Commission (HHSC) shall submit an annual report on the Child Care Regulation Division, due November 1 of each year, to the Chair of the House Appropriations Committee and the Chair of the Senate Finance Committee, and to be published on the agency's public website, that includes the following:

(1) The number of inspections and investigations by the Child Care Regulation Division;

(2) The number of deficiencies issued as a result of inspections and investigations;

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(3) The average number of deficiencies across operations;

(4) The number of deficiencies that are overturned as the result of an administrative review;

(5) The number of deficiencies that are in an enforcement action that is heard at the State Office of Administrative Hearings; and

(6) Justification and trends for the overturn decisions.

(b) It is the intent of the Legislature that if HHSC identifies any single investigator, or investigative unit, that has a high rate of investigative findings overturned in the administrative review of investigative findings stage, or at the State Office of Administrative Hearings, the agency shall take immediate corrective action, including but not limited to training, technical assistance, or personnel action.

Sec. 29. Transparency in State Monitoring. Included in amounts appropriated above, the Health and Human Services Commission (HHSC) and the Department of Family and Protective Services (DFPS) shall report the following: deidentified information on each residential child-care facility that has been placed on heightened monitoring since January 1, 2020, including operation type, licensed or actual capacity, whether the operation remains on heightened monitoring, whether the operation is open or closed, when the operation was placed on heightened monitoring, any improvements the State attributes to the monitoring process, and the total number of staff with responsibility for heightened monitoring activities and the associated expenditures. The agencies shall report to the Legislative Budget Board, the Governor, the House Committee on Human Services, the Senate Committee on Health and Human Services, and any Joint Legislative Oversight Committees, as appropriate no later than November 1 of each year of the biennium.

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Sec. 29. Contract Reporting. Out of funds appropriated above, the health and human Services agencies listed in Article II of this Act shall include the following information on the agencies' websites, accessible directly from its website homepage, concerning certain contracts for services provided to the agency:

(a) An inventory listing all organizations that have "no cost" contracts or agreement for services. For the purposes of this rider, no cost is defined as an external third party that exchanges consulting or other services to agency staff or for agency infrastructure for no compensation. In providing the list, agencies shall report:

(1) the name of the organization;

(2) the headquarters address of the organization or the location of the organization performing services if it is different from the headquarters address;

(3) the date the contract or agreement was entered into and the duration of the contract;

(4) the recipient, division, or sub-agency within the health and human services agency receiving the services; and

(5) a description of the services rendered at no cost.

(b) An inventory of all interagency contracts with institutions of higher education for services. In providing the list, agencies shall report:

(1) The specific university and/or sub-agency and/or organization within the university performing the services;

(2) the date the contract or agreement was entered into and the direction of the contract;

(3) the recipient, division, or sub-agency within the health and human services agency receiving the services; and

(4) a description of services rendered and cost of the valued service.

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(c) The information in subsections (a) and (b) shall be posted quarterly on the agencies' websites.

Sec. 30. Consolidation of Data Collected from Hospitals. Out of funds appropriated elsewhere in this Act, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DSHS) shall improve hospital reporting and transparency, including elimination of duplicative reporting requirements or modification of data collection tools to increase efficiency. Not later than November 1, 2026, HHSC shall submit a report to the Legislative Budget Board and the Office of the Governor that includes a list of all mandatory and optional data or information collection requirements for hospitals operating in Texas, a summary and list of any eliminated or modified reports, and the stated purpose for all remaining information or data collection requirements.