Health and Human Services Commission
CFO Reference Guide

An Overview of Key Financial Topics

January 2023

TEXAS
Health and Human Services

Forward

The Health and Human Services Commission's Chief Financial Officer division is proud to offer the first edition of *The Health and Human Services Commission CFO Reference Guide: An Overview of Key Financial Topics.* We created it to serve as a foundation for those who manage and make decisions about the budget for Texas' social services.

This guide reflects the combined knowledge and expertise of HHSC's financial teams. It's our hope this document will help explain our agency's complex financial topics and serve as a reference for HHSC's financial history.

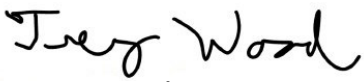
We will continue to refine this document each biennium to facilitate efficient and well-informed decision making for the State of Texas.

The Guide is a result of two years of work from across HHSC. Our teams gathered and organized white papers that answer frequently-asked questions and provided overviews of programs from a financial perspective.

I want to thank the CFO directors and their staff:

- Paula Reed, Accounting
- Michael Joyner, Actuarial Analysis
- Ray Jasik, Budget Management
- April Ferrino, Fiscal Coordination and Special Projects
- Michael Ghasemi, Forecasting
- Mike Markl, Payroll and Time, Labor and Leave
- Victoria Grady, Provider Finance
- Chris Matthews, Deputy Chief Financial Officer

A special thanks to Michael Diehl and Samantha Brock who compiled, checked and rechecked it all while knowing we could not capture everything perfectly.



Trey Wood
Chief Financial Officer

TABLE OF CONTENTS

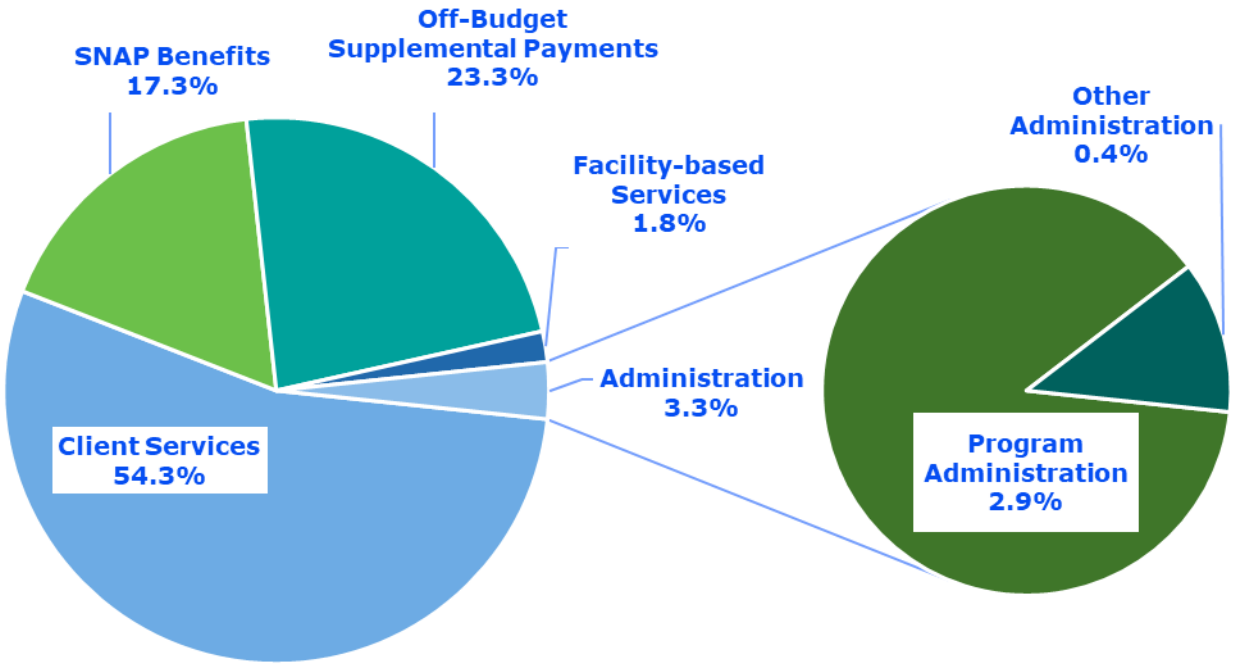
Agency Financial Overview

Article II Health and Human Services is the second-largest function of Texas state government, and the Health and Human Services Commission is the largest portion of Article II, with the Medicaid program as its primary cost driver.

Below are some financial facts and an overview of historical and current appropriations to provide a general idea about the scale and scope of HHSC:

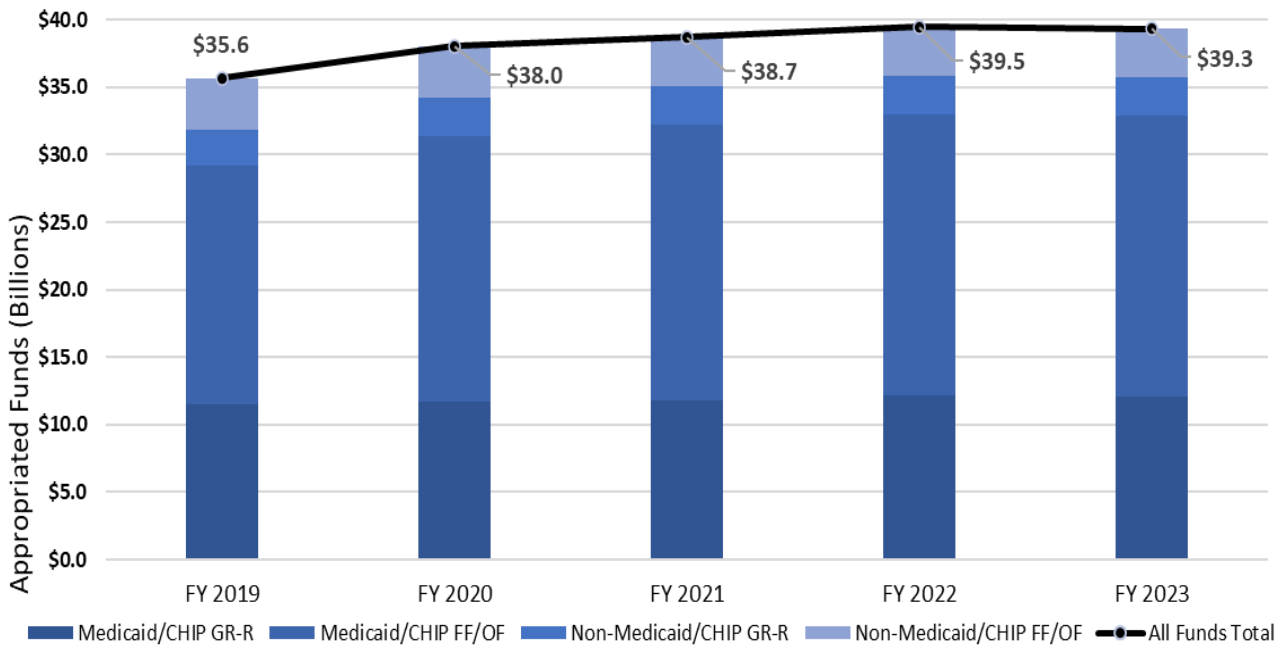
- HHSC is responsible for forecasting costs for the state's Medicaid program, which is among the state's major cost drivers
- HHSC administers 59.6 percent of the state's appropriated federal funds and provides payroll and timekeeping functions for 24.8 percent of the state's full-time equivalents
- Only about 3.3 percent of the total available funds that are appropriated to or administered by HHSC are used for direct and indirect agency administration
- HHSC is responsible for facility construction related to SSLCs and State Hospitals
- HHSC is responsible for more than $50 billion in off-budget funds for the 2022-23 biennium (funds not appropriated through the General Appropriations Act) related to Medicaid supplemental payment programs and Supplemental Nutrition Assistance (SNAP) benefits

Percentages of Estimated Total Available Funds (2022-23 biennium)



The chart above provides a breakout of the total estimated funds available for HHSC in the 2022-23 biennium. Does not include Interagency Contract Funds in 2022-23 General Appropriations Act HHSC Goal K, Office of Inspector General ($10.6 million) and Goal L, System Oversight and Program Support ($294.0 million). SNAP Benefits and Off-Budget Supplemental Payments are shown using 2022-23 estimates.

Health and Human Services Commission Appropriations (2019-2023)



		FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Medicaid and CHIP	GR-R	11,452,803,757	11,690,917,723	11,788,980,942	12,118,551,850	12,047,862,869
	AF	29,218,962,797	31,334,575,651	32,222,883,870	33,022,541,462	32,871,710,598
Non-Medicaid and CHIP	GR-R	2,583,469,957	2,859,269,483	2,828,358,382	2,834,918,020	2,843,018,544
	AF	6,428,667,168	6,689,957,202	6,486,097,837	6,436,747,477	6,436,382,579
Total	**GR-R**	**14,036,273,714**	**14,550,187,206**	**14,617,339,324**	**14,953,469,870**	**14,890,881,413**
	AF	**35,647,629,965**	**38,024,532,853**	**38,708,981,707**	**39,459,288,939**	**39,308,093,177**

The chart above provides historical and current appropriations from state fiscal year 2019 to 2023. Figures do not include supplemental appropriations. Supplemental appropriations include $2.0 billion in General Revenue in FY 2019 to cover shortfalls in the Medicaid program and $731.1 million in Federal Funds related to SB 8 (87th Legislature, Third Called Session, 2021), and $657.3 million in All Funds related to HB 2 (87th Legislature, Regular Session, 2021) in FY 2021. Medicaid and CHIP refers to strategies in Goal A and Goal C in the agency bill pattern in the 2022-23 General Appropriations Act.

Client Services

Approximately $71,650.5 million (54.3%) of Health and Human Services appropriations were provided for client services programs in the 2022-23 biennium. Client services refer to services provided directly to agency clients.

The Medicaid and Children's Health Insurance Program (CHIP) account for the majority of HHSC client service appropriations, but HHSC has many other client service programs including Non-Medicaid Nutrition Services, Aging Services, Mental Health Services, and Family Violence Prevention Services.

In addition to client services programs funded through the General Appropriations Act, HHSC is responsible for determining eligibility for and issuing monthly benefits for the Supplemental Nutrition Assistance Program (SNAP) and several supplemental and directed payment programs.

Medicaid and CHIP Client Services

Medicaid accounts for the significant majority, approximately 89.5 percent, of HHSC client service appropriations. Medicaid is a health insurance program jointly funded by the federal and state government for certain groups of low-income individuals. The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for administrative oversight of all Medicaid program at the federal level and sets minimum Medicaid standards related to eligible populations and required benefits. Each state is responsible for designing and administering its own Medicaid program. States have latitude to make decisions about program eligibility, optional benefits, premiums and cost sharing, and provider reimbursement.

In Texas, Medicaid provides health care and long-term services and supports to low-income children and their families, pregnant women, former foster care youth, individuals with disabilities, and people aged 65 and older[1].

First Medicaid Appropriations in Texas

The Medicaid program was established in federal law in 1965. The Texas Medical Assistance (Medicaid) Program was implemented on September 1, 1967, under the provisions of Title XIX of the federal Social Security Act and Chapter 32 of the Texas Human Resources Code (Senate Bill 2, 60th Legislature, Regular Session, 1967). The Department of Public Welfare was designated as the administering agency.

The 60th Texas Legislature appropriated a total of $808.0 million to the Department of Public Welfare for "Assistance Payments", including Federal Funds for Medical

[1] Texas Health and Human Services Commission, 13th Edition Texas Medicaid and CHIP Reference Guide

Assistance under Congressional Bill H.R. 6675 (H.R. 6675 resulted in the creation of Medicare and Medicaid). Biennial appropriations for Assistance Payments are listed in the table below.

Assistance Payments Appropriations, 1968-69 Biennium[2]

Assistance Payments	1968-69 Biennial Appropriations
Old Age Assistance	96,400,000
Needy Blind	2,800,000
Families with Dependent Children	12,300,000
Permanently and Totally Disabled	8,500,000
Medical Assistance	48,659,994
Medical Assistance for patients in state hospitals and special schools	6,793,978
Allocation to the State for Child Welfare Services, Assistance, Medical Assistance under Congressional Bill HR 6675 and Administration, estimated to be	632,552,007
Total of Assistance Payments	**808,005,979**

Amounts are a combination of Medicaid appropriations and appropriations for payments made under assistance programs established prior to the implementation of the Medicaid program (for example, Old Age Assistance Payments made under SB 36, Acts of the 46th Legislature, Regular Session).

The General Appropriations Act(s) for the 1968-69 biennium also included a provision authorizing the Department of Public Welfare to transfer funds appropriated for payments of Old Age Assistance, Blind Assistance, Children's

[2] Senate Bill 15 (60th Legislature, Regular Session, 1967) and House Bill 5 (60th Legislature, 1st Called Session, 1967).

Assistance, and Disabled Assistance into the Medical Assistance Fund if needed to match Federal Funds to provide Assistance and Medical Assistance to the greatest extent possible within appropriations.

The tables on the following page provides a comparison of appropriations for Assistance Payments at the Department of Public Welfare from fiscal year 1964 to fiscal year 1971.

Assistance Payment Appropriations, FY 1964 - 1971

Assistance Program	FY 1964	FY 1965	FY 1966	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971
Old Age Assistance	41,700,000	41,700,000	41,700,000	41,700,000	48,200,000	48,200,000	48,200,000	48,200,000
Needy Blind	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000	1,400,000
Families with Dependent Children	3,900,000	3,900,000	5,650,000	5,650,000	6,150,000	6,150,000	6,150,000	6,150,000
Permanently and Totally Disabled	1,500,000	1,500,000	3,250,000	3,250,000	4,250,000	4,250,000	4,250,000	4,250,000
Medical Assistance	7,992,000	7,992,000	13,509,400	12,054,000	22,419,459	26,240,535	52,274,269	55,075,655
Medical Assistance for patients in state hospitals and special schools	-	-	-	-	3,302,900	3,491,078	4,832,016	4,832,016
Federal Funds: Child Welfare Services, Assistance, Medical Assistance under Congressional Bill HR 6675 and Administration	166,910,000	168,110,000	203,187,062	211,027,726	307,598,788	324,953,219	344,054,050	350,012,929
Total, Assistance Payments	**223,402,000**	**224,602,000**	**268,696,462**	**275,081,726**	**393,321,147**	**414,684,832**	**461,160,335**	**469,920,600**
Source:	HB 86 (58R)	HB 86 (58R)	HB 12 (59R)	HB 12 (59R)	SB 15 (60R)	HB 5 (60R)	HB 2 (61R)	HB 2 (61R)

Medical Assistance Payments and Estimated Federal Funds, FY 1964 - 1971

Assistance Program	FY 1964	FY 1965	FY 1966	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971
Medical Assistance	7,992,000	7,992,000	13,509,400	12,054,000	22,419,459	26,240,535	52,274,269	55,075,655
Estimated Federal Funds - Medical Assistance	12,739,518	12,739,518	23,431,809	20,907,444	45,724,793	53,517,930	104,517,180	110,118,271
Total, Medical	**20,731,518**	**20,731,518**	**36,941,209**	**32,961,444**	**68,144,252**	**79,758,465**	**156,791,449**	**165,193,926**
Medical Assistance for patients in state hospitals and special schools	-	-	-	-	3,302,900	3,491,078	4,832,016	4,832,016
Estimated Federal Funds - Medical Assistance for patients in state hospitals and special schools	-	-	-	-	6,736,310	7,120,101	9,661,133	9,661,133
Total, Medical	**-**	**-**	**-**	**-**	**10,039,210**	**10,611,179**	**14,493,149**	**14,493,149**
Total, Medical	**20,731,518**	**20,731,518**	**36,941,209**	**32,961,444**	**78,183,462**	**90,369,644**	**171,284,598**	**179,687,076**
FMAP[3]	61.45%	61.45%	63.43%	63.43%	67.10%	67.10%	66.66%	66.66%

[3] Federal Percentages and Federal Medical Assistance Percentages, FY 1961 - FY 2011 | ASPE (hhs.gov)

Medicaid Managed Care in Texas

Medicaid managed care is a health care delivery system organized to manage cost, use, and quality. Managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs). MCOs accept a set per member per month (PMPM) payment for these services, which is known as a capitation payment[4].

Texas has been operating managed care since 1993 when it implemented STAR, which covers acute and primary care services for low-income women and children. Over time, the state has expanded managed care to cover additional populations and services. Appendix 1 provides additional detail on the percentage of Medicaid clients enrolled in Managed Care from state fiscal year 1994 to 2021.

The state's Section 1115 waiver program, approved in late 2011, authorized the expansion of STAR and STAR+PLUS to additional counties.

1115 Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. Under this authority, the Secretary may waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.[5] States use Section 1115 waivers for a variety of purposes.[6] For example, some states use these waivers to make broad changes to Medicaid eligibility, benefits, and provider payments. States also use Section 1115 waivers for more targeted purposes, such as focusing on specific populations or services.

In 2011, the Texas Legislature[7] directed HHSC to expand Medicaid managed care to achieve program savings and to preserve access to federal hospital funding

[4] https://www.medicaid.gov/medicaid/managed-care/index.html
[5] https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html
[6] The Kaiser Family Foundation publishes aggregated information about all pending and approved Section 1115 Medicaid waivers: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/
[7] House Bill 1, 82nd Legislature, Regular Session, 2011 Rider 51, and Senate Bill (SB) 7, 82nd Legislature, First Called Session, 2011, instructed HHSC to expand its use of Medicaid managed care. Additionally, SB 7 directed HHSC to preserve federal hospital funding historically received as supplemental payments.

historically received as supplemental payments under the Upper Payment Limit program. HHSC determined a Section 1115 waiver was the best approach to meet legislative mandates, preserve funding, expand managed care, achieve savings, and improve quality. Accordingly, HHSC submitted an application to CMS for a five-year Section 1115 waiver entitled the "Texas Healthcare Transformation and Quality Improvement Program" (1115 waiver) and received CMS approval in December 2011.

Through the 1115 waiver, HHSC expanded its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The 1115 waiver created two supplemental payment funding pools: Uncompensated Care (UC) and the Delivery System Reform Incentive Payment (DSRIP). The UC pool was designed to reimburse providers for uncompensated care costs. The DSRIP pool provided incentive payments to providers for delivery system reforms.

The 1115 waiver has been renewed and extended several times since the 2011 approval. In May 2016, CMS granted Texas a 15-month extension of the waiver through December 31, 2017. In December 2017, HHSC received a five-year extension of the waiver through September 30, 2022, including an extension of the UC pool for five years and the DSRIP pool for four years. CMS authorized only four years of DSRIP funding in the extension to reflect its decision that DSRIP funding was intended to be "time-limited".[8]

On January 15, 2021, CMS approved a 10-year extension of Texas' 1115 waiver through September 30, 2030.

Budget Neutrality

Medicaid spending under Section 1115 demonstrations is required to be budget neutral, meaning that the federal spending under the demonstration cannot exceed projected costs in the absence of the demonstration. Essentially, the state must ensure that delivery of care under the Waiver is not more costly than the delivery of care would have been under the state plan (or without the Waiver). The requirement for Medicaid spending under Section 1115 demonstrations to be budget neutral is not defined by federal statute or regulations but has been in

[8] In CMS's approval letter, it states that "The fifth year of the extension, from October 1, 2021 through September 30, 2022, will not include any funding for DSRIP, to reflect the time-limited nature of DSRIP payments to support demonstrable delivery system transformation." The extension included two years of level funding followed by two years of funding that decreased each year.

practice since the late 1970s. The budget neutrality requirement for Section 1115 was initially adopted by the Carter administration, has been maintained by succeeding administrations, and was explicitly described in 1994[9].

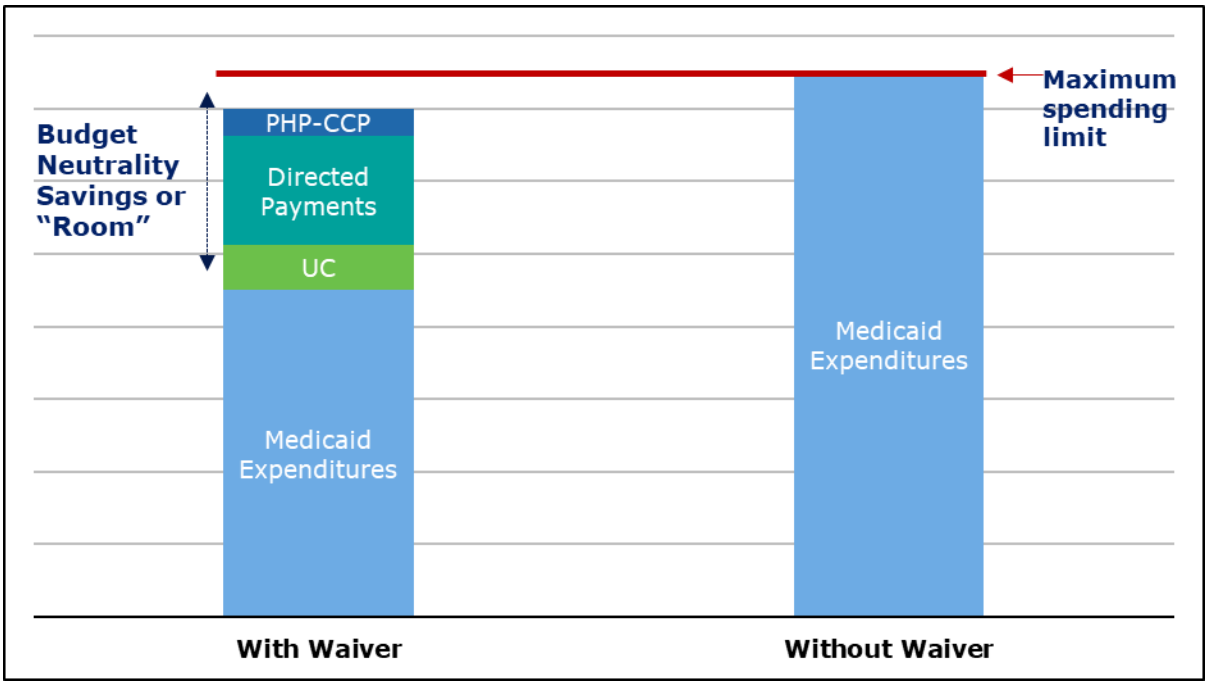
CMS provides states with instructions for calculating budget neutrality and periodically updates guidance. There is a cap on expenditures that are eligible for federal matching funds, and the calculation of this cap is often referred to as Budget Neutrality. The difference between the actual expenditures of the state (With Waiver or WW) and the cap (Without Waiver or WOW) is referred to as Budget Neutrality Room.

Previously, the per capita spending limit against which neutrality was assessed (known as the Without Waiver (WOW) cost per member per month Baseline) was calculated by trending forward the state's existing without waiver spending per enrollment category by the lower of its historical trend rate, or the expected national average growth rate as reflected in the most recent president's budget submission to Congress. Updated budget neutrality terms and guidance are currently under review with the Centers for Medicare and Medicaid Services and may impact the discussion of budget neutrality in this section.

The WOW Baseline is developed to mirror the same benefits and populations provided under actual With Waiver expenditures. Should the actual benefits or populations change from those considered as part of the WOW baseline development, an amendment is needed to re-align the WOW PMPMs to mirror the populations and services included under the demonstration.

[9] https://www.kff.org/wp-content/uploads/2001/07/section-1115-wiavers-in-medicaid-and-the-state-children-s-health-insurance-program-an-overview.pdf

Budget Neutrality Illustration



The graphic above is for illustrative purposes only and does not depict the actual value of each program.

The table below is a general guideline of budget neutrality influences:

Budget Neutrality Influences

Items that can impact Budget Neutrality	• Abnormal Cost Growth • Rate Increases • MCO specific rate increases (e.g. risk margin, administration, service coordination, tax) • Uncompensated Care Pool Increases • Directed Payment Program increases that increase the PMPM cost (after a rebase)
Items that do not impact Budget Neutrality	• Caseload Impacts – fluctuations to existing populations or new populations (amendment may be necessary for new populations) • New Client Services – an amendment is done to build new benefits into the Without Waiver baseline • Impact to populations/services outside of 1115 Budget Neutrality authority (e.g., 1915c waivers, Disproportionate Share Hospitals (DSH), Graduate Medical Education (GME), School Health and Related Services (SHARS), excluded populations)

PMPM expenditure data is categorized by Medicaid Eligibility Group (MEG). Texas has 4 MEGs – Adults, Children, Disability, and Aged/Medicare Related beneficiaries. The MEGs represent the populations and services included in the demonstration.

To account for healthcare inflation factors, the WOW MEG expenditures increase year over year at a predetermined growth trend. The Texas model applies a per capita budget neutrality test (no limitation to caseload levels). Therefore, the state is at risk only for increases to the PMPM cost growth – not for increases in its caseload.

Capitation Methodology and Cost Drivers

Like all insurance arrangements, the Medicaid managed care health plans are at risk for their financial performance and rates are developed using actuarial principles. However, unlike group health insurance arrangements where insurance companies negotiate rates with companies for coverage, HHSC unilaterally sets the rates and there is no rate negotiation.

All Medicaid rates are submitted to the federal Centers for Medicare and Medicaid Services (CMS) and the Office of the Actuary (OACT) for review and approval. The Texas Department of Insurance (TDI) will monitor companies for compliance but does not review or issue approval of the Medicaid managed care rates.

Capitation Rate Overview

- Developed prospectively
- Fixed amount of money paid per member per month (PMPM).
- Health plans are paid monthly.
- Paid on all enrolled clients, regardless of whether they seek healthcare services in that month.
- Intended to provide reasonable provision to the MCO for the delivery and administration of health care services.
- Actual financial experience will be different in the prospective period.

MCOs are at risk if their costs are higher than projected in the rates and the health plan loses money. Health plans are not protected from financial losses.

To ensure that the capitation rates paid are not excessive compared with MCO costs, HHSC includes a settlement requirement in its managed care contracts. Above certain thresholds, if an MCO is profitable, they must share a portion of the profits with HHSC in the form of a profit-sharing arrangement known as an experience rebate[10].

Methodology

Capitation rates are set primarily on base year experience data, adjusted for cost, inflation, and use trends. Capitation rates include the following components:

---

[10] Texas Administrative Code §353.3 – Each MCO participating in Medicaid managed care must pay to the state an experience rebate calculated according to the graduated rebate method described in the MCO's contract with the Health and Human Services Commission. Texas Government Code §533.104 requires HHSC to adopt rules to ensure MCOs share profits earned through the managed care program.

1) An amount for health care services performed, including adjustments for service-specific rate changes or the addition of new benefits

2) An amount for administration, including both fixed and variable administrative components

3) An amount for the risk margin, which reflect the level of uncertainty regarding the costs of providing coverage

   Risk margin percentages were reduced beginning in fiscal year 2018 per Health and Human Services Commission Rider 37 in the 2018-19 General Appropriations Act.

   - From 2.0 to 1.5 percent for STAR and STAR Health
   - From 2.0 to 1.75 percent for STAR+PLUS and STAR Kids

4) An amount for premium tax.

Rates are set for each:

- Program
  - Six managed care programs: STAR, STAR+PLUS, STAR Kids, STAR Health, Dual Demonstration, and CHIP
  - Two managed dental programs: Medicaid and CHIP Dental
- Type of service
  - Depending on the managed care program, the total capitation rate can include several components. The components are developed separately to improve the predictability of setting prospective rates.
    - Acute Care
    - Long-term Care
    - Pharmacy
    - Non-Emergency Medical Transportation
  - Dental managed care organization (DMO) Rates
- Geographical survey area

- Defined under the contract

- Risk group
  - Recognition that different groups of clients will use different services and have a different cost structure.
    - For example: Pregnant women, TANF adults, Children's age-groups, Dual Eligible Individuals A

Rating Example: Risk Group[11]

		Risk Group Amount	PMPM	
1	Base Year (FY2019)			
	Member Months	100,000		*- Provided by HHS Forecasting*
	Claims Cost	$35,000,000	$350.00	*- Claims costs reported by MCOs, and validated by HHSC.*
	Projected Member Months (FY2021)	110,000		*- Provided by HHS Forecasting*
2	Trend	2.50%		*- Needed to project historical costs to the future rating period.*
3	Adjustments			*- Changes that are not reflected in the base period.*
	Provider Reimbursement Adjustment	1.005		*- Ex: Cost Containment, Benefit & Fee Schedule changes.*
	FQHC Wrap Carve Out	0.993		
	Projected Incurred Claims (FY2021)	$40,366,749	$366.97	*- Projected claims costs without add'l expenses listed below.*
4	Other Expenses	$137,500	$1.25	*- Additional expenses not reported in claims costs above.*
5	Net Reinsurance	$19,800	$0.18	*- Reinsurance cost net of recoveries.*
6	Administrative Costs			*- Source is FSRs.*
	Fixed - General Admin	$660,000	$6.00	*- Target average cost.*
	Fixed - Quality Improvement	$330,000	$3.00	
	Variable	$2,382,395	5.25%	
	Total	$3,372,395	$30.66	
7	Taxes			*- State taxes*
	Premium Tax	$794,131.80	1.75%	
	Maintenance Tax	$7,700	$0.07	
8	Risk Margin	$680,684	1.50%	*- Needed to recognize risk. No other margins are included.*
9	Projected Total Cost	$45,378,960	**$412.54**	

1) **Base Year Experience Data**. The starting point for all calculations is historical data from a complete state fiscal year.

2) **Trend**. Trends are applied to the base year PMPM costs to recognize underlying changes in cost and utilization. Trends assumptions exclude prior adjustments, and are developed as the average of the most recent 3-4 years of trends to the extent that they represent long–term assumptions.

[11] HHSC Actuarial Analysis Department

3) **Adjustments**. Adjustments to the base year PMPM are made for any material changes that are not reflected in the base year or trends. Adjustments could include changes to policy or benefits; cost containment initiatives, Medicaid Fee Schedule rates, and others.

4) **Other Expenses**. Other expenses are added for costs not captured in the Base Year Data or reported outside of those sources. For example, sub-capitation costs for vision services.

5) **Net Reinsurance**. Some MCOs purchase reinsurance to protect from unexpected, high-cost events. Net Reinsurance is calculated as the MCOs reinsurance premium cost minus expected recoveries. Max is $0.50 PMPM.

6) **Administrative Costs**. Uses Financial Statistical Reports (FSRs) to calculate the average MCO administrative cost and set the fixed and variable components to achieve roughly the average PMPM.

7) **State Premium and Maintenance Tax.** State taxes on premiums and maintenance tax.

8) **Risk Margin.** Incentives for MCOs to participate and to recognize risk of actual costs exceeding projected costs. The risk margin is 1.5%-1.75 percent depending on the managed care program. No other margins are included in the rate development.

9) **Projected Total Cost.** Represents the community rate for the risk group.

After this step, HHSC applies acuity adjustment factors to the community rates to arrive at the MCO-specific capitation rates. Essentially, rates are increased for MCOs with higher-acuity clients and rates are lowered for MCOs with lower acuity clients.

Impact of COVID-19

Actuarial models to derive rates rely primarily on historical health plan experience. Due to the significant impact of COVID-19 and the associated public health emergency (PHE), adjustments were made to standard base periods in prior rate settings. Beginning March 2020, all programs experienced significant declines in the average cost due to large scale shutdowns and deferral of services. As a result, March 2020 through August 2020 data was determined to not be indicative of future cost patterns. The base period for all rating components for FY 2022 rates

was therefore defined as March 2019 through February 2020, which was the most recent twelve-month period not impacted by COVID-19 and the PHE[12].

Rate Setting Timeline[13]

Rate setting activities begin 10 months before the next rating period.

November-December

- Begin collecting and validating claims data
- Request enrollment data from HHSC Forecasting department

January-April

- Additional data collection and validation (Financial Statistical Reports, supplemental requests to MCOs)
- Collect information from HHSC departments on changes and considerations
- Request new benefit information from MCOs
- Receive certified encounter data sets and acuity factors from the contracted External Quality Review Organization (EQRO)
- Develop rate adjustments

May

- Prepare preliminary rates
- Preliminary rate notification to the Legislative Budget Board (LBB), Office of the Governor (OOG), State Auditor's Office (SAO), Comptroller of Public Accounts (CPA). Rate notifications are required per Special Provisions Relating to All Health and Human Services Agencies, Sec. 12, Rate Limitations and Reporting Requirements (2022-23 General Appropriations Act).
- Send preliminary rates to MCOs and host a meeting to review

[12] State of Texas Medicaid Managed Care STAR Program Rate Setting State Fiscal Year 2022 (Rudd & Wisdom).
[13] HHSC Actuarial Analysis Department

- Collect MCO comments on preliminary rates

June

- Finalize capitation rates
- Send final rates to MCOs
- Finalize Direct Payment Program add-on rates
- Contracted actuaries prepare actuarial certification reports

July

- Submit final, proposed rates and certification report to LBB, OOG, SAO, CPA
- Submit final, proposed rates and certification reports to CMS and Office of the Actuary

September

- Implement rates
- Respond to state and federal inquiries
- Receive approval from state and federal agencies
- Monitor financial performance throughout the year

Medicaid Payment Types

Generally, state Medicaid payments fall into three broad categories: base payments, supplemental payments, and directed payments.

Base Payments

Base payments are made for specific services (e.g., surgery, x-rays, diagnostic tests) provided to persons with Medicaid. These payments are made through a fee-for-service method or through a managed care service delivery system.

Fee-for-service

Under a FFS arrangement, each service is paid for separately. FFS is paid directly to the provider of a service for each claim submitted for payment.

As of August 2022, three percent of Texas Medicaid payments are made through FFS.

Managed Care

In a managed care delivery system, the state makes monthly capitation payments to contracted MCOs. Capitation payments are a fixed amount based on the number of Medicaid members enrolled in a health plan with the MCO. The MCO contracts with health care providers and makes payments to them based on their agreements.

See Managed Care Capitation Methodology and Cost Drivers for additional information about managed care capitation payments.

Provider Rate Considerations and Methodology

The Health and Human Services Commission Provider Finance department (PFD) publishes provider reimbursement rate tables to serve as a public and transparent resource about reimbursement levels for various Medicaid and non-Medicaid services reimbursed by the state (available on the HHSC website at https://pfd.hhs.texas.gov/rate-tables).

Direct services received by Health and Human Services clients are predominantly provided through the private sector and local public entities. While state employees determine client eligibility and provide regulatory services, clients generally receive medical, residential and social services in residential or community settings from private and local public-sector individuals or entities[14]. These providers may also serve people who do not receive state-funded services.

The provider community expects, at a minimum, to be reimbursed for the cost of rendering service, and most providers operate as a business, desiring the opportunity to earn a profit when providing efficient care which meets regulatory standards. The Texas HHS system should provide adequate reimbursement to permit client access to necessary and efficiently delivered services of acceptable quality for clients enrolled in state-funded programs.

Reimbursement rates for Medicaid providers are not all established on a cost basis. HHSC develops approximately 46,344 different rates, primarily for the Medicaid program. Of this amount, 360 rates are for health maintenance organizations;

[14] State employees also provide mental health and residential services at state hospitals, state supported living centers and state centers.

1,000 are for long-term services programs; 1,000 are for nursing facilities; 25 for child foster care services; 43 for School Health and Related Services (SHARS); 515 for inpatient hospital standard dollar amounts; 326 for inpatient hospital diagnostic related groups; 40,000 for physicians and other professionals; 2,300 for durable medical equipment; and 700 for therapy providers.

HHSC uses different methodologies dependent upon the information that is available to HHSC and to the public to evaluate the appropriate rates to reimburse providers. CMS requires reimbursement rates for client services be "consistent with efficiency, economy, and quality of care" and be "sufficient to enlist enough providers so that services are available to beneficiaries at least to the extent that those services are available to the general population."

Many Texas Medicaid providers do not receive reimbursement rates sufficient to cover costs incurred to provide services for Medicaid clients and rely on other revenue sources to be able to operate and serve Medicaid clients. The difference between the cost of providing care and the Medicaid reimbursement rate is sometimes referred to as the "Medicaid shortfall."

The rate tables contain overall percent rate changes required to recognize increases/decreases in costs incurred by providers based on various established methodologies. Without additional funding for rate increases, rising costs incurred by providers could erode the quality of services delivered and could result in access-to-care problems for clients if fewer providers are willing to deliver services for the level of Medicaid reimbursement, unless providers can adjust their business practices to reduce costs.

The estimated fiscal impact of a one percent rate change can be used to estimate most of the fiscal impact to the state for each one percent rate increase or decrease in provider reimbursement, though it is important to note that the table does not include all costs to the state related to the cost of rate changes for services delivered through the managed care model. In addition to the rate tables, information is provided on several specific rate issues, including supplemental payment programs, hospital inpatient rates, nursing facility financing, long-term services and supports and compensation for attendant workers.

Supplemental and Directed Payment Programs

Medicaid supplemental and directed payments provide critical funding to health care providers in Texas. Base Medicaid payments don't always reflect what a provider charges or the cost of providing services. Historically, rates paid to hospitals for

services have been below the average costs facilities incur to provide Medicaid covered services. In addition, the expansion of managed care has greatly impacted the way hospitals are funded in Texas.

Through a combination of funding programs, including those established under the 1115 Healthcare Transformation Waiver, HHSC administers supplemental hospital funding to help cover the cost of uncompensated care, incentivize improvements to service delivery, and fund graduate medical education.

The federal government allows each state to develop its own method to reimburse hospitals for the health care they provide to persons with Medicaid. Generally, states' Medicaid payments to hospitals fall into three broad categories: base payments, supplemental payments, and directed payments.

Supplemental Payments

Supplemental payments are Medicaid payments to health care providers that are separate from and in addition to base payments. Supplemental payments give additional funding to certain health care providers, like hospitals. The payments may be made in a lump sum. However, some supplemental payments may be linked to the achieving certain goals or to support health care providers that see significant numbers of uninsured or persons without much money. For example, states may provide supplemental payments to providers to support quality initiatives, residency training for doctors, and certain types of facilities (e.g., rural or safety net providers).

Supplemental payment programs at HHSC include Disproportionate Share Hospital (DSH), Uncompensated Care (UC), Graduate Medical Education (GME), Public Health Provider - Charity Care Program (PHP-CCP), and Hospital Augmented Reimbursement Program (HARP).

Supplemental Payment Programs – Federal and State Authority

Program	Federal Authority	State Authority
Disproportionate Share Hospital	§1923 of the Social Security Act	Texas Medicaid State Plan; Texas Administrative Code (TAC) §§355.8065, 355.8066
Uncompensated Care	§1115 Waiver	TAC §§355.8208, 355.8210, 355.8212, 355.8214
Graduate Medical Education		Texas Medicaid State Plan; TAC §355.8058
Public Health Provider-Charity Care Pool	§1115 Waiver	TAC §§355.8215, 355.8217
Hospital Augmented Reimbursement Program	42 CFR 447.272; 42 CFR 447.321	Texas Medicaid State Plan; TAC §355.8070

Disproportionate Share Hospital

Disproportionate Share Hospital (DSH) payments are statutorily required supplemental payments to hospitals that treat a large number of Medicaid and uninsured individuals. DSH payments are intended to help offset hospitals' cost of providing inpatient and outpatient hospital services to Medicaid and uninsured individuals that is unreimbursed, known as uncompensated care costs.

Federal DSH funding is capped by the federal government. Each state receives an annual DSH allotment which is the maximum amount of federal funding a state will receive for Medicaid DSH payments. To receive federal funding for DSH payments, federal statute requires states to submit an independent certified audit and an annual report to CMS that describes the DSH payments made to each hospital.

State DSH allotments are calculated in accordance with a methodology described in federal statute and are generally based on the state's prior year allotment but

adjusted for inflation.[15],[16] CMS publishes state DSH allotments in the Federal Register. States will not receive additional federal funding if they make DSH payments greater than their allotment. Additionally, states are not required to spend their entire allotment.

The amount of an individual hospital's DSH payment cannot exceed the hospital's cost of providing uncompensated care to individuals who are Medicaid eligible or uninsured. This limitation is known as the "hospital-specific limit" (HSL). In Texas, HHSC calculates two types of HSLs: a state payment cap (formerly known as the "interim HSL"), and the final HSL.

- The state payment cap is defined by HHSC[17] and is calculated in the payment year and determines the interim DSH payment amounts using historical Medicaid and uninsured data.

- The final HSL is the federal payment cap and is defined in federal statute[18] The HSL is calculated during the audit of the program year, which is two years after the payment year, using actual Medicaid and uninsured data to determine whether hospitals were overpaid.

Proposed DSH Reductions

Historically, the DSH program provides reliable financial assistance to certain hospitals. However, the possibility of reducing DSH allotments to states was introduced in the Patient Protection and Affordable Care Act of 2010 (ACA). The DSH allotment reductions were included in the ACA under the assumption that increased insurance coverage through Medicaid expansion and the health insurance exchanges would lead to lower hospital uncompensated care and thereby, lessen the need for DSH payments.[19]

---

[15] §1923(f) of the Social Security Act provides that a state's DSH allotment is calculated by increasing the amount of its DSH allotment for the preceding fiscal year by the percentage change in the consumer price index for all urban consumers for the previous fiscal year. Further, a state's DSH allotment for a fiscal year cannot exceed the greater of the prior year's allotment or 12 percent of the state's total Medicaid spending during the fiscal year.
[16]The American Rescue Plan Act of 2021 (ARPA) temporarily adjusted the DSH allotment calculations to account for the effect of the enhanced FMAP available to states due to the COVID-19 public health emergency.
[17] 1 TAC §355.8066(c)(1)
[18] §1923(g)(1)(A) of the Social Security Act
[19] MACPAC Annual Analysis of Disproportionate Share Hospital Allotments to States, March 2022

Under the ACA, the Medicaid DSH reductions were scheduled to begin in federal fiscal year (FFY) 2014 and continue through FFY 2020. However, numerous pieces of legislation have been passed since 2010 that have delayed their implementation and increased the total amount of the reductions. Most recently, Congress passed the Consolidated Appropriations Act of 2021 which delays the implementation of the reductions until FFY 2024 and extends the reductions through FFY 2027. Under the Consolidated Appropriations Act, the reductions are currently set at $8 billion annually, bringing the total aggregate reductions to $32 billion versus the $18.1 billion that was scheduled under the ACA. In FFY 2028, DSH allotments will rebound to the pre-reduced levels, with annual inflation adjustments for FFY2024 to FFY2027.[20]

DSH allotment reductions will be applied using the DSH Health Reform Reduction Methodology (DHRM). This methodology uses specific statutorily defined criteria, such as applying greater DSH reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals.[21]

According to the most recent analysis by the MACPAC, reductions will affect states differently, with estimated reductions ranging from 6.4 percent to 90 percent of unreduced allotment amounts. Smaller reductions are applied to states with historically low DSH allotments (low-DSH states). Among states that do not meet the low-DSH criteria, which includes Texas, the projected percentage reduction in DSH allotments is larger for states that expanded Medicaid as of January 1, 2021 (61.1 percent in the aggregate), than for states that did not expand Medicaid (58.8 percent in the aggregate). For Texas, MACPAC estimates a reduction of 41 percent of Texas' unreduced DSH allotment for FFY 2024.[22] While it is unknown how each state will respond to the reductions, MACPAC reports that states may be able to offset some of the effects of DSH allotment reductions by increasing other types of Medicaid payments to providers.

Uncompensated Care

Uncompensated care (UC) payments are intended to help offset the costs of uncompensated care provided by hospitals and other health care providers. UC payments are authorized under the 1115 waiver. The UC funding pool was first established in December 2011 when the 1115 waiver was approved. From

[20] https://crsreports.congress.gov/product/pdf/IF/IF10422
[21] MACPAC Annual Analysis of Disproportionate Share Hospital Allotments to States, March 2022
[22] MACPAC Annual Analysis of Disproportionate Share Hospital Allotments to States, March 2022

December 2011 through September 2019 (waiver demonstration years 1-8), UC payments were used to defray the actual uncompensated cost of medical services[23] provided to Medicaid eligible or uninsured individuals by hospitals, clinics, and certain other health care providers.

Beginning October 1, 2019, the UC program transitioned to a charity care model and UC payments could only be used to defray the actual uncompensated cost of medical services provided to uninsured individuals who meet a provider's charity-care policy.[24] This change meant that UC payments could no longer be used to reimburse providers for the Medicaid shortfall or bad debt.

Annual UC payments are limited to the annual UC pool limits approved under the 1115 waiver. The annual UC pool is authorized at $4.51 billion for FFYs 2023 to 2027. The UC pool will then be recalculated to determine the annual limits for FFYs 2027 to 2030.[25]

Providers eligible to receive UC payments include public and private hospitals, public ambulance providers, physicians, and public dental providers.

Graduate Medical Education

Multiple funding sources reimburse teaching hospitals for the cost of Graduate Medical Education (GME). The largest funding source comes from the federal government through Medicare. According to an analysis by the United States Government Accountability Office (GAO) in 2018, three-quarters of federal GME spending was from Medicare.[26] The second largest funding source is through state Medicaid programs.

Medicaid GME payments support teaching hospitals that operate approved medical residency training programs. Teaching hospitals typically incur additional costs

---

[23] Medical services must meet the definition of medical assistance contained in section 1905(a) of the Social Security Act.

[24] A provider's charity-care policy must adhere to the Healthcare Financial Management Association (HFMA) charity-care principles. Charity-care includes full or partial discounts given to uninsured individuals who meet the provider's financial assistance policy.

[25] STC 41 of the 1115 waiver (approved January 2021) requires the UC pool to be resized twice during the duration of the waiver. The first resizing determines the annual limits for DYs 12-16 (FFYs 2023-2027) and is based on a reassessment of actual uncompensated care cost data for 2019. The second resizing determines the annual limits for DYs 17-19 (FFYs 2028-2030) and is based on a reassessment of actual uncompensated care cost data for 2025. The annual UC limits for DYs 12-16 are included in the CMS' approval letter dated June 8, 2022.

[26] Congressional Research Service, September 29, 2022, Medicare Graduate Medical Education Payments: An Overview

because they are a training site for medical school graduates to receive hands-on, practical experience in treating patients. In addition to medical residents' salary and benefits, teaching hospitals also incur additional costs for more testing and for treating sicker and more complex patients.

Texas' Medicaid GME supplemental payments provide reimbursement for Medicaid inpatient direct GME costs, such as resident salaries, faculty salaries, administration, and overhead.[27] Hospitals eligible to receive Medicaid GME supplemental payments include state owned teaching hospitals and non-state government-owned and operated teaching hospitals.[28]

Public Health Provider Charity Care Pool

The Public Health Provider - Charity Care Pool (PHP-CCP) provides payments to qualifying providers to reimburse them for the cost of delivering certain health care services when those costs are not reimbursed by another source. Health care services include behavioral health services, immunizations, public health services, and other preventative services.

The PHP-CCP funding pool is authorized under the 1115 waiver approved January 2021. The first year of the program began October 1, 2021.

In accordance with the special terms and conditions of the current 1115 waiver, to participate in the program, qualifying providers must be funded by a unit of government able to certify expenditures.[29] Qualifying providers include:

- Publicly owned and operated Community Mental Health Clinics, community centers, Local Behavioral Health Authorities, and Local Mental Health Authorities, that are established under Chapters 533 and 534 of the Texas Health and Safety Code and are primarily providing behavioral health services

[27] In addition to Medicaid GME supplemental payments, state-owned and non-state owned Texas teaching hospitals also receive Medicaid GME support in the form off an add-on to their Medicaid hospital inpatient reimbursement. This add-on, called Indirect Medical Education (IME), is an adjustment to the base "standard dollar amount" assigned to each hospital to reflect higher patient care costs for teaching hospitals compared with those at non-teaching hospitals..
[28] Effective, October 1, 2018, HHSC expanded Medicaid direct GME payments to non-state government owned and operated teaching hospitals (Texas Medicaid State plan amendment approval letter dated February 21, 2019)
[29] STC 39(a)

- Publicly owned and operated Local Health Departments and public health districts that are established under Chapter 121 of the Texas Health and Safety Code

For the first year of the program (October 1, 2021, to September 30, 2022), PHP-CCP payments may be used to defray uncompensated costs, including the Medicaid shortfall and bad debt. Then starting October 1, 2022, the program shifts to a charity care model and PHP-CCP payments may only be used to defray uncompensated costs associated with services provided to patients under the provider's charity care policy.

The annual PHP-CCP pool limit is authorized at $500 million for the first two years of the program (FFYs 2022 to 2023). The pool will then undergo resizing for FFYs 2024-2028, and again for FFYs 2029-2030, based on a reassessment of providers' actual uncompensated charity care costs.[30]

A provider must submit an annual application to the state containing cost and payment data on services eligible for reimbursement under the PHP-CCP program.

Hospital Augmented Reimbursement Program

The Hospital Augmented Reimbursement Program (HARP) is a statewide supplemental program providing Medicaid payments to hospitals for inpatient and outpatient services that serve Texas Medicaid fee-for-service (FFS) patients. The program serves as a financial transition for providers historically participating in the Delivery System Reform Incentive Payment program. HARP provides additional funding to hospitals to offset the cost hospitals incur while providing Medicaid services. On August 31, 2022, HHSC received CMS approval to implement HARP for non-state government-owned and operated hospitals. The approval is retroactive to October 1, 2021. HHSC's request to implement HARP for private hospitals is pending CMS approval.

[30] STC 41 of the 1115 waiver (approved January 2021) requires the PHP-CCP pool to be resized twice during the duration of the waiver. The first resizing determines the annual limits for DYs 13-17 (FFYs 2024-2028) and is based on a reassessment of actual uncompensated care cost data for the most recent available year. The second resizing determines the annual limits for DYs 18-19 (FFYs 2029-2030) and is based on a reassessment of actual uncompensated care cost data for the most recent available year.

Directed Payments

In 2016, CMS created a new option for states to direct managed care plan to pay providers according to specific rates or methods. This payment arrangement is referred to as a directed payment.

Directed managed care payments are authorized under 42 CFR 438.6(c)(1)(i) through (iii), which specifies ways states may set parameters for Medicaid managed care spending to help states to achieve their overall goal of delivery system and payment reform, as well as improved performance. Specifically, it allows Medicaid MCOs to make payments to health care providers at the specific direction of the Medicaid agency when the payments support overall Medicaid program goals and objectives, either through an adjustment to the monthly base capitation rates or through a separate payment term.

Current Directed Payment Programs at HHSC consist of the Comprehensive Hospital Increase Reimbursement Program (CHIRP), Quality Incentive Payment Program (QIPP), Texas Incentives for Physician and Professional Services (TIPPS), Rural Access to Primary and Preventive Services (RAPPS) and Directed Payment Programs for Behavioral Health Services (DPP-BHS).

Directed Payment Programs – Federal and State Authority

Program	Federal Authority	State Authority
Comprehensive Hospital Increase Reimbursement Program	42 CFR §438.6(c)	TAC §§353.1301, 353.1306, 353.1307
Quality Incentive Payment Program	42 CFR §438.6(c)	TAC §§353.1301, 353.1302, 353.1304
Texas Incentives for Physician and Professional Services	42 CFR §438.6(c)	TAC §§353.1301, 353.1309, 353.1311
Rural Access to Primary and Preventive Services	42 CFR §438.6(c)	TAC §§353.1301, 353.1315, 353.1317
Directed Payment Program for Behavioral Health Services	42 CFR §438.6(c)	TAC §§353.1301, 353.1320, 353.1322

Comprehensive Hospital Increase Reimbursement Program

The Comprehensive Hospital Increase Reimbursement Program (CHIRP) is a directed payment program (DPP) that provides increased Medicaid payments to hospitals for inpatient and outpatient services provided to persons enrolled in STAR and STAR+PLUS Medicaid managed care programs. The program began as the Uniform Hospital Rate Increase Program (UHRIP) in state fiscal year 2018. UHRIP was renewed annually in state fiscal year 2019, 2020 and 2021.

For state fiscal year 2022, HHSC implemented several changes for the program, including renaming the program, CHIRP. To continue incentivizing hospitals to improve access, quality, and innovation in the provision of hospital services, HHSC developed new eligibility requirements, hospital classes and financing components for the program. HHSC implemented new quality metrics for evaluating the program and new reporting requirements as a condition of participation in the program.

Six classes of hospitals are eligible to participate in CHIRP: (1) children's hospitals, (2) rural hospitals, (3) state-owned hospitals that are not institutions for mental diseases (IMDs), (4) urban hospitals, (5) non-state-owned IMDs and (6) state-owned IMDs.

CHIRP funds are paid through two components of the managed care capitation rates:

- The Uniform Hospital Rate Increase Payment (UHRIP) provides a uniform rate increase payment that is based on a percentage of the Medicare gap (the difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services).

- The Average Commercial Incentive Award (ACIA) is an optional component that a hospital may choose to apply for. It provides a uniform rate increase payment that is based on a percentage of the average commercial reimbursement (ACR) gap (the difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services), less payments received under the UHRIP component. ACIA payments are capped at 90 percent of the total estimated ACR for the hospital class.

MCOs are directed to increase the reimbursement rate to enrolled hospitals for inpatient and outpatient services. The percentage increase is uniform for hospitals within a class within a service area, but increases may vary between classes of hospitals based on the hospital's choice to participate in the optional component, ACIA.

Participating hospitals must semi-annually report data for all measures for which they are eligible as a condition of participation in the program.

Quality Incentive Payment Program

The Quality Incentive Payment Program (QIPP) is a performance-based DPP that provides incentive payments to qualifying nursing facilities that meet performance requirements on specified quality metrics or program-specific targets. Medicaid MCOs with STAR+PLUS beneficiaries are directed to make payments to qualifying nursing facilities once the facilities demonstrate meeting the required goals.

Two classes of providers are eligible to participate in QIPP: (1) non-state government-owned nursing facilities, and (2) private nursing facilities.

QIPP funds are paid through four components of the STAR+PLUS managed care capitation rates:

- Component 1 is equal to 110 percent of the estimated amount of the non-federal share and provides a uniform rate increase payment paid monthly. Only non-state government-owned nursing facilities are eligible for Component 1.

- Component 2 is equal to 40 percent of the remaining QIPP funds after accounting for the funding of Components 1 and 4. It provides a monthly payment that is triggered by achievement of performance requirements.

- Component 3 is equal to 60 percent of the remaining QIPP funds after accounting for the funding of Components 1 and 4. It provides a quarterly payment that is triggered by achievement of performance requirements.

- Component 4 is equal to 16 percent of the total value of the program and provides a quarterly payment that is triggered by achievement of performance requirements. Only non-state government-owned nursing facilities are eligible for Component 4.

Texas Incentives for Physician and Professional Services

The Texas Incentives for Physician and Professional Services (TIPPS) is a DPP for certain physician groups providing health care services to children and adults enrolled in the STAR, STAR+PLUS and STAR Kids Medicaid managed care programs. The TIPPS program was implemented in state fiscal year 2022 as a part of an effort to replace funding provided under the Texas Delivery System Reform Incentive Payment (DSRIP) program and the Network Access Improvement Program (NAIP)[31].

Three classes of physician groups are eligible to participate in TIPPS: (1) Health-Related Institution (HRI) physician groups, (2) Indirect Medical Education (IME) physician groups and (3) other physician groups.

TIPPS funds are paid through three components of the managed care capitation rates:

[31] NAIP provides pass-through payments to participating physician practices in health-related institutions and public hospitals through managed care. NAIP operates within the 1115 waiver under authority conferred in 42 CFR 438.6(d). Under federal law, pass-through payments to physicians must be phased out by July 1, 2022, and pass-through payments to hospitals must be phased out by July 1, 2027.

- Component 1 is equal to 65 percent of the total program value and provides a uniform dollar increase paid monthly. Only health-related institutions and indirect medical education physician groups are eligible for Component 1.

- Component 2 is equal to 25 percent of the total program value and provides a uniform rate increase paid semi-annually. Only health-related institutions and indirect medical education physician groups are eligible for Component 2.

- Component 3 is equal to 10 percent of the total program value and provides a uniform rate increase for applicable outpatient services and is paid at the time of claim adjudication. All participating physician groups are eligible for Component 3.

Participating physician groups must semi-annually report data for all measures in the components for which they are eligible as a condition of participation in the program.

Rural Access to Primary and Preventive Services

The Rural Access to Primary and Preventive Services (RAPPS) is a DPP for rural health clinics (RHCs) that provide primary and preventive services to persons in rural areas of Texas enrolled in STAR, STAR+PLUS and STAR Kids Medicaid managed care programs. The RAPPS program was implemented in state fiscal year 2022 to help continue funding for key activities started under DSRIP.

Two classes of RHCs are eligible for the program: (1) Hospital-based RHCs, which include non-state government-owned and private RHCs, and (2) free-standing RHCs.

RAPPS funds are paid through two components of the managed care capitation rate:

- Component 1 is equal to 75 percent of the total program value and provides a uniform dollar increase paid monthly that is based on RHC class.

- Component 2 is equal to 25 percent of the total program value and provides a uniform rate increase on applicable services.

Participating RHCs must semi-annually report data for all measures as a condition of participation in the program.

Directed Payment Program for Behavioral Health Services

The Directed Payment Program for Behavioral Health Services (DPP-BHS) is a DPP for Community Mental Health Centers (CMHCs) and Local Behavioral Health Authorities (LBHAs) to promote and improve access to behavioral health services, care coordination, and successful care transitions. It also incentivizes continuation of care for STAR, STAR+PLUS and STAR Kids members using the Certified Community Behavioral Health Clinic (CCBHC) model of care. In state fiscal year 2022, HHSC implemented the DPP-BHS program as a part of an effort to replace the DSRIP program funding.

Two classes of providers are eligible for the program: (1) CMHCs and LBHAs with the CCBHC certification and (2) CMHCs and LBHAs without CCBHC Certification. LBHAs were added as an eligible provider beginning in state fiscal year 2023 (year two).

DPP BHS funds are paid through two components of the managed care capitation rates:

- Component 1 is equal to 65 percent of the total program value and provides a uniform dollar increase paid prospectively on a monthly basis.
- Component 2 is equal to 35 percent of the total program value and provides a uniform rate increase applied to the top 20 CCBHC codes and is paid at the time of claim adjudication.

Participating DPP-BHS providers must semi-annually report data for all measures as a condition of participation in the program.

1115 Waiver Approval and DSRIP Replacement Programs

Texas recently received approval of a 10-year extension on its 1115 waiver which included significant to changes to supplemental and directed payment programs, including programs designed to replace the expiring DSRIP funding pool.

1115 Waiver Approval

On January 15, 2021, CMS approved a 10-year extension of the waiver through September 30, 2030. However, on April 16, 2021, CMS sent HHSC a letter notifying the state that it was rescinding its approval letter issued on January 15, 2021.[32] CMS's purported rationale for rescinding the prior approval related to CMS's public notice provisions, which CMS had previously agreed to waive pursuant to the public

[32] Letter from CMS to HHSC (April 16, 2021) (https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tx-healthcare-transformation-cms-ltr-st.pdf)

health emergency. On May 14, 2021, the Texas Office of the Attorney General sought legal redress and filed a complaint in federal court against CMS. On August 20, 2021, the court issued a preliminary injunction, ordering that CMS treat the waiver as remaining in effect as it existed on April 15, 2021.[33] This meant that CMS and HHSC were to operate under the special terms and conditions (STCs) of the January 2021 waiver while the litigation continued.

The January 2021 waiver included new STCs related to the state's submission and approval of directed payment programs. In March 2021, HHSC submitted five proposed directed payment programs for state fiscal year 2022. CMS sent HHSC several rounds of requests for additional information for each proposed directed payment program from April 2021 to July 2021 to which HHSC responded.

After reviewing the state's response to CMS's requests for additional information, under STC 33 CMS was required to issue a formal decision letter or notify the state within 20 calendar days that further modifications were required. However, although CMS required additional modifications, HHSC did not receive a written request from CMS until August 13, 2021.[34] HHSC issued a response letter to CMS on August 16, 2021, that stated Texas' desire to work with CMS toward approval of its proposed directed payment programs, requested more specificity from CMS about the modifications needed, and indicated that it looked forward to beginning regular meetings to resolve CMS's concerns.[35]

On August 26, 2021, as required by STC 34, HHSC and CMS commenced regular meetings that occurred every two business days. The last meeting between HHSC and CMS occurred on March 24, 2022. In addition to meeting every two business days, HHSC also responded to multiple rounds of CMS questions from September 2021 to March 2022. On March 25, 2022, HHSC received CMS approval of the pending directed payment programs proposed for state fiscal year 2022.[36]

---

[33] Opinion and Order, Texas v. Brooks-LaSure, No. 6:21-cv-00191 (E.D. Tex. 2021)
[34] Letter from CMS to HHSC (August 13, 2021) (https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/medicaid-supp-pay/cms-letter-sdp-texas.pdf)
[35] Letter from HHSC to CMS (August 16, 2021) (https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/medicaid-supp-pay/20210816-letter-mr-tsai.pdf)
[36] On November 15, 2021, CMS approved two of five proposed directed payment programs for state fiscal year 2022: Quality Incentive Payment Program (QIPP) and the Directed Payment Program for Behavioral Health Services (DPP BHS). On March 25, 2022, CMS approved the remaining three proposed directed payment programs: Comprehensive Hospital Increase Reimbursement Program (CHIRP), Texas Incentives for Physicians and

On April 22, 2022, CMS withdrew their April 16, 2021 rescission letter and confirmed the January 2021 waiver was in effect.[37]

DSRIP Replacement Programs

When the 1115 waiver was first approved in 2011, HHSC received the authority to create a supplemental payment program known as DSRIP. Through the DSRIP funding pool, HHSC made incentive payments to providers who engaged in innovations and reforms that were meant to improve access to care, quality of care, and population health outcomes.

Under the terms of the December 2017 waiver extension, the DSRIP funding pool expired on September 30, 2021. Prior to the funding pool ending, HHSC was required to submit a transition plan to CMS describing how the state will further develop its delivery system reform efforts without DSRIP funding and/or phase out DSRIP funded activities. In its DSRIP transition plan, HHSC proposed a series of directed payment programs to sustain key DSRIP initiative areas and support further delivery system reform after DSRIP ended. A new supplemental payment program, the Public Health Provider Charity Care Pool (PHP-CCP), was part of the DSRIP transition plan to continue financial support for local public providers following the expiration of the DSRIP pool.

Non-Federal Share Funding

All states are required to provide the non-federal share of Medicaid funding to receive federal matching funds referred to as federal financial participation (FFP). The non-federal share can include:

- State General Revenue appropriated for Medicaid.
- Contributions from units of local government provided to the state through:
    - Intergovernmental transfer (IGT)[38],[39]

Professional Services (TIPPS), and Rural Access to Primary and Preventive Services (RAPPS).

[37] Letter from CMS to HHSC (April 22, 2022) (https://www.hhs.texas.gov/sites/default/files/documents/cms-letter-04222022.pdf)

[38] §1903(w)(6) of the Social Security Act and 42 CFR §433.51 specify that funds transferred from or certified by units of government within a state may be used as the non-federal share of Medicaid expenditures.

[39] §1903(w)(7)(G) of the Social Security Act defines a unit of local government as a "city, county, special purpose district, or other governmental unit in the state".

IGTs are transfers of public funds from a governmental entity to the state. The state receives federal matching Medicaid funds for IGTs used as the non-federal share. The transfer of funds must occur before a Medicaid payment is made; or

- Certified public expenditures (CPEs)

  CPEs are expenditures that have been certified by a governmental entity to represent its contribution of public funds in providing services that are eligible for federal matching Medicaid funds. Governmental entities report CPEs to the state and the state will then claim the federal matching funds. States have the flexibility to retain some of the matching funds.

- Health care-related taxes

  Health care-related taxes are defined as a licensing fee, assessment, or other mandatory payment that is related to a health care services, the provision of or authority to provide the service, or the payment for the service. A tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.[40],[41]

Under federal statute, at least 40 percent of the state's share of total Medicaid expenditures must be funded using state funds.[42] State funds that may be used to meet the 40 percent requirement include state general funds, health care-related taxes imposed by the state, and intra-agency funds from non-Medicaid state agencies. The remaining 60 percent of the state's share of total Medicaid expenditures may be derived from local governments, including health care-related provider taxes imposed by the local government.[43]

---

[40] Health care-related taxes are defined at §1903(w)(3) of the Social Security Act and 42 CFR §433.55.
[41] Health care-related taxes must be broad-based (i.e., imposed on all nonfederal, nonpublic providers within a category of services in the state), uniformly imposed (e.g., the tax is the same amount for all providers furnishing the services within the same category), and not hold providers harmless (e.g., must not provide a direct or indirect guarantee that providers will receive all or a portion of tax payments back). (§1903(w)(3) of the Social Security Act and 42 CFR §433.68)
[42] §1902(a)(2) of the Social Security Act
[43] GAO-21-98, CMS Needs More Information on States' Financing and Payment Arrangements to Improve Oversight, December 2020

Non-Federal Share Funding in Texas

State general revenue has generally not been available to support the non-federal share of Medicaid supplemental and directed payments in Texas. Therefore, most of the non-federal share for these payments is funded using public funds provided by local governmental entities in Texas.

There are many eligible sources of public funds that a local governmental entity may use to fund the Medicaid program, including:

- State-appropriated funding
- Funds received through the implementation of an ad valorem tax
- Funds appropriated from other local governmental entities
- Patient revenue (so long as no federal payor program funds are used)
- Tuition or fees at state institutions of higher education
- Implementation of a health-care-related tax

In Texas, some jurisdictions also chose to implement a Local Provider Participation Fund (LPPF), which is an account in a financial institution (e.g. bank) in which a local government entity deposits a health-care related tax that is collected from local health care providers. The LPPF is administered by an existing unit of local government and designed specifically to meet federal requirements associated with eligible local funds. The local government operating an LPPF will collect mandatory payments (i.e., taxes) from the non-public hospitals located in the local government's jurisdiction. LPPF funding collected by the local governmental entity is provided to HHSC through an IGT for use as the non-federal share of Medicaid payments.

There are three main methods used to support the non-federal share of Texas' Medicaid supplemental and directed payment programs: IGTs, IGTs using LPPF funds, and CPEs. The method used for each program is identified in the table below.

Non-Federal Share Funds Used for Texas Medicaid Supplemental and Directed Payment Programs

Program	IGT	CPE
Disproportionate Share Hospital	X[44]	
Uncompensated Care	X	X[45]
Graduate Medical Education	X	
Public Health Provider-Charity Care Pool		X
Hospital Augmented Reimbursement Program	X	
Comprehensive Hospital Increase Reimbursement Program	X	
Quality Incentive Payment Program	X	
Texas Incentives for Physician and Professional Services	X	
Rural Access to Primary and Preventive Services	X	
Directed Payment Program for Behavioral Health Services	X	

[44] Non-federal share of Disproportionate Share Hospital (DSH) payments is primarily provided by the major, urban hospital districts in Texas. (1 TAC §355.8066(h)(2)(C)(iii)(III))
[45] CPEs are only used to fund the non-federal share of uncompensated care payments to governmental ambulance providers.

Federal Medical Assistance Percentage (FMAP)

The Medicaid and CHIP programs are funded by a combination of state and federal funds but have different federal matching rates.

Medicaid Matching Funds

Medicaid is funded by a combination of federal and state funds. The federal share of Medicaid spending, known as federal financial participation (FFP), is provided on a matching basis. This means the federal government will reimburse each state a set share of its Medicaid spending. The share that the federal government pays in each state varies and is determined by each state's FMAP rate[46].

FMAP rates are calculated annually according to a formula described in federal statute and are based on a state's per capita income relative to the national average[47]. As a state's per capita income increases in relation to national per capital income, the FMAP rate decreases. For FFY 2022, the Texas FMAP was set at 60.80 percent[48].

Texas uses a state fiscal year-adjusted FMAP that considers the differences between the federal fiscal year (FFY), which runs October – September, and the state fiscal year (SFY), which runs September – August. For SFY 2022, the Texas FMAP is 60.88 percent (one month of FFY 2021 FMAP of 61.81 percent and 11 months of FFY 2022 FMAP of 60.80 percent).

[46] The federal share for Medicaid administrative costs does not vary by state and is generally set at 50 percent, although certain administrative functions have a higher federal match.
[47] §1905(b) of the Social Security Act
[48] Published in the Federal Register.

Federal Matching Rates Affected by the COVID-19 Public Health Emergency

The federal Families First Coronavirus Response Act (FFCRA) included a temporary 6.2 percentage point increase to FMAP during the COVID-19 public health emergency. The temporary increase is not included in the FMAP amounts referenced above. As of January 1, 2023, the most recent Public Health Emergency declaration will expire in January. The recently passed federal Consolidated Appropriations Act, 2023 (which became P.L. 117-328 on 12/29/2022) delinks the enhanced FMAP from the PHE authorization. The legislation provides for a phase-out of enhanced funding over nine months for states that adhere to certain conditions beginning April 1, 2023.

The American Rescue Plan Act provided qualifying states with a temporary 10 percentage point increase to FMAP for home and community-based services (HCBS) between April 1, 2021 to March 31, 2022. To receive the increased FMAP for HCBS services, HHSC must maintain eligibility requirements for HCBS services until the state savings are fully expended towards activities that enhance or strengthen HCBS. Savings will be used for variety of activities that will enhance or strengthen HCBS infrastructure, recipient supports, and support providers per Federal requirements.

CHIP Matching Funds

Unlike Medicaid, the Children's Health Insurance Program (CHIP) is a federal block program rather than an entitlement program. Total federal funds allotted to CHIP each year are capped, as are the funds allotted to each state. Each state is allotted a portion of the total federal funds based on a formula set in federal statute, and each state receives federal matching payments up to the allotment.

In addition, CHIP offers a more favorable federal matching rate than Medicaid. The federal CHIP funds that states receive are based on the enhanced federal medical assistance percentage (EFMAP). Derived from each state's average per capita income, CMS updates this rate annually. Consequently, the percentage of total CHIP spending that is paid with federal funds also changes annually. For FFY 2022, the Texas EFMAP was set at 72.56 percent[49].

Texas uses a state fiscal year-adjusted FMAP that considers the differences between the federal fiscal year (FFY), which runs October – September, and the state fiscal year (SFY), which runs September – August. For SFY 2022, the Texas EFMAP is

[49] Published in the Federal Register.

72.62 percent (one month of FFY 2021 EFMAP of 73.27 percent and 11 months of FFY 2022 FMAP of 72.56 percent).

The Affordable Care Act (ACA) temporarily increased the EFMAP for FFYs 2016 through 2019. Following the end of this increase, the EFMAP rate was decreased by 23 percentage points.

See Appendix 2 for additional details about FMAP/EFMAP and Per Capita Personal Income.

Medicaid and CHIP Supplemental Funding Need

HHSC has historically received supplemental appropriations in each legislative session for additional needs above appropriations in entitlement programs like Medicaid client services, or to account for other changes over the interim that create an additional need. Supplemental appropriations are typically net of HHSC surpluses in other programs that can be transferred to partially offset the overall need.

This section presents an analysis of HHSC's estimated 2022-23 supplemental funding needs and offsetting funding surpluses as of September 2022. Supplemental estimates are updated as HHSC completes forecast updates throughout the legislative session.

HHSC's estimated 2022-23 supplemental funding needs and offsetting funding surpluses as of September 2022 appear in the table below. The rest of this section provides additional detail on items contributing to the supplemental need.

HHSC Estimated 2022-23 Supplemental Funding Need (as of September 2022)

Item	State Funds
Medicaid	
Client Services	(1,046.8)
Federal Matching Rates	(404.0)
Cost Containment	(350.0)
Program Changes	(39.5)
Revenue Collections	(4.4)
Disaster Transfers	(200.0)
Other Actions	(1,850.0)
Medicaid Total	(3,894.7)
Children's Health Insurance Program (CHIP)	
Client Services	247.0
Federal Matching Rates	(7.2)
CHIP Total	**239.8**
Agency-wide Total	**(3,654.9)**

Medicaid

HHSC is projecting a $3,654.9 million supplemental need in Goal A, Medicaid Client Services. Without supplemental HHSC estimates that the agency will not be able to

[50] State funding includes General Revenue Funds, General Revenue-Dedicated Funds, and Other Funds (including Interagency Contracts, Appropriated Receipts, Subrogation Receipts, or Public Health Medicaid Reimbursements).

make payments to Medicaid providers beginning in May 2023. Primary factors contributing to the shortfall include:

- Significant growth in Medicaid caseload due to the public health emergency (PHE) and suspension of disenrollments
- Appropriation reductions assumed in the 2022-23 General Appropriations Act (GAA)
- Transfer of funds out of Medicaid to the Department of State Health Services (DSHS) to assist with the agency's COVID-19 response

Detail on factors contributing to the shortfall is below.

Client Services

HHSC is projecting an additional $1,046.8 million supplemental need in Medicaid for acute care, long-term care, and other medical services. This projection is based on the Base Reconciliation Forecast using data through March 2022. Estimated need by major category of client service is noted in the table below.

Estimated Need for Baseline Services in Medicaid

Client Services	State Funds (millions)
Medicaid Acute Care for Full Benefit Clients	(898.8)
Medicaid Long-Term Care Entitlement	0.0
Medicaid Long-Term Care Non-Entitlement	23.4
Medicaid Other Medical Services	(171.4)
Total	**(1,046.8)**

Forecast and Other Key Assumptions Regarding Medicaid Shortfall Estimate

- Baseline client service need in Medicaid is primarily driven by caseload and cost assumptions. See the Medicaid and CHIP Caseload and Cost section of this document for additional details.

- PHE Impact: The forecast assumes a PHE end date of October 2022, which includes the following assumptions concerning caseloads and cost:

    - Suspension of disenrollments: HHSC cannot disenroll existing Medicaid clients determined ineligible during the COVID-19 emergency period. Beginning in April 2020, the PHE and suspension of disenrollments has led to consistent monthly caseload growth. This growth is expected to continue over the PHE period, which was set to expire in mid-October 2022 as of this estimate, with disenrollments beginning in November 2022[51].

        - Stimulus FMAP: The Families First Coronavirus Response Act (FFCRA) provided qualifying states with a temporary 6.2 percentage point increase to the Federal Medical Assistance Percentage (FMAP) for certain Medicaid expenditures. To receive the increased FMAP, HHSC must maintain Medicaid coverage for most people enrolled in Medicaid until the end of the month in which the PHE ends. The increased FMAP would continue through the end of the federal fiscal quarter in which the PHE ends. The forecast assumes the increased FMAP from January 2020 through December 2022. See the Medicaid Matching Funds section of this document for more details.

    - The tipping point, or the point at which monthly costs associated with the PHE Maintenance of Eligibility (MOE) exceed the monthly benefit of the FMAP, was projected to have occurred in May 2022. The inflection point, or the point at which all monthly COVID-19 impact costs begin to exceed

[51] The PHE has been renewed since the Base Reconciliation forecast. As of January 1, 2023, the most recent declaration will expire in January. The recently passed federal Consolidated Appropriations Act, 2023 (which became P.L. 117-328 on 12/29/2022) will also cause changes to the agency's assumptions. A critical part of this legislation is that it delinks the enhanced FMAP from the PHE authorization. The legislation provides for a phase-out of enhanced funding over nine months for states that adhere to certain conditions beginning April 1, 2023.

the benefit of the FMAP, is still estimated to have occurred late summer of 2021.

- Other assumptions impacting the Medicaid supplemental need include:
  - Caseload growth associated with an increase in unemployment levels;
  - Testing and treatment-related costs for COVID-19;
  - Temporary rate increases for hospitals and nursing facilities removed effective November 2022;
  - Temporary rate increases for intellectual and developmental disabilities (IDD) waivers removed effective April 2023;
    - Assumption on end date is based on federal guidance to continue PHE efforts for waiver programs up to six months after the end of the PHE, which was assumed to occur in mid-October 2022.
  - Lower use experienced in various fee-for-service programs and services will begin to return to normal levels after the end of the PHE;
  - Extension of coverage for women enrolled in Medicaid for Pregnant Women from two to six months postpartum effective September 2022 pursuant to House Bill 133, 87th Legislature, Regular Session, 2021; and
  - Reflection of final managed care rates for fiscal year 2022.

The table below shows the average monthly historical and projected caseload for Medicaid entitlement full-benefit and Medicaid long-term services and supports programs from fiscal years 2020 through 2023.

Average Monthly Client Service Caseloads for Fiscal Years 2020 – 2023

Program	FY 2020	FY 2021	FY 2022	FY 2023
Medicaid Entitlement Full-Benefit	3,984,967	4,682,819	5,286,226	5,012,215
Medicaid Non-Entitlement Long Term Services and Supports	37,704	37,585	38,461	40,394

Federal Matching Rates

HHSC is projecting an additional $404.0 million supplemental need in Medicaid due to differences between the FMAP assumed in the 2022-23 General Appropriations Act (GAA) and the actual, final FMAP for state fiscal year 2023.

The GAA historically includes a Special Provision Relating to All Health and Human Services Agencies that specifies the FMAP assumptions used to determine state and federal appropriations for that biennium. For the 2022-23 biennium, Special Provisions 4, Federal Match Assumptions and Limitations on Use of Available General Revenue Funds, provides the federal match percentages assumed in Article II appropriations. The first fiscal year of the biennium is based on actual FMAP, while the second fiscal year is based on assumed FMAP, as the final FMAP are not known at the time of the bill's development. If actual FMAP is lower than what is assumed in the GAA, additional state funds are required to finance the Medicaid program over what was assumed in the GAA.

The 2022-23 GAA assumed an FMAP of 61.07 percent for state fiscal year 2023. Since the publication of the GAA, the federal Health and Human Services Department issued final FMAPs for states. The final FMAP for state fiscal year 2023 is 59.95 percent, resulting in an additional $404.0 million need. These percentages do not include the 6.2 percentage point increase awarded through the FFCRA.

PHE-Impacted Federal Matching Rates

The Families First Coronavirus Response Act (FFCRA) provided qualifying states with a temporary 6.2 percentage point increase to FMAP for certain Medicaid and CHIP expenditures. To receive the increased FMAP, HHSC must maintain Medicaid coverage for most people enrolled in Medicaid until the end of the month in which the PHE ends. HHSC also cannot disenroll clients until the first of the month after

the PHE ends. The increased FMAP would continue until the end of the fiscal quarter in which the PHE ends[52].

The American Rescue Plan Act (ARPA) provided qualifying states with a temporary 10 percentage point increase to FMAP for home and community-based services (HCBS) between April 1, 2021 to March 31, 2022. As a result, HHSC has an estimated $495.2 million in state savings from the increased matching rate to existing 1915(c) waiver services and managed care long-term services and supports. To receive the increased FMAP for HCBS services, HHSC must maintain eligibility requirements for HCBS services until the state savings are fully expended towards activities that enhance or strengthen HCBS. Savings will be spent on a variety of activities that will enhance or strengthen HCBS infrastructure, recipient supports, and support providers per Federal requirements.

Cost Containment

The 2022-23 GAA reduces Medicaid client service appropriations to reflect an assumed savings of $350.0 million associated with cost containment initiatives. The current estimated need reflects the full reduction associated with cost containment. HHSC assumes cost containment efforts will not result in savings sufficient to meet this target and additional state funds will be required to offset the reduction.

Per Rider 24, Health and Human Services Cost Containment, 2022-23 GAA, the initiatives should include:

- Increasing prevention and detection of fraud, waste, and abuse;
- Maximizing federal flexibility under the Medicaid program;
- Insourcing contracted services;
- Encouraging the use of telemedicine, telehealth, or telephone services;
- Applying for a waiver to receive Medicaid funds for services provided in Institutions for Mental Diseases; and

[52] The PHE has been renewed since the Base Reconciliation forecast. As of January 1, 2023, the most recent declaration will expire in January. The recently passed federal Consolidated Appropriations Act, 2023 (which became P.L. 117-328 on 12/29/2022) will also cause changes to the agency's assumptions. A critical part of this legislation is that it delinks the enhanced FMAP from the PHE authorization. The legislation provides for a phase-out of enhanced funding over nine months for states that adhere to certain conditions beginning April 1, 2023.

- Achieving other programmatic and administrative efficiencies, including efficiencies identified in Rider 27, Medicaid Program Efficiencies.
    - Efficiencies identified in Rider 27 include: 1) streamlining Medicaid provider enrollment; 2) Streamlining managed care enrollment and disenrollment; 3) Reducing paper waste; and 4) Modernize use of electronic communication.

Program Changes

HHSC is projecting an additional $39.5 million supplemental need in Medicaid to add applied behavior analysis (ABA) services as a new Medicaid benefit.

The 2022-23 GAA identified $111.9 million in All Funds ($43.7 million in General Revenue Funds) included in appropriations in Goal A, Medicaid Client Services, for ABA services. HHSC held a public hearing on proposed Medicaid payment rates for the Medicaid biennial calendar fee review on December 13, 2021, which included a proposed rate increase for certain autism services above the level that was assumed in the 2022-23 GAA. The current estimate includes an estimated $11.3 million in General Revenue Funds associated with the proposed rate increase for the 2022-23 biennium.

Per Rider 28, Applied Behavioral Analysis, 2022-23 GAA, ABA evaluation and treatment was implemented as a new, covered benefit for Texas Medicaid recipients who are 20 years or younger and who meet eligibility criteria. The benefit took effect February 1, 2022.

Program-generated Revenue

HHSC is projecting an additional $4.4 million supplemental need in Strategy A.4.1, Non-Full Benefit Payments, due to an anticipated reduction in Public Health Medicaid Reimbursement revenues. The need is based on Department of State Health Services (DSHS) projections, the agency responsible for Public Health Medicaid Reimbursement collections, and may vary based on actual collections.

The 2022-23 GAA identified $218.4 million in Public Health Medicaid Reimbursements, including $142.9 million for HHSC and $75.5 million at DSHS, appropriated for various programs at the two agencies. According to the DSHS Monthly Financial Report for May 2022, year-to-date collections for Public Health Medicaid Reimbursement revenues totaled $98.5 million as of May 31, 2022.

Public Health Medicaid Reimbursements are third-party revenues generated by the DSHS for newborn screenings. Public Health Medicaid Reimbursements may be used broadly, and the Legislature has historically appropriated additional revenues to DSHS for laboratory services and to HHSC to partially fund inpatient mental health services at state and community mental health hospitals and to reimburse Medicaid. The agencies and strategies that receive Public Health Medicaid Reimbursement appropriations are identified in Special Provisions 14, Limitation: Expenditure and Transfer of Public Health Medicaid Reimbursements, 2022-23 GAA.

Pursuant to Special Provisions 14, if actual Public Health Medicaid Reimbursements are insufficient to support appropriated amounts, a reduction shall be made in HHSC Strategy A.4.1, Non-Full Benefit Payments.

Disaster-related Transfers

HHSC had originally projected an additional $1,000.0 million supplemental need in Medicaid to replace General Revenue Funds that was transferred to DSHS for cashflow related to COVID-19 response. HHSC will continue to have a supplemental need until DSHS receives reimbursement through Federal Emergency Management Agency (FEMA) Public Assistance funding and returns the funds back to HHSC. DSHS returned $800.0 million of the original $1,000.0 million transfer to HHSC on May 10, 2022.

In the event of a disaster proclamation by the Governor, Article IX, Section 14.04, Disaster Related Transfer Authority, 2022-23 GAA, permits the Commissioner of Health and Human Services to transfer funds among Article II agencies of the GAA for disaster response. Article II agencies of the GAA are not typically appropriated state funding for disaster response, and instead utilize the transfer flexibility afforded through Article IX, Section 14.04 of the GAA to respond to a disaster. HHSC historically has reflected a supplemental need to replace funding transferred from Goal A, Medicaid Client Services, to other strategies or agencies for disaster response.

HHSC submitted notification in October 2021 to transfer funds from Goal A, Medicaid Client Services, to DSHS Strategy A.1.1, Public Health, to allow DSHS to assist local healthcare providers with surge medical staffing and supplies related to COVID-19 response.

Other Actions

HHSC is projecting a combined $1,850.0 million supplemental need due to other Medicaid reductions and transfer authority included in the 2022-23 GAA. The reductions and transfers are noted below in Table 3.

Table 3. Other Actions Impacting Goal A, Medicaid Client Services

Item	General Revenue (millions)	Impacted Goal or Strategy	Associated Rider in 2022-23 GAA
Medicaid Reduction	(1,850.0)	Strategy A.1.1, Aged and Medicare-Related	
Individualized Skills and Socialization Benefit	(0.0)	Goal A, Medicaid Client Services	Rider 23
Intellectual and Developmental Disability System Redesign	(0.0)	Goal A, Medicaid Client Services	Rider 25
Total	**(1,850.0)**		

The 2022-23 GAA includes a reduction of $1,850.0 million in General Revenue Funds in Strategy A.1.1, Aged and Medicare-Related.

The 2022-23 GAA does not include reductions associated with the Individualized Skills and Socialization (ISS) benefit or Intellectual and Developmental Disability (IDD) System Redesign, but allows HHSC to transfer existing appropriations from Goal A, Medicaid Client Services, in order to implement the items. The current estimated need assumes transfers authorized by rider can be paid for using freed-up General Revenue Funds made available through the HCBS 10 percentage point increase. If the freed-up General Revenue Funds are not sufficient to cover ISS benefit or IDD system redesign costs, additional state funds will be required to offset the transfer.

Individualized Skills and Socialization Benefit

HHSC's Exceptional Item 9, Community Integration, in the 2022-23 Legislative Appropriations Request included $90.5 million in All Funds ($35.3 million in General Revenue Funds) to bring the current day habilitation model used by the Home and Community-based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind Multiple Disabilities (DBMD) waiver programs administered by HHSC into compliance with Federal rule related to engagement in community life, integrated work environments, and control of personal resources.

Rider 23, Individualized Skills and Socialization, 2022-23 GAA, allows HHSC to transfer General Revenue Funds from Goal A, Medicaid Client Services, without approval or notification to provide for reimbursement for the provision of ISS services. Any transfers made to provide for reimbursement for the provision of ISS services contribute to the Medicaid shortfall in fiscal year 2023.

The rider also authorizes HHSC to transfer funds from Goal A, Medicaid Client Services, to Strategy I.2.1, Long-Term Care Intake & Access, in fiscal year 2023 to address staffing needs related to the provision of ISS services and increase the agency FTE authority by 6.0 FTEs.

Intellectual and Developmental Disability System Redesign

House Bill 4533, 86th Legislature, Regular Session, 2019, requires HHSC to collaborate with the Intellectual and Developmental Disability System Redesign Advisory Committee and to establish and collaborate with a pilot program workgroup to develop and implement a Medicaid pilot program to provide managed LTSS for certain individuals with IDD or similar functional needs.

HHSC's Exceptional Item 8, IDD System Redesign, in the 2022-23 Legislative Appropriations Request included funding for the 2022-23 biennium to develop critical infrastructure to support legislative requirements for the operation of a pilot and the future transition of the IDD 1915(c) waiver programs to managed care.

Rider 25, STAR+PLUS Pilot Program and Medically Fragile Benefit, authorizes HHSC to transfer $5.0 million in General Revenue Funds from Goal A, Medicaid Client Services, without approval or notification to implement the STAR+PLUS pilot and the medically fragile benefit. The rider also allows HHSC to increase FTE authority by 2.0 FTEs in fiscal year 2022 and 14.0 FTEs in fiscal year 2023.

CHIP

HHSC is projecting a $239.8 million General Revenue surplus in Goal C, CHIP Client Services. This surplus may be available to partially offset the Medicaid supplemental need in the 2022-23 biennium. Primary factors contributing to the surplus include:

- Declines in CHIP caseload due to the PHE and suspension of disenrollments in Medicaid, which has resulted in declining CHIP caseloads due to eligible individuals transferring to or sustaining enrollment in Medicaid instead of CHIP; and
- Declines in CHIP applications during the PHE.

Client Services

HHSC is projecting an estimated $247.0 million in General Revenue surplus in CHIP for perinatal, prescription, and other medical and dental services. This projection is based on the Base Reconciliation Forecast Update using data received through March 2022. Estimated surplus by major category of client service is noted in the table below.

Estimated Need for Baseline Services in CHIP

Client Service	State Funds (millions)
CHIP	$167.2
CHIP Perinatal Services	$4.5
CHIP Prescription Drugs	$34.3
CHIP Dental Services	$26.6
Total	$247.0

Forecast and Other Key Assumptions Regarding CHIP Surplus Estimate

- PHE Impact: The forecast assumes a PHE end date of April 2022, which includes the following assumptions concerning caseloads and cost:

- Suspension of disenrollments: HHSC cannot disenroll existing Medicaid clients determined ineligible during the COVID-19 emergency period. This has resulted in consistent monthly declines in CHIP, as children that would have otherwise transitioned from Medicaid to CHIP continue to stay enrolled in Medicaid.

- Other assumptions impacting the CHIP surplus estimate include:
  - Caseload growth associated with an increase in unemployment levels; and
  - Testing and treatment-related costs for COVID-19.

The table below shows the average monthly historical and projected caseload for Medicaid entitlement full-benefit and Medicaid long-term services and supports (LTSS) programs from fiscal years 2020 through 2023.

Average Monthly Client Service Caseloads for Fiscal Years 2020 – 2023

Program	FY 2020	FY 2021	FY 2022	FY 2023
CHIP	340,731	238,849	101,808	213,764
CHIP Perinatal	28,670	25,916	27,241	27,474

Federal Matching Rates

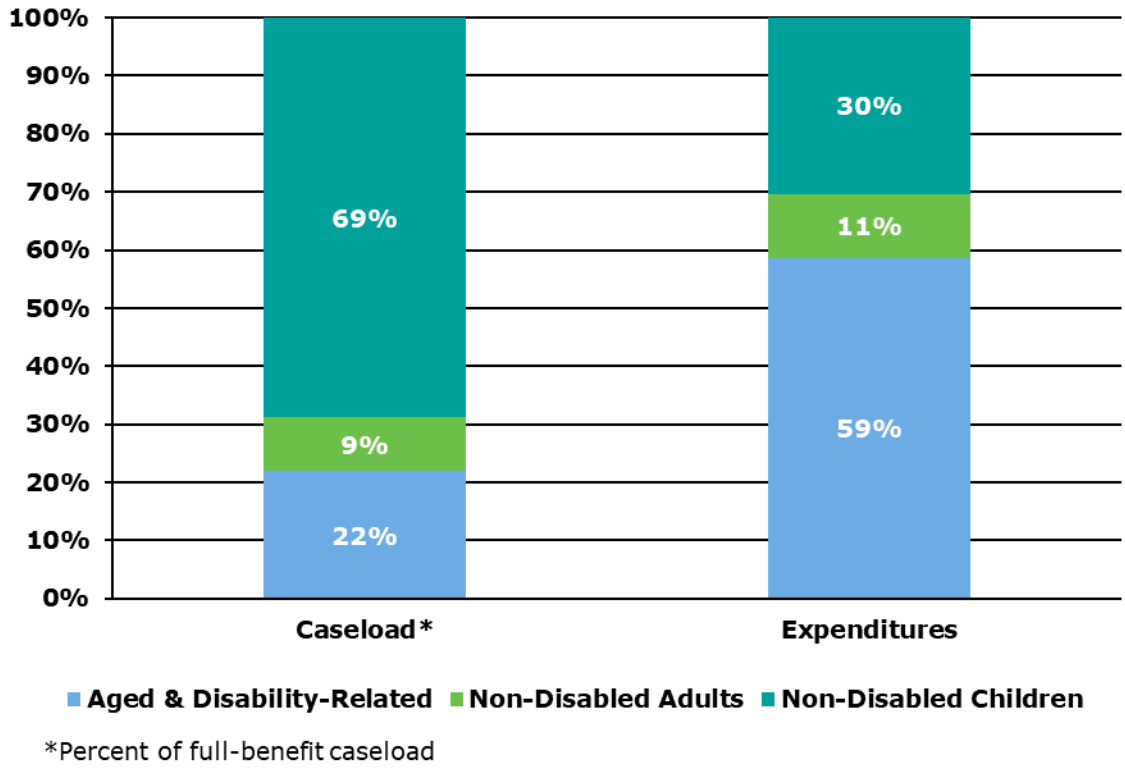
HHSC is projecting an additional $7.2 million supplemental need in CHIP due to differences between the enhanced FMAP (EFMAP) assumed in the 2022-23 GAA and the actual, final EFMAP for state fiscal year 2023.

The 2022-23 GAA assumed an EFMAP of 72.74 percent for state fiscal year 2023. Since the publication of the GAA, the federal Health and Human Services Department issued final EFMAPs for states. The final EFMAP for state fiscal year 2023 is 71.96 percent, resulting in an additional $7.2 million need. These percentages do not include the 6.2 percentage point increase awarded through the FFCRA.

Medicaid and CHIP Caseload and Cost

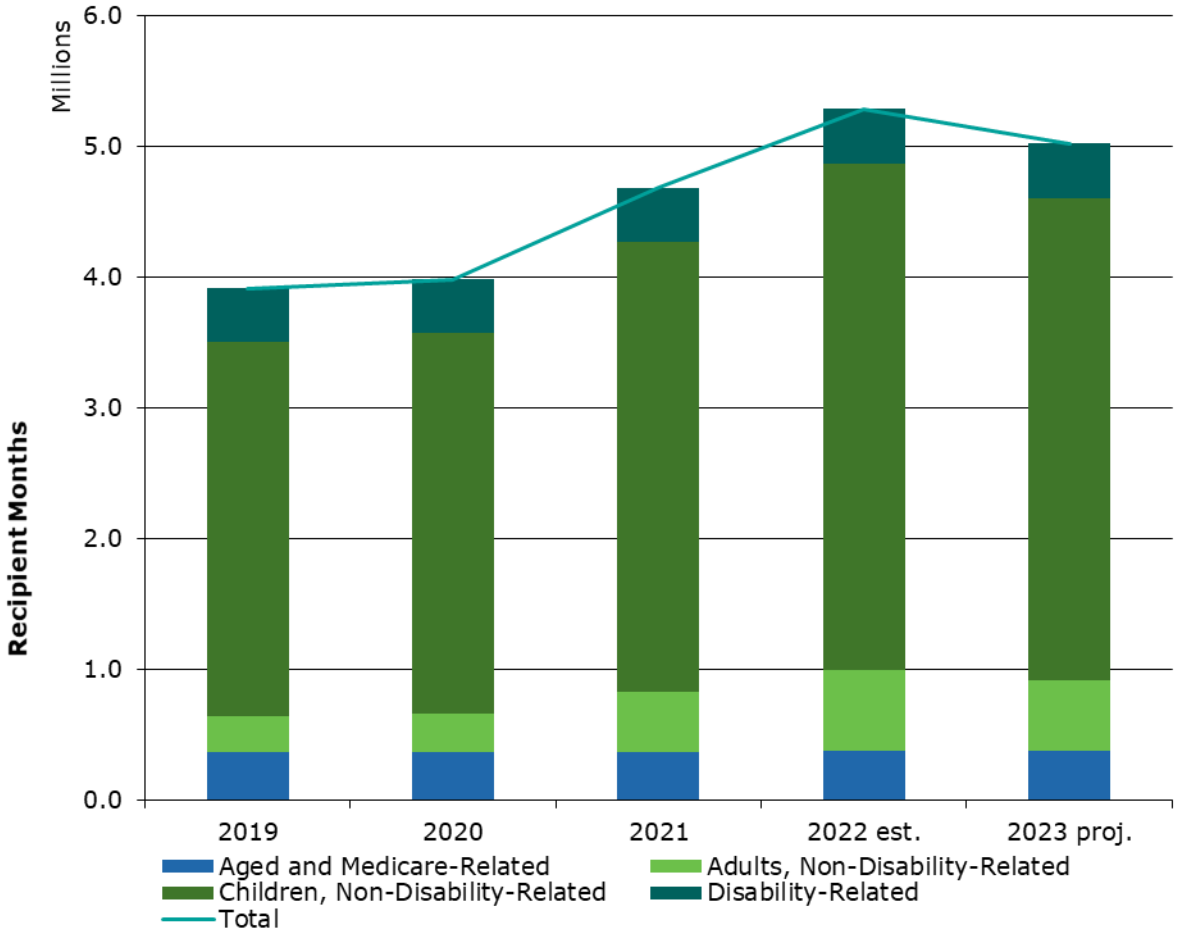
The Medicaid and CHIP programs primary cost drivers are changes in caseload and cost per client that are impacted by policy, the economy, and changes in the population. This section illustrates several facets of caseload and cost to illustrate the historical and current impact of these factors. Additional charts and tables may be found in Appendix 3.

Texas Medicaid Percent Caseload vs. Percent Spending – SFY 2021



This chart shows the differences between Medicaid caseload and cost by Medicaid Eligibility Group.

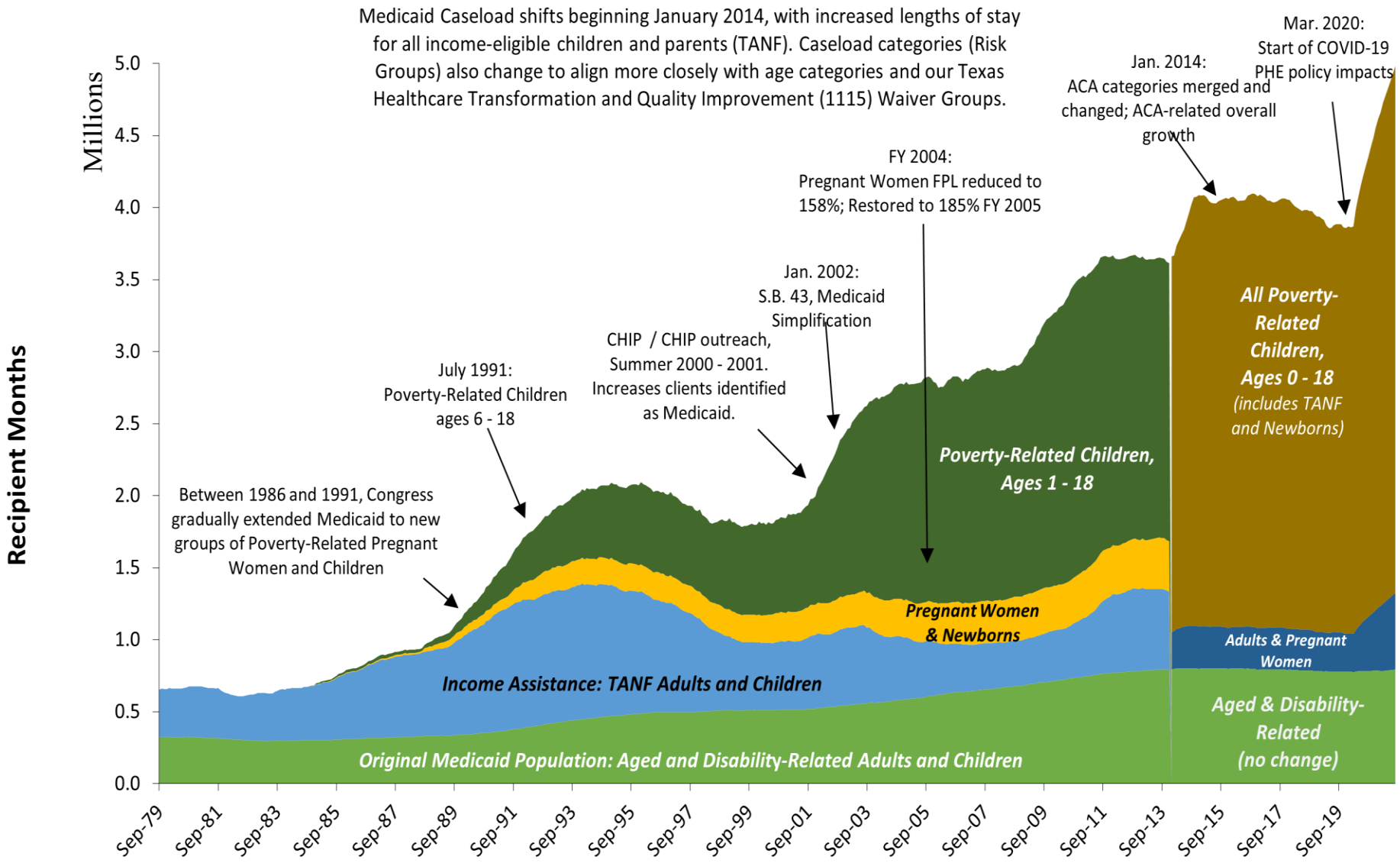
Texas Medicaid Full-Benefit Caseload – SFYs 2019-2023



Note: Non-Disability Related Adults include TANF-level parents and Pregnant Women; children are all non-Disability-Related children under age 21; Disability-Related clients include clients both over and under age 21. Caseloads are measured in average recipient months. FY2023 projection based on June 2022 LAR forecast and PHE October 2022 end.

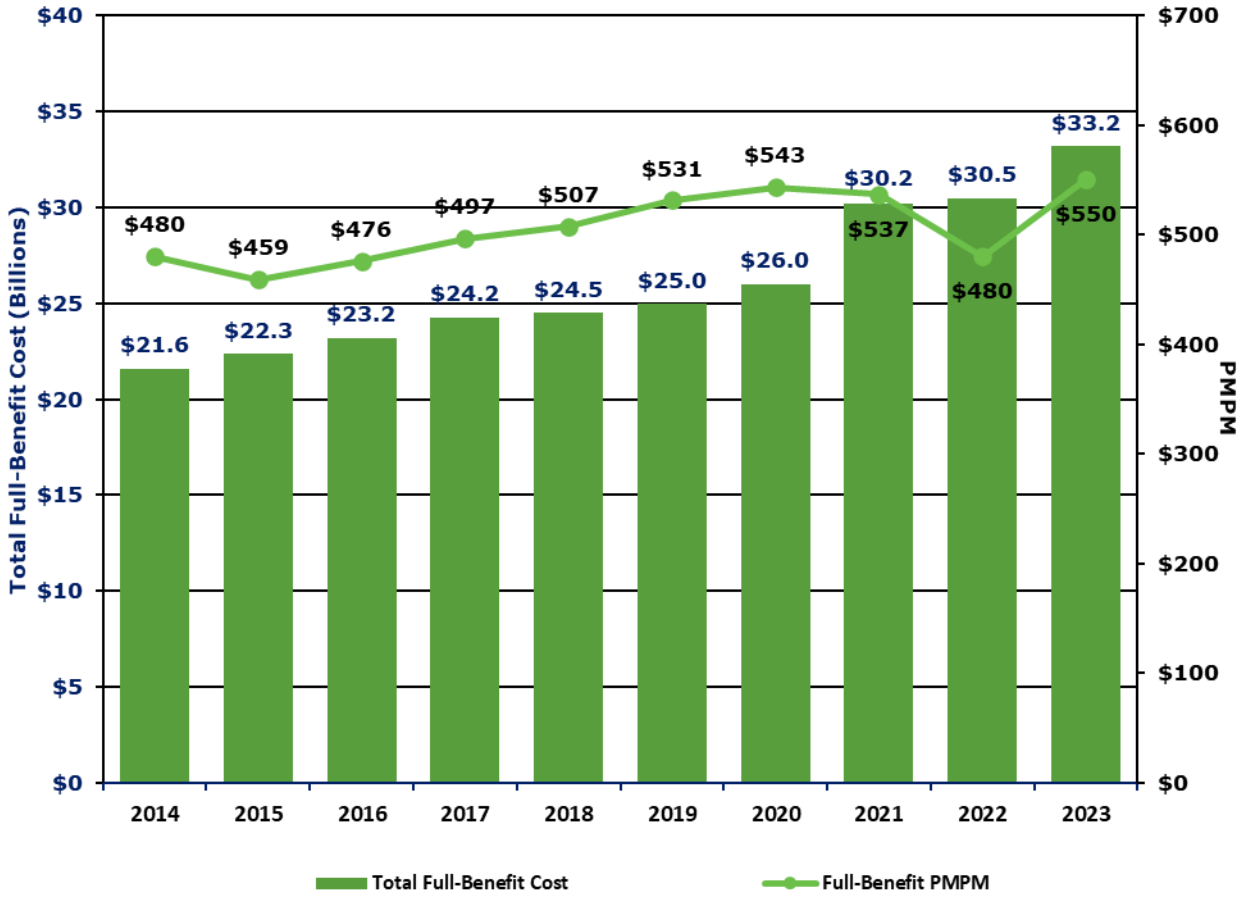
This chart displays Medicaid caseload over time by Medicaid Eligibility Group.

FMAP/EFMAP and Per Capital Personal Income (FFY 2008-2024)



Note: Includes full-benefit caseload only

Texas Medicaid Acute and Long-Term Services Costs, FY 2014-2023: Total and Per Member Per Month Full-Benefit Cost Clients



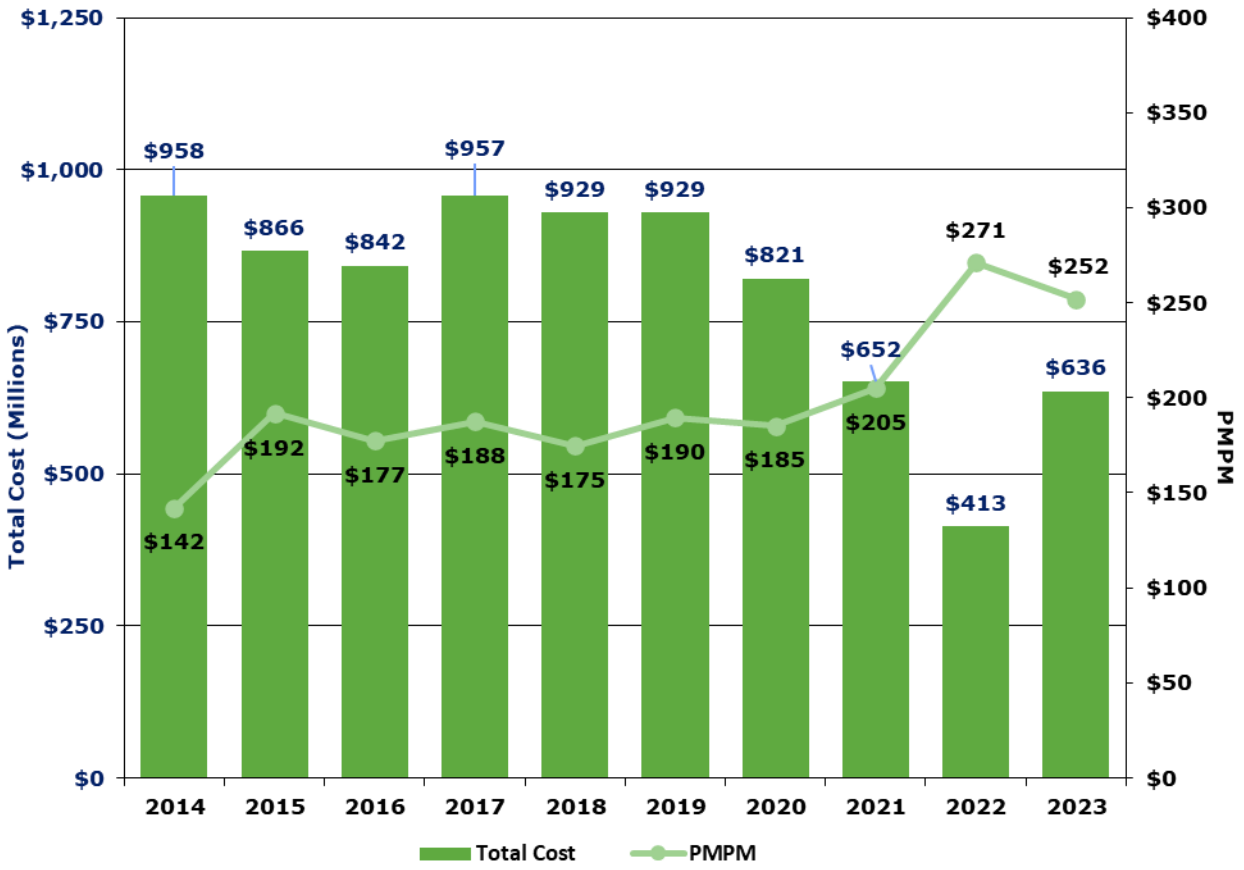
Medicaid Caseload (Recipient Months) and Per Member Per Month Costs with Trends

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
RMs	3,746,124	4,056,702	4,060,564	4,067,380	4,021,686	3,915,011	3,984,967	4,682,819	5,287,561	5,021,963
RM Trend	*2%*	*8%*	*0%*	*0%*	*-1%*	*-3%*	*2%*	*18%*	*13%*	*-5%*
PMPM	$480	$459	$476	$497	$507	$531	$543	$537	$480	$550
PMPM Trend	*2%*	*-4%*	*4%*	*4%*	*2%*	*5%*	*2%*	*-1%*	*-11%*	*15%*

Notes: FY 2022 is estimated; FY 2023 is projected. Excludes Supplemental & Directed Payment Programs, SHARS, Medicare premiums, clawback, drug rebates, and agency admin. Source: PPS, CMS-37 Historical (FFY).

This table displays Medicaid caseload, total costs, and the average cost per each enrolled member each month beginning in fiscal year 2014. Overall cost per member per month (PMPM) is influenced in fiscal years 2021-2023 by federal public health emergency policy impacting caseload growth. The majority of growth occurred among lower cost non-disability related eligibility groups.

Texas CHIP Costs, FY 2014-2023: Total and Per Member Per Month



CHIP Caseload (Recipient Months) and Per Member Per Month Costs with Trends

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
RMs	561,458	376,366	395,859	425,082	443,115	408,277	369,401	264,765	127,003	210,174
RM Trend	*-11%*	*-33%*	*5%*	*7%*	*4%*	*-8%*	*-10%*	*-28%*	*-52%*	*65%*
PMPM	$142	$192	$177	$188	$175	$190	$185	$205	$271	$252
Trend	*-8%*	*35%*	*-8%*	*6%*	*-7%*	*9%*	*-2%*	*9%*	*20%*	*-8%*

Notes: FY22 is estimated; FY23 is projected. Data includes CHIP Perinatal.
Source: PPS, CMS-21B (FFY). HHSC Forecasting, July 2022. FY 2023 projections based on June 2022 LAR forecast and PHE October 2022 end.

This table displays CHIP caseload, total costs, and the average cost per each enrolled member each month beginning in fiscal year 2014. Overall cost per member per month is influenced in fiscal years 2021-2023 by federal PHE policy impacting caseload growth. Clients that maintained continuous eligibility in Medicaid under PHE policy resulted in traditional CHIP caseload declines while higher cost CHIP Perinatal clients remained steady.

Non-Medicaid Client Services

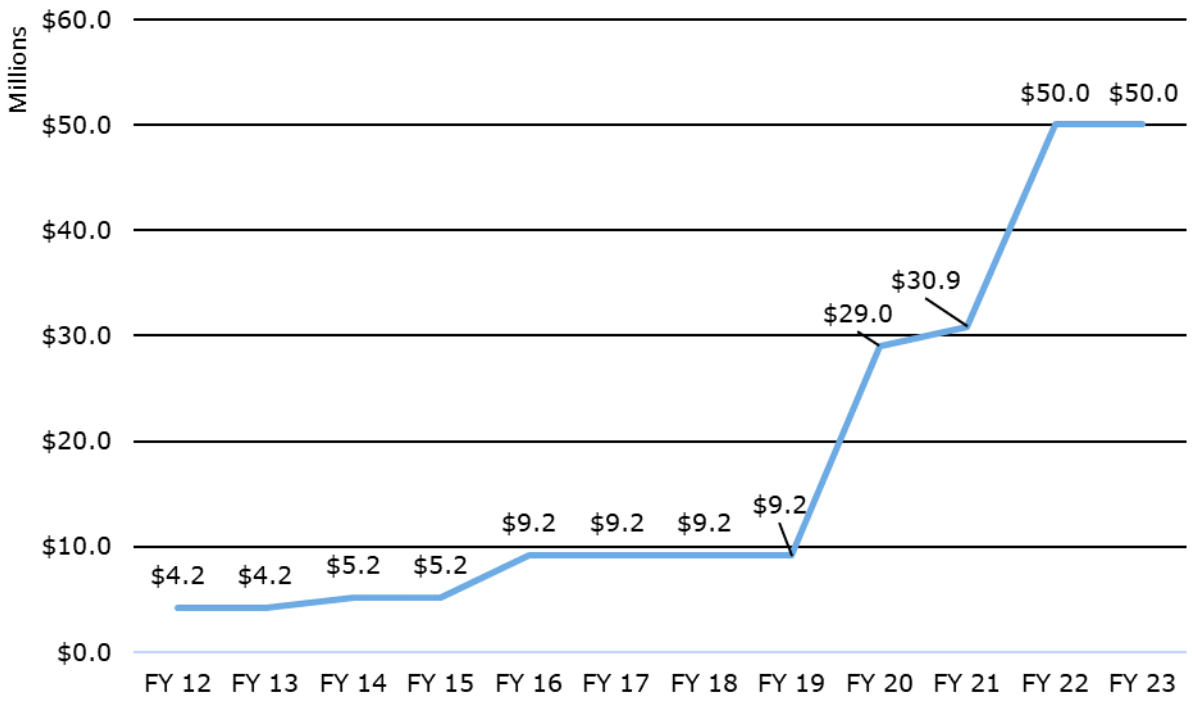
In addition to Medicaid Client Services, HHSC administers a variety of non-Medicaid client service programs, including behavioral health services, Early Childhood Intervention services, women's health programs, kidney health, non-Medicaid nutrition and aging services, among many others.

Alternatives to Abortion

Alternatives to Abortion (A2A) is a statewide program that promotes childbirth and provides support services to pregnant women, their families, and adoptive parents. HHSC uses funds in Strategy D.1.2, Alternatives to Abortion, to contract for coordinated services and support to expectant mother who seek alternatives to abortion in a secure, healthy, and nurturing environment. In fiscal year 2021, services were provided to 126,533 unduplicated clients. The program was established by the General Appropriations Act (2006-07 Biennium), Special Provisions Relating to All Health and Human Services Agencies, Sec. 50.

Appropriations for the A2A program have increased significantly over time, from approximately $8.4 million in the 2012-13 biennium to approximately $100.0 million in the 2022-23 biennium.

Alternatives to Abortion Appropriations – State Fiscal Year 2012 to 2023



Alternatives to Abortion Program Resources:

HHSC Website - Alternatives to Abortion

Alternatives to Abortion Report for Fiscal Year 2021 - December 2021

Behavioral Health

The tables below detail historical funding for statewide behavioral health services, including appropriations provided through the General Appropriations Acts (GAA), supplemental appropriations and reductions, budget execution orders, and off-budget supplemental payments for providers. Funding supports a variety of programs at multiple agencies and articles, including outpatient and inpatient mental health services at the Health and Human Services Commission (HHSC), behavioral health services provided through Medicaid and CHIP, and payments made to providers to promote and improve access to services.

Overall, funding provided for statewide behavioral health services across the last three biennia totals $26.5 billion in All Funds.

Article IX, Sec. 10.04, Statewide Behavioral Health Strategic Plan and Coordinated Expenditures was first added in the 2016-17 General Appropriations Act. The provision:

- Provides an informational listing of appropriations for behavioral health service
- Established a Statewide Behavioral Health Coordinating Council which is chaired by HHSC
- Requires the council to submit a Coordinated Statewide Expenditure Proposal in each fiscal year of the biennium

Behavioral Health Resources:

Coordinated Statewide Behavioral Health Expenditure Proposal FY 2022

Statewide Funding for Behavioral Health Services (millions)

Funding for behavioral health is provided through a variety of mechanisms including funds appropriated in the General Appropriations Act (GAA), appropriations made in supplemental appropriations bills outside of the GAA, off-budget funds through the Delivery System Reform Incentive Payment (DSRIP) program under Texas' Medicaid 1115 Transformation Waiver, and for the 2022-23 biennium, additional funding provided for behavioral health through a Budget Execution Order.

Total behavioral funding has increased by about $1.1 billion (12.8 percent) from the 2018-19 biennium to the 2022-23 biennium.

Statewide Behavioral Health Funding

Funding Source	2018-19	2020-21	% Change	2022-23	% Change	Total
General Appropriations Act[53]	7,604.5	7,783.0		8,120.3		23,507.9
Supplemental Appropriations[54]	15.1	475.1		727.3		1,217.4
Budget Execution Order[55]	0.0	0.0		16.5		16.5
Off-Budget Behavioral Health[56]	598.0	802.6		406.3		1,806.9
Total	**8,217.6**	**9,060.7**	**10.26%**	**9,270.4**	**2.31%**	**26,548.8**

[53] Article IX, Sec. 10.04, 2018-19 General Appropriations Act (GAA), 2020-21 GAA, and 2022-23 GAA. Includes estimated Medicaid and CHIP expenditures.
[54] HB 2, 85th Legislature, Regular Session, 2017; SB 500, 86th Legislature, Regular Session, 2019; HB 2, 87th Legislature, Regular Session, 2021; SB 8, 87th Legislature, Third Called Session, 2021
[55] Budget Execution Order dated June 28, 2022. Supplemental appropriations are reflected in the biennium in which the bill was passed and may not represent when funds will be spent.
[56] Coordinated Expenditure Proposal for Fiscal Year 2022; 2024-25 Legislative Appropriations Request

General Appropriations Act, Article IX, Sec. 10.04 Informational Listing of Appropriations

Non-Medicaid/CHIP Behavioral Health Programs (millions)						
Method of Finance	2018-19	2020-21	%	2022-23	% Change	Total
General Revenue	2,893.6	3,297.7		3,405.2		9,596.5
GR-Dedicated	5.4	33.7		27.4		66.5
Federal Funds	561.2	736.8		766.6		2,064.6
Other Funds	578.5	298.4		145.2		1,022.2
All Funds	**4,038.7**	**4,366.7**	**8.12%**	**4,344.3**	**0.51%**	**12,749.7**
Medicaid/CHIP Behavioral Health Programs (millions)						
All Funds	2018-19	2020-21	%	2022-23	% Change	Total
Medicaid	3,517.1	3,314.9		3,677.1		10,509.1
CHIP	48.7	101.5		98.9		249.1
All Funds, Incl. Medicaid/CHIP[57]	**7,604.5**	**7,783.0**	**2.3%**	**8,120.3**	**4.3%**	**23,507.9**

Supplemental Behavioral Health Appropriations

Over the last three biennia, approximately $1.2 billion in funding for behavioral health has been provided through appropriations made outside of the GAA including several supplemental appropriation bills and a Budget Execution Order. The following tables provides additional information on the source of these supplemental appropriations and the amounts appropriated by each source.

[57] Estimated expenditures in Medicaid and CHIP are provided at an All Funds level and include projected cost growth that is not funded in the GAA

Supplemental Behavioral Health Appropriations by Method of Finance and Legislation

Supplemental Appropriations by Method-of-Finance (millions)				
Method-of-Finance	**2018-19**	**2020-21**	**2022-23**	**Total**
General Revenue	15.1	31.7	16.6	63.4
GR-Dedicated	0.0	0.0	0.0	0.0
Federal Funds	0.0	0.0	405.9	405.9
Other Funds	0.0	443.4	321.3	764.6
Total - All Funds	**15.1**	**475.1**	**743.7**	**1,233.9**
Bill Title	2018-19	2020-21	2022-23	Total
House Bill 85th Legislature, Regular Session, 2021	15.1	0.0	0.0	15.1
Senate Bill 500, 86th Legislature, Regular Session, 2019[58]	0.0	475.1	0.0	475.1
House Bill 2, 87th Legislature, Regular Session, 2021	0.0	0.0	321.4	321.4
Senate Bill 8, 87th Legislature, Third Called Session, 2021	0.0	0.0	405.9	405.9
Budget Execution Order, June 28 2022[59]	0.0	0.0	16.5	16.5
Total - All Funds	**15.1**	**475.1**	**743.7**	**1,233.9**

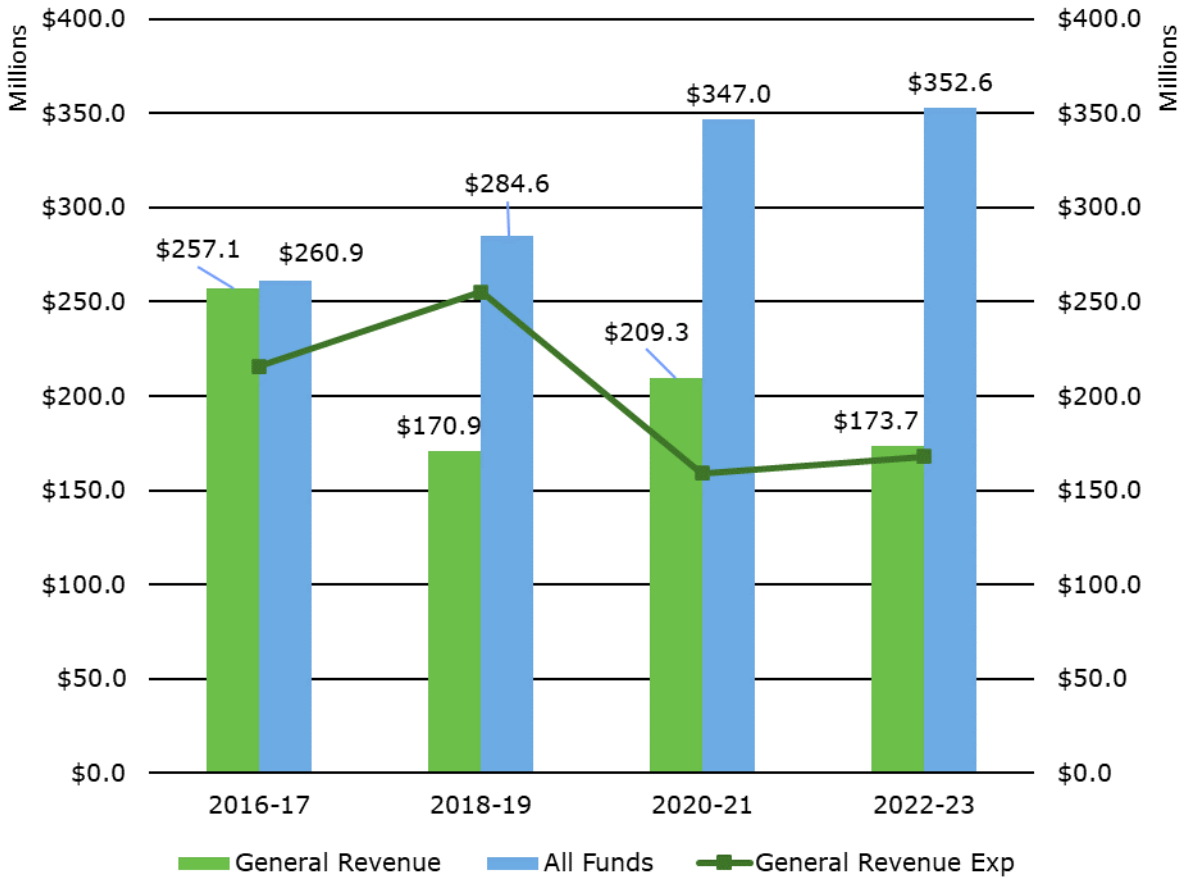
[58] Appropriations listed for Senate Bill 500 do not include $10.6 million in All Funds provided to the Department of Family and Protective Services for substance abuse purchased services, as amounts provided for behavioral health services cannot be disaggregated at this time.

[59] Budget Execution appropriations include $10.7 million in All Funds at the Health and Human Services Commission and $5.8 million in All Funds at the Texas Higher Education Coordinating Board.

Women's Health Programs

Women's Health Programs at HHSC include the Healthy Texas Women Program (HTW), the Family Planning Program (FPP), and the Breast and Cervical Cancer Services (BCCS) Program. Appropriations for Women's Health Programs have increased by approximately $91.7 million All Funds from the 2016-17 biennium to the 2022-23 biennium. However, General Revenue appropriation levels for HTW assumed approval of an HTW 1115 demonstration waiver providing federal matching funds for the HTW program that differed from the actual approval date in January 2020.

Biennial Appropriations and Expenditures – Women's Health Programs (2016-17 Biennium to 2022-23 Biennium)



HTW and FPP offer women's health and family planning services at low cost or no cost to eligible individuals in Texas. BCCS provides no-cost breast and cervical cancer screenings, diagnostics, and patient navigation to eligible Texas women.

Healthy Texas Women

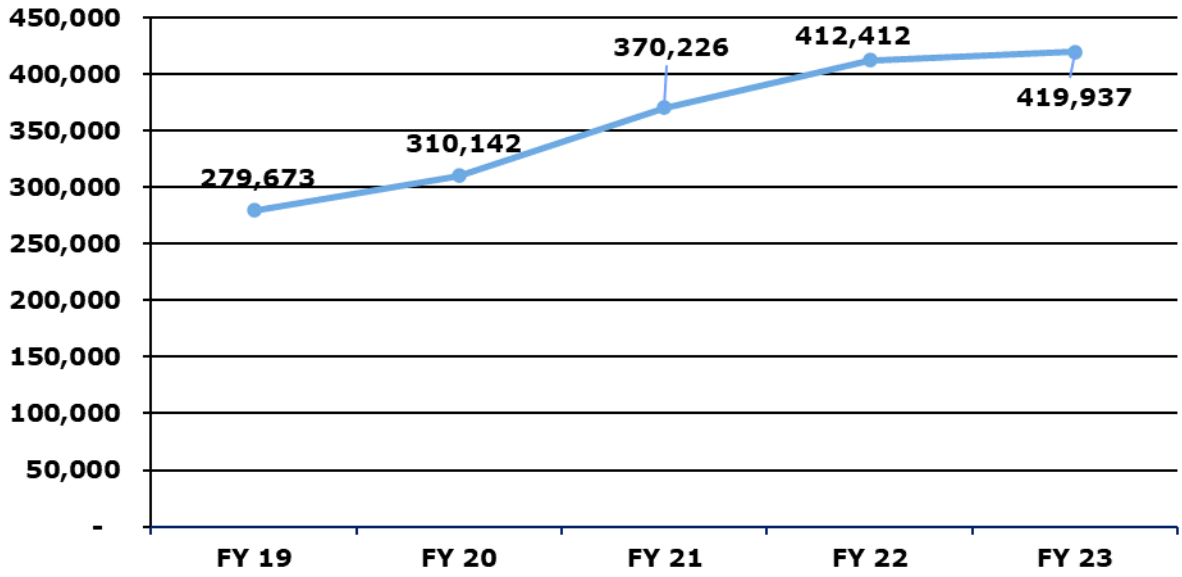
HHSC launched the Health Texas Women (HTW) program in July 2016. In June 2017, HHSC submitted an HTW 1115 Waiver application to the Centers for Medicare and Medicaid Services, which was approved in January 2020. HHSC began to receive federal matching funds for HTW in February 2020. Not all of HTW is covered by the waiver, including cost reimbursement contracts, services for clients under age 18, and HTW+PLUS Services.

FY 2019 appropriations for Strategy D.1.1 assumed HHSC would seek approval to receive federal matching funds for the HTW Program. The 2018-19 GAA included $90.0 million in Medicaid Federal Funds and $10.0 million in General Revenue Match for Medicaid in fiscal year 2019 for HTW (HHSC Rider 104). The waiver application was not approved during the 2018-19 biennium.

The 2020-21 GAA assumed HHSC would receive approval for the HTW 1115 demonstration waiver by September 1, 2019. HHSC received approval from CMS for the waiver in January 2020. HHSC requested and received approval for certain transfers to Strategy D.1.1 in FY 19 and FY 20 to replace Medicaid Federal Funds that were not available because the waiver had not yet been approved.

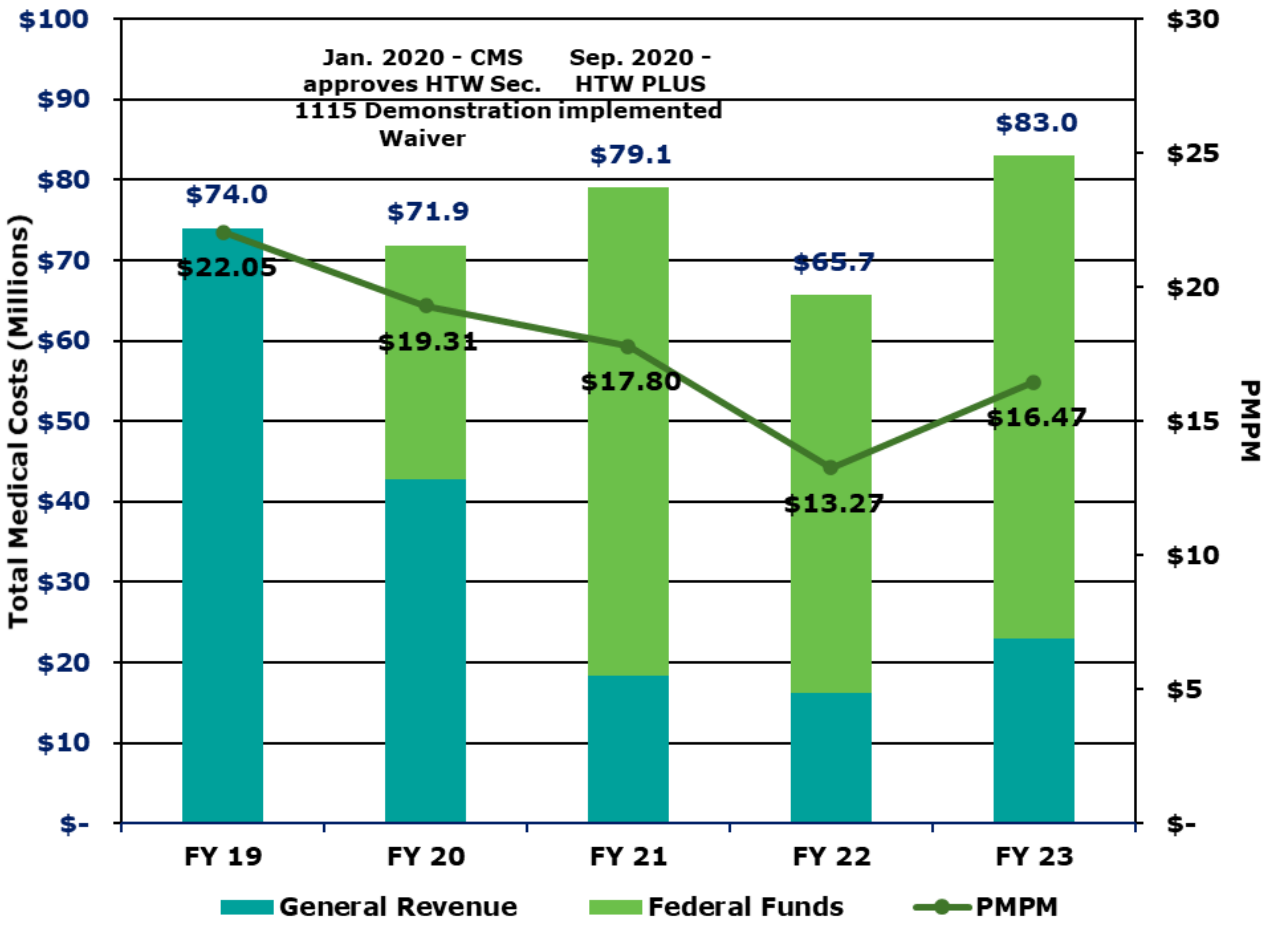
The following tables provide enrollment and expenditure metrics for the HTW program between fiscal year 2019 and fiscal year 2023. Cost per member per month is influenced in fiscal years 2021-2023 by federal PHE policy impacting caseload growth.

Healthy Texas Women: Average Monthly Enrollment



Note: Data as of Sep-22, FY22 is not yet final and FY23 is projected (Jun-22 LAR forecast)

Healthy Texas Women: Total Medical Costs and Per Member Per Month for Enrolled Clients



Note: Does not include categorial costs. PMPM is cost per enrolled client. Data as of Sep-22, FY22 is not yet final and FY23 is projected (Jun-22 LAR forecast)

Women's Health Program Resources:

Texas Women's Health Programs Report - August 2022

https://www.hhs.texas.gov/sites/default/files/documents/texas-womens-health-programs-report-fy2021-august-2022.pdf

Facility-based Services

Facility-based Services include services provided at the State Supported Living Centers (SSLCs) and State Hospitals, residential services and support for persons with intellectual disabilities at the bond homes at Corpus Christi State Supported Living Center, contracted community inpatient psychiatric facilities, and associated program support and capital repairs and renovations.

- SSLCs are state-operated intermediate care facilities for individuals with intellectual disabilities (ICF/IID). HHSC operates 13 SSLCs across Texas (including an ICF/IID component of Rio Grande State Center).
- The mental health state hospital system includes nine state-operated mental health hospitals, including inpatient mental health services at the Rio Grande State Center, and one state-owned inpatient residential treatment facility for adolescents.
- The average monthly census at the SSLCs has decreased significantly over the past 10 years.
- The Texas Legislature has invested more than $1 billion for replacement and renovation of the state hospitals in Austin, Kerrville, Rusk, and San Antonio, and a new hospital in Houston. In addition, the 87th Legislature appropriated another $282.5 million for a new hospital in the Dallas Metroplex, which is still in the planning stages. More information on investments in and changes to the state hospital can be found on the HHSC website and in the State Hospital Infrastructure section in this document.

State Hospital Infrastructure

The Texas Legislature has invested more than $1.3 billion for replacement, renovation, and repair of the state hospital system over the last several biennia. Appropriations have included a variety of fund sources including Economic Stabilization Funds, General Revenue, Master Lease Purchase Program (MLPP) Revenue Bonds, and Coronavirus State Fiscal Recovery Funds (CSFRF).

The table below shows funding for major construction projects since the 2018-19 biennium. Projects are in various stages of completion. Projects followed a three-phased approach originally outlined in HHSC Rider 147 in the 2018-19 General Appropriations Act. Projects began with planning and pre-planning appropriations in

the 2018-10 GAA with two additional phases of construction appropriations provided in the 2020-21 and 2022-23 biennia.

Overview of State Hospital Construction Projects Funding (2018-19 Biennium to 2022-23 Biennium)

Construction Project	Source	2018-19	2020-21	2022-23	Total
Austin State Hospital	ESF	15.5	165.0	124.1	304.6
Kerrville State Hospital	ESF	30.5	-	-	30.5
Rusk State Hospital	ESF	91.5	-	-	91.5
Rusk State Hospital	ESF	4.5	90.1	-	94.6
San Antonio State Hospital	ESF	14.5	190.3	152.4	357.2
San Antonio State Hospital	ESF	11.5	-	-	11.5
DFW Area Hospital	ESF/CSFRF	-	44.8	237.8	282.6
John S Dunn Center	ESF	125.0	-	-	125.0
Total		**293.0**	**490.1**	**514.3**	**1,297.4**
Appropriating Legislation					
2018-19 GAA	ESF	293.0	-	-	293.0
SB 500 (86th Legislature)	ESF	-	445.4	-	445.4
HB 2 (87th Legislature)	ESF	-	44.8	276.5	321.3
SB 8 (87th Legislature, 3rd Called Session)	CSFRF	-	-	237.8	237.8
Total		**293.0**	**490.1**	**514.3**	**1,297.4**

In addition to the major construction projects described above, HHSC received an additional $375.4 million over the last three biennia for other construction projects and deferred maintenance at the state hospitals, including:

- $3.0 million for demolition
- $367.4 million for deferred maintenance ($208.8 million in 2020-21 and $158.6 million in 2018-19)
- $3.8 million for storm water run-off systems
- $0.5 million for fiber infrastructure at Rusk State Hospital

State Hospital Infrastructure Resources:

Health and Human Services Commission Changes to the State Hospital System

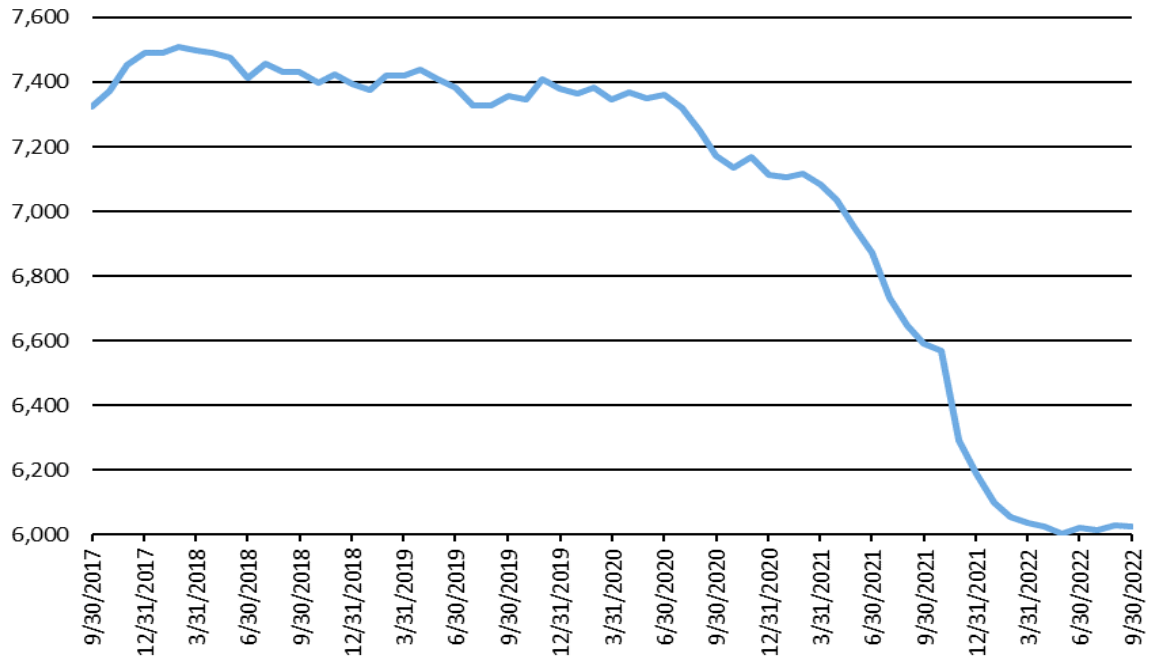
A Comprehensive Plan for State-Funded Inpatient Mental Health Services

State Hospital and SSLC Staffing

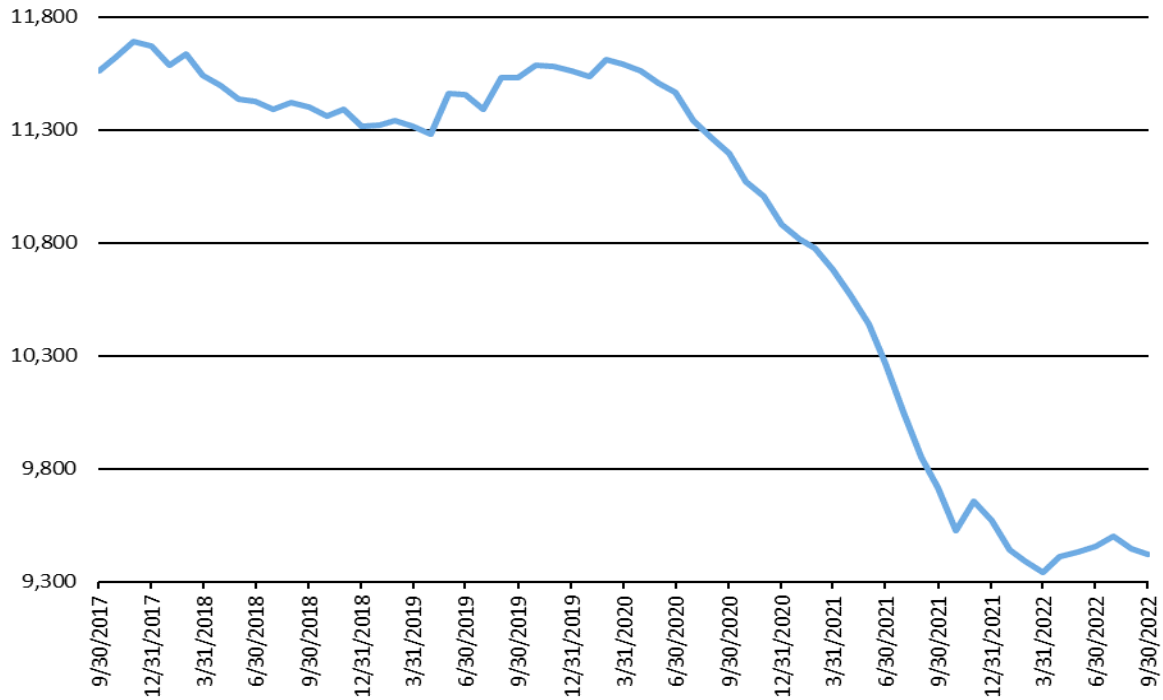
The Health and Human Services Commission has faced significant challenges in recruiting and retaining facilities staff necessary to meet resident-to-staff ratios and keep State Hospital and State Supported Living Centers beds online.

Beginning in March 2022, HHSC implemented on-going salary increases for the 2022-23 biennium to stabilize the declining state hospital workforce using salary lapse caused by high vacancy rates. The salary increase beginning in March 2022 was successful in helping to mitigate the reduction of staffing levels and stabilized staffing numbers but has not significantly helped with recruiting new staff to increase fill rates.

State Hospital Filled Positions 9/30/2017 – 9/30/2022



State Supported Living Centers Filled Positions 9/30/2017 – 9/30/2022



Other Agency Topics

Shared Administrative Services

As the administrator of federally financed public assistance programs as identified in Subpart E of 45 Code of Federal Regulations (CFR) Part 95, HHSC is required to have a public assistance cost allocation plan. All administrative costs (direct and indirect) are normally charged to Federal awards by implementing the public assistance cost allocation plan.

HHSC provides administrative support in a variety of capacities for several different state agencies including:

- Certain administration functions performed on behalf of the HHS System and the Department of Family and Protective Services (DFPS)
- Administrative support for the semi-independent Office of Inspector General (OIG)
- Administrative support for other independent entities, including for the Texas Civil Commitment Office (TCCO) and the HHS Office of the Ombudsman
- Payroll processing for the Cancer Prevention and Research Institute of Texas (CPRIT)

Special Provisions, Sec. 9, System Support Services, outlines amounts appropriated in Article II for annual system support services assessments. HHSC provides administrative support to the Department of State Health Services and DFPS that are subsequently required to be paid by the relevant fund sources at those agencies.

System Support Services Assessment Appropriations

Special Provisions, Sec. 9 includes an informational listing of appropriations to DFPS, DSHS, and HHSC to support Article II system support services assessments. HHSC has submitted updated assumptions for these amounts for the 2024-25 biennium. See the 2024-25 Legislative Appropriations Request Summary section of this document (Other Items of Interest – Special Provisions, Sec. 9, System Support Services) for additional detail.

Master Lease Purchase Program

The Master Lease Purchase Program (MLPP) is a lease revenue financing program established in 1992, primarily to finance capital equipment acquisitions by state agencies, as authorized by Texas Government Code, §1232.102. MLPP may also be used to finance other types of projects that have been specifically authorized by the Legislature and approved by the Texas Public Finance Authority Board.

Under the program, the TPFA borrows money to pay for an agency's equipment or other project by issuing debt instruments (typically commercial paper notes). The agency and TPFA enter into a lease pursuant to which TPFA takes title to the equipment or other project and leases it to the agency which is required to make rent payments to TPFA. TPFA uses the rent payment to pay the principal and interest on the outstanding debt. When the lease is fully paid, the agency receives title to the equipment or other financed project.

HHSC has two MLPP financed capital budget projects appropriated for the 2022-23 biennium:

1) Energy Conservation – provides for debt service payments related to energy conservation projects at the State Supported Living Centers (SSLCs) and State Hospitals. The mandate to implement energy and water conservation projects is found in Texas Government Code Ch. 447. Authority to contract with Texas Public Finance Authority (TPFA) for long-term financing of energy and water conservation projects is found in Texas Government Code, §2166.406 and Article IX, Sec. 6.17, (k) (1)-(3), HB 1, 78th Legislature, Regular Session.

2) Deferred Maintenance – provides for debt service payments related to MLPP funded facility repairs and renovations at the SSLCs and State Hospitals.

Debt service estimates provided by TPFA total $36.1 million in the 2024-25 biennium, an increase of $9.3 million in General Revenue from the 2022-23 biennium.

Fiscal Year 2024-25 Legislative Appropriations Request Summary

The Health and Human Services Commission (HHSC) submitted its Legislative Appropriations Request (LAR) for the 88th Legislative Session (2024-25 biennium) on September 9, 2022. The LAR is a document prepared by each state agency

which details the amount of funding the agency is seeking from the legislature and is developed based on detailed instruction developed and distributed by the Legislative Budget Board (LBB) and the governor's office. The LAR serves as the starting point for the Introduced appropriations bills prepared by the Legislative Budget Board and other funding decisions made throughout the legislative session.

Baseline funding and requested Exceptional Item funding are summarized below.

Health and Human Services Commission, 2024-25 LAR

	2024-25 Baseline LAR Request	2024-25 Exceptional Items	Total
FY 2025 Full-time Equivalents (FTEs)	38,509.3	105.5	38,614.8
Method of Financing			
General Revenue	33,876.0	3,183.4	37,059.4
General Revenue-Dedicated	190.9	0.8	191.6
Federal Funds	50,979.1	3,829.0	54,808,1
Other Funds	1,626.2	-	1,626.2
All Funds	**86,672.3**	**7,013.1**	**93,685.4**

Health and Human Services Commission, Comparison to 2022-23 Appropriated

	2022-23 Appropriated	2024-25 Baseline Request Over/(Under) Appropriated	2024-25 Exceptional Items	2024-25 Total Request
Full-time Equivalents (FTEs)	38,467.3	42.0	105.5	38,614.8
Method of Financing (millions)				
General Revenue	29,652.4	4,223.6	3,183.4	37,059.4
General Revenue-Dedicated	192.0	(1.1)	0.8	191.6
Federal Funds	47,336.5	3,642.6	3,829.0	54,808.1
Other Funds	1,586.5	39.7	-	1,626.2
All Funds	**78,767.4**	**7,904.9**	**7,013.1**	**93,685.4**

This section includes:

- A brief overview of the LAR development process
- Baseline and Exceptional Item funding requested in HHSC's 2024-25 Legislative Appropriations Request

The document does not include:

- An exhaustive list of requested rider changes;
- Funding requests for the Texas Civil Commitment Office, which is a separate agency administratively attached to HHSC, except where necessary to reconcile total Exceptional Item funding, where it is included as a separate line item from HHSC.

Overview

Budget Process

The LAR is one of the primary deliverables for Budget Development. The Budget Development Process began in February 2022 with the Strategic Plan that culminated in the approved budget structure through which HHSC submitted its budget requests in the LAR. The Budget Development phase will continue into the beginning of the legislative session when the Introduced General Appropriations Bill will be filed in both the House and Senate. At that point, the state will begin Budget Mark-up, a process wherein the 88th Legislature makes and reconciles its funding decisions for the final version of the General Appropriations Bill.

General Revenue/General Revenue-Dedicated Limit

On August 2, 2022, HHSC received its General Revenue and General Revenue – Dedicated Limit from the Legislative Budget Board and the Office of the Governor. Pursuant to the LAR instructions received from the LBB and OOG, an agency's baseline request may not exceed the sum of the amounts expended in FY 2022 and budgeted in FY 2023, with certain exceptions.

The primary exception impacting HHSC includes amounts necessary to maintain benefits and eligibility under state law in Medicaid and CHIP. In practice, this exception means that HHSC may request projected Medicaid and CHIP caseload growth in the baseline request. Amounts for cost growth in Medicaid and CHIP must be requested as an Exceptional Item.

Funding requests that exceed the baseline spending level may not be included in the baseline request and must instead be submitted as exceptional items. HHSC's GR/GR-D Limit (excluding Medicaid and CHIP Entitlement Client Services) for the 2024-25 LAR was $7,128,956,347.

2024-25 Baseline Request

HHSC's LAR baseline funding request totals $86,672.3 million All Funds, including $73,210.1 million All Funds related to Medicaid and CHIP client services and $13,462.2 million All Funds related to other client services and agency operations. A breakout of baseline and Exceptional Item funding by major agency function can be found on page 90. This section provides additional detail on the adjustments to agency funding included in the baseline request.

Base Reconciliation

The table below details significant changes from appropriations in the 2022-23 General Appropriations Act. The adjusted 2022-23 base is the foundation on which HHSC's baseline request for the 2024-25 biennium is built.

The total amount becomes the starting point for the baseline request, below, which illustrates adjustments made to the 2024-25 baseline request. See table on next page

Base Reconciliation Summary (2022-23 base)

Method of Financing (millions)						
Description	General Revenue	GR-D	Federal Funds	Other Funds	All Funds	FTE
FY 2022-23 Conference Appropriated	29,558.7	192.0	47,263.0	1,586.5	78,600.1	38,404.8
Rider/ Contingency	93.7		73.6		167.3	62.5
FY 2022-23 Fiscal Size-up Appropriated	29,652.4	192.0	47,336.5	1,586.5	78,767.4	38,467.3
Supplemental Approp.[60]	172.5	-	1,064.4	108.6	1,345.5	
Adjustments Notifications/ Approvals	(202.9)		2,739.8	14.6	2,551.4	
Entitlement Demand	3,563.1		5,816.0		9,379.1	
Federal Funds Adjustments	-	-	3,645.8		3,645.8	
Revenue Adjustments	833.1	(1.4)	1,660.6	59.6	2,552.0	
Other	17.0		(19.7)	42.2	39.6	42.0
Total	**34,035.**	**190.5**	**62,243.6**	**1,811.5**	**98,280.9**	**38,509.3**

[60] Includes unexpended balances of appropriations made in House Bill 2, appropriations made in Senate Bill 8, and the Budget Execution Order dated June 28, 2022.

Baseline Request

Table 3 details any adjustment in the baseline request that deviates from the standard methodology of maintaining the 2022-23 base. Essentially, any time the baseline request for 2024-25 varies from the 2022-23 base, it results in an adjustment that will be captured by one of the categories of changes outlined in more detail throughout this section.

Baseline Request Summary

Method of Financing (millions)						
Description	General Revenue	GR-Dedicated	Federal Funds	Other Funds	All Funds	FTE
FY 2022-23 Base Reconciliation	34,035.2	190.5	62,243.6	1,811.5	98,280.9	38,509.3
Medicaid and CHIP						
(1) Medicaid Forecast	(434.8)	0.3	(10,968.1)	33.8	(11,368.8)	-
(2) CHIP Forecast	249.9	-	530.9	-	780.8	-
Subtotal, Medicaid and CHIP	(184.9)	0.3	(10,437.2)	33.8	(10,588.0)	(184.9)
Other Baseline Changes						-
(3) Restore Non-COVID GR Transfer	71.6	-	(71.6)	-	-	-
(4) One Time Reductions (GR Limit)	(47.8)	-	(69.5)	-	(117.3)	-

Method of Financing (millions)						
(5) COVID-19	(13.0)	-	(532.1)	-	(545.1)	-
(6) Cost Allocation	0.0	-	18.5	0.8	19.2	-
(7) MLPP	9.3	-	-	-	9.3	-
(8) Budget Execution	5.7	-	-	-	5.7	-
(9) Updated Client Service Forecast	0.0	-	(10.3)	(0.3)	(10.6)	-
(10) Updated projection	0.0	-	(162.2)	15.5	(146.7)	-
(11) One Time Construction Reduction	-	-	-	(235.1)	(235.1)	-
(12) Biennialize Transfer	-	-	-	-	-	
Subtotal, Other Baseline Changes	25.7	-	(827.2)	(219.1)	(1,020.6)	-
Total	**33,876.0**	**190.9**	**50,979.1**	**1,626.2**	**86,672.3**	**38,509.3**

Medicaid and CHIP

(1) Medicaid

The LAR baseline request for Medicaid Client Services holds costs at FY 2023 levels for projected caseloads in the 2024-25 biennium.

Major Caseload and Cost Assumptions

1. PHE end date of October 2022

    - Caseloads assume a large decline in November through April due to loss of MOE growth related to pent-up ineligible clients, followed by a ramp down of growth as subsequent renewals come due (through first quarter of fiscal year 2025).

    - Temporary rate increases for hospitals and nursing facilities removed effective November 2022.

    - Temporary rate increases for IDD waivers removed effective May 2023 due to CMS guidance on continuing 1915(c) PHE efforts up to 6 months after PHE end.

2. Testing and treatment-related costs for COVID-19, based on Medicaid experience, DSHS data, and recent wave/infection rates.

3. Lower use experienced in various fee-for-service (FFS) programs/services will return to normal levels over the biennium as caseload stabilizes and behavior returns to a more normal state.

4. The applied behavioral analysis (ABA) benefit for children diagnosed with autism was made available on February 1, 2022, consistent with Rider 28, Applied Behavioral Analysis, of the 2022-23 General Appropriations Act.

5. Extension of coverage for women enrolled in Medicaid for Pregnant Women from two to six months postpartum pursuant to House Bill 133, Eighty-Seventh Legislature, Regular Session, 2021. Caseload impacts will begin to be seen starting in November 2022 for the extra coverage.

6. Transition of Day Habilitation to Individualized Skills and Socialization (ISS) in the HCS, TxHmL, and DBMD waiver programs.

7. Addition of COVID-19 vaccine counseling in December 2022.

8. Includes final managed care rates for fiscal year 2023 (latest available).

Medicaid caseload experienced significant growth due to the COVID-19 public health emergency (PHE) and Families First Coronavirus Response Act policies. Suspension of Medicaid disenrollments lead to consistent monthly growth and an increase of 40.7%, or over 1.5 million full benefit clients as of June 2022. Growth is expected

to continue over the PHE period, which is assumed to expire in mid-October 2022. The forecast assumes that the 6.2 percentage point increase in FMAP will continue through December 2022, the end of the federal fiscal quarter in which the PHE is assumed to end.

Caseloads are projected to decline beginning in November of 2022 as disenrollments resume and full recovery of PHE related growth is assumed to occur over two years and stabilize by November of 2024.

	FY 2023	FY 2024	FY 2025
Projected Average Monthly Caseload	5,020,901	4,191,726	4,102,922
Percent Change	-5.0%	-16.5%	-2.1%

Amounts for forecasted case growth are included in Exceptional Item 1 – Maintain Program Cost Growth. For Medicaid, the EI includes cost growth of 5.5% per year for entitlement and non-entitlement services combined. Due to the disparate impact of the public health emergency on non-disability related population growth and overall use in the COVID-19 public health emergency, cost trends appear inflated due to both case mix change from an anticipated reduction in lower cost clients and a restoration of use as recovery from the PHE continues.

(2) CHIP

The CHIP forecast assumes:

1. PHE end date of October 2022 - stimulus EFMAP ends December 2022. Assumes a significant caseload increase in November through April to account for potential pent-up CHIP-eligible children in Medicaid that transfer over. Continued growth thereafter as caseload continues to stabilize.

2. Testing and treatment-related costs for COVID-19, based on CHIP experience, DSHS data, and recent wave/infection rates.

CHIP caseload has been declining since the PHE began. While CHIP is not subject to the same PHE Maintenance of Eligibility (MOE) requirements as Medicaid, the state initiated a program to suspend disenrollments through the first year of the PHE. Despite this, there have been consistent monthly declines occurring in CHIP primarily due to fewer clients transitioning to CHIP as they continue enrollment in

Medicaid (upwards of 20k monthly transfers under normal conditions). Application volume has also been lower during the PHE, putting additional negative pressure on normal new enrollment volume.

Due to the combined impact of these factors, as of June 2022, CHIP caseload (excluding Perinatal) has declined by 268.5k clients to 73.9k clients enrolled. Fiscal year 2020 CHIP caseload experienced a decline of 9.7%, fiscal year 2021 a decline of 29.9%, and a projected decline of -58.3% in 2022. Caseload growth is expected to begin in November of fiscal year 2022 as transitions from Medicaid to CHIP resume. Annual growth for fiscal year 2023 is estimated to be 82.9% as large cohorts of children transfer from Medicaid to CHIP followed by 74.3% in fiscal year 2024 and 6.9% in fiscal year 2025. Like the Medicaid assumption, CHIP recovery is estimated to occur over 2 years and impact fiscal years 2023-25.

	FY 2023	FY 2024	FY 2025
Projected Average Monthly Caseload	182,275	317,639	339,420
Percent Change	82.9%	74.3%	6.9%

Amounts for forecasted case growth are included in Exceptional Item 1 – Maintain Program Cost Growth. For CHIP, the EI includes cost growth of 4.2% per year.

Non-Medicaid/CHIP

Additional details about baseline adjustments impacting non-Medicaid and CHIP programs and services appear in the following sections.

(3) Restore Non-COVID General Revenue Transfer

HHSC transferred $71.6 million in General Revenue originally appropriated in FY 2022 to the Trusteed Programs within the Office of the Governor. The transfer supported the Governor's Disaster Fund to respond quickly and ensure the safety of Texans in disasters occurring in the 2022-23 biennium.

Funds were transferred from Strategies G.2.1, State Hospitals, and G.3.1, Other State Medical Facilities as FY 2022 appropriations were fully funded with other fund sources, including Coronavirus Relief Funds.

This item restores the transferred General Revenue to the original strategies.

(4) One-Time Reductions Related to General Revenue Limit

As discussed previously in the General Revenue/General Revenue-Dedicated Limit section, baseline General Revenue funding may not exceed the FY 2022-2023 base spending level. In calculating agency limits, the Legislative Budget Board and Office of the Governor historically remove certain one-time appropriations made in the preceding session.

HHSC's General Revenue limit calculation removed $41.4 million in General Revenue for non-Medicaid and CHIP programs and services. This item also includes Federal Funds adjustments associated with the General Revenue reductions.

HHSC did not project its full need for General Revenue related to System Support Costs because General Revenue limit reductions included $25.0 million in General Revenue for certain one-time System Support Services that should have been allocated among all Article II agencies (DFPS, DSHS, and HHSC). See section on Special Provisions, Sec. 9, System Support Services for additional detail.

(5) COVID-19 Related Adjustments

Description	General Revenue	General Revenue-Dedicated	Federal Funds	Other Funds	All Funds
(5.1) Restore GR Transferred to Medicaid Entitlement (HHSC-2022-A-702)	9.5	-	(9.5)	-	-
(5.2) Home and Community Based Services 10% FMAP Increase	(22.5)	-	(19.9)	-	(42.4)
(5.3) Senate Bill 8	-	-	(277.8)	-	(277.8)
(5.4) COVID Federal Funds	-	-	(185.8)	-	(185.8)
(5.5) Restore GR Transferred between Strategies GR (HHSC-2022-N-706)	-	-	(38.9)	-	(38.9)
(5.6) Adjustments to account for loss of 6.2% COVID FMAP Increase	(0.0)	-	(0.2)	-	(0.2)
Total	**(13.0)**	**-**	**(532.1)**	**-**	**(545.1)**

5.1 Restore General Revenue Transferred to Medicaid Entitlement

HHSC transferred $9.5 million in General Revenue from multiple strategies to Strategy A.1.5, Children, to support critical client services within the Medicaid program and decrease the estimated Medicaid supplemental need. Funds were available because of the 6.2 percentage point increase in FMAP implemented throughout the COVID-19 public health emergency (PHE).

This item restores the transferred General Revenue to the original strategy. The table illustrates the transfers made in FY 2022.

Strategy	Name	General Revenue
D.1.1	Women's Health Program	(2,998,474)
D.2.5	BH Waiver & Plan Amendment	(1,117,915)
G.3.1	Other State Medical Facilities	(113,961)
I.2.1	Long-term Care Intake & Access	(5,238,764)
A.1.5	Children	9,469,114

5.2 Home and Community-Based Services 10 Percentage Point FMAP Increase

HHSC transferred certain General Revenue made available due to a 10-percentage point increase to the FMAP for Home and Community-Based Services authorized by Section 9817 of the federal American Rescue Plan Act. Funds were used for a variety of initiatives, including certain initiatives outside of Goal A, Medicaid Client Services.

This item reduces General Revenue and associated federal funds included in the 2022-23 base in strategies to which freed-up General Revenue was transferred. The table below illustrates the initiatives and strategies for which freed-up General Revenue was transferred.

HCBS 10% Enhanced FMAP Freed-up General Revenue				
Initiative	B.1.1	D.2.5	F.1.3	L.1.2
Infrastructure				
Assess Compliance with HCBS Settings	(0.2)	-	-	-
Build a Registry for ISS Provider Oversight	-	-	-	(0.5)
Build Infrastructure for the LTSS Redesign Pilot Program	(5.0)	-	-	-
Conduct a Comprehensive Evaluation of the HCBS-AMH Program	-	(0.3)	-	-
Digitize Provider Oversight Tools	(1.3)	-	-	-
Evaluation of Transportation in HCBS Programs	(0.3)	-	-	-
Strengthen Consumer Directed Services	(0.0)	-	-	-
Infrastructure Total	(6.7)	(0.3)	-	(0.5)
Recipient Supports				
Assess the Needs of Texans on Waiver Interest Lists	(6.5)	-	-	-
Campaign to Support Caregivers	(1.0)	-	-	-
Enhance the "No Wrong Door" System	(1.9)	-	-	-
Recipient Supports Total	(9.4)	-	-	-
Support Providers				
Enhance Efficiency through Electronic Data Interfaces	(0.4)	-	-	-

HCBS 10% Enhanced FMAP Freed-up General Revenue				
Enhance Technology to Support Other Long-term Services and Support Providers	(0.5)	-	-	-
Enhance Technology to Support Waiver Providers	(1.3)	-	-	-
Increase Technology Use by HCBS Providers of Mental Health Services	-	(0.6)	-	-
Support Providers of Mental Health Services in Home and Community Based Settings - Provider Training	-	(0.6)	-	-
Support Providers Total	(2.2)	-	(2.1)	-
Total Proposed Expenditures	**(0.5)**	**(1.3)**	**(2.1)**	**-**

5.3 Senate Bill 8, 87th Legislature, 3rd Called Session, 2021

SB 8 appropriated a total of $731.1 million in Coronavirus State Fiscal Recovery Funds to HHSC for a two-year period, including $277.8 million in strategies outside of Goal A, Medicaid Client Services.

This item removes the one-time Federal funding in non-Medicaid and CHIP strategies for the 2024-25 biennium as illustrated in the table below.

Strategy	S.B. 8 Title	Section #	Federal
G.4.2	Dallas State Hospital	11	237.8
B.1.1	Internet Portal	13	20.0
B.1.1	Technology Updates	14	5.0
G.2.2	Sunrise Canyon Hospital	22	15.0
	Total		**277.8**

5.4 COVID-19 Related Federal Funds

This item encompasses several adjustments to Covid-19 related Federal Funds across multiple strategies to reflect 1) reductions for certain grants that were one-time for the 2022-23 biennium and 2) to reflect certain grant that are projected to continue to spend in the 2024-25 biennium.

COVID-19 Impact	COVID Federal Funds
Aging Services	(45.4)
Behavioral Health	(69.2)
ECI	(0.7)
Family Violence Services	8.7
Nutrition Services	(44.2)
Regulatory Services	(0.1)
TANF PEAF	(34.9)
Total	**(185.8)**

5.5 Restore General Revenue Transferred between Strategies

HHSC transferred $38.9 million in General Revenue from Strategy G.1.1, State Supported Living Centers, to Strategy I.1.1, Integrated Eligibility and Enrollment. The General Revenue was available as a result of the 6.2 percentage point increase in the FMAP during the ongoing public health emergency and was needed to address challenges facing the eligibility operations workforce and support the PHE.

This item removes the freed-up GR from the 2022-23 base in Strategy I.1.1 and returns it to Strategy G.1.1 and removes the additional Federal Funds in G.1.1 resulting from the 6.2 percentage point FMAP increase.

5.6 Adjustments to Account for Loss of 6.2 Percentage Point FMAP Increase

This item encompasses adjustments to multiple strategies to reflect reclassification of certain General Revenue to General Revenue Match for Medicaid and associated Federal Fund reductions to align with the assumed loss of the 6.2 percentage point FMAP increase during the ongoing public health emergency.

(6) Cost Allocation

This item encompasses adjustment to multiple strategies to align with cost allocation assumptions. The net General Revenue impact is $0, but adjustments result in a net increase of $18.5 million in Federal Funds and a net increase of $0.8 million in Other Funds.

(7) Master Lease Purchase Program

This item aligns estimated debt service amounts for MLPP with estimated provided by the Texas Public Finance Authority. Estimates total $36.1 million for the 2024-25 biennium and increase of $9.3 million in General Revenue from the 2022-23 biennium. As mentioned previously, the Policy Letter for the 2024-25 LAR exempts amounts necessary to satisfy debt service requirements for bond authorizations.

(8) Budget Execution

Pursuant to a budget execution order ratified by Governor Greg Abbott on June 28, 2022, HHSC received $5.7 million in additional appropriations to support mental health and school safety initiatives during the 2022-23 biennium, including:

- $950,000 to expand Coordinated Specialty Care teams across the state; and
- $4,725,000 to increase Multisystemic Therapy services across the state.

This item biennializes the General Revenue provided in the budget execution order to continue services for the full 2024-25 biennium.

(9) Updated Client Service Forecast

This item encompasses adjustments to align with updated client services forecasts for Women's Health Programs (Strategy D.1.1) and Early Childhood Intervention (Strategy D.1.3).

(10) Updated projections

	Method of Financing (millions)				
Description	General Revenue	General Revenue-Dedicated	Federal Funds	Other Funds	All Funds
(10.1) Adjustments to align with base Federal awards	-	-	(113.7)	-	(113.7)
(10.2) Federal match rate assumptions	0.0	-	(33.7)	-	(33.7)
(10.3) Allocation of System Support Costs	-	-	-	0.4	0.4
(10.4) Contingency Contracts (HHSC-2022-N-696)	-	-	-	(9.7)	(9.7)
(10.5) MOF Update based on forecasted TIERS projects	0.0	-	3.1	-	3.1
(10.6) Other Updated Projections	-	-	(17.8)	24.9	7.1
Total	**0.0**	**-**	**(162.2)**	**15.5**	**(146.7)**

(10.1) Adjustments to align with base Federal awards

This item encompasses adjustments to several behavioral health-related Federal grants to align projections with the anticipated base award, including reductions of $23.0 million for Community Mental Health Block Grant (MHBG), $47.4 million for Substance Abuse Prevention and Treatment Block Grant (SABG), and $41.3 million for State Targeted Response to the Opioid Crisis Grants. Carryforward amounts for these grants in the 2022-23 biennium are excluded from the 2024-25 baseline request.

(10.2) Federal match rate assumptions

This item includes adjustments to multiple strategies to align Medicaid matching funds with Federal Medical Assistance Percentage (FMAP) assumptions for the 2024-25 biennium. The FMAP is used to reimburse states for the federal share of most Medicaid expenditures. The FMAP is determined by a formula that accounts for the average per capita income for each state relative to the national average, and the Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

(10.3) Allocation of System Support Costs

This item includes allocations of system support costs between indirect administration strategies and includes a reduction in Interagency Contracts for certain one-time projects that were reduced at the Department of Family and Protective Services and Department of State Health Services. To increase transparency, costs were aligned with the staff that perform them.

(10.4) Contingency Contracts

This item removes certain additional collections of Medicaid Subrogation Receipts in the 2022-23 biennium that were the result of COVID-19. The 2022-23 base includes $9.7 million in Medicaid Subrogation Receipts collected under certain contingency-based contracts in the Medicaid program. The increase is not assumed in the 2024-25 biennium as the increased collections were primarily the result of increased opportunities for collections from the significant increase in federal funding available to providers and individuals during the COVID-19 public health emergency.

(10.5) Method of Finance Updated based on Forecasted TIERS Projects

This item encompasses updated methods of financing based on TIERS projects forecasted for the 2024-25 biennium, resulting in a net increase of $3.1 million in Federal Funds.

(10.6) Other Updated Projections

This item encompasses adjustments across multiple strategies and funding sources, including reduced projections for certain fund sources based on actual collections in the 2022-23 biennium and changes to anticipated Federal grants, including expiring grants. For example, this item includes an increase of $28.1 million in Appropriated Receipts for the WIC program based on actual collections in the 2022-23 biennium. Federal Funds decreases include $9.4 million to align with the anticipated Money Follows the Person supplemental award and $6.5 million to reflect the end of certain

federal grants in the 2022-23 biennium, including grants related to the First Responders-Comprehensive Addiction and Recovery Act (CARA) and CMHS Child Mental Health Service Initiative.

(11) One Time Construction Reduction

This item removes $235.1 million in Other Funds in the 2022-23 base for one-time construction projects in Strategy G.4.2, Capital Repair and Renovations related to the State Hospitals and State Supported Living Centers.

Fund Source	Reduction
Economic Stabilization Funds	(76.4)
General Obligation Bonds	(0.0)
MLPP Revenue Bonds	(158.6)
Total	**(235.1)**

(12) Biennialize Transfer of Payment Error Rate Measurement

HHSC transferred funds from the Office of Inspector General to Strategy B.1.1, Medicaid Contracts & Admin related to the Payment Error Rate Measurement (PERM) program.

This item biennializes the transfer to reflect the PERM program in Strategy B.1.1 for the full 2024-25 biennium. There is no net impact to General Revenue or Other Funds.

Exceptional Items

HHSC's Exceptional Item request of $3,161.0 in General Revenue ($6,980.6 million All Funds) consists of $2,334.0 million General Revenue ($5,773.6 million All Funds) related to Medicaid and CHIP client services cost growth and $827.0 million General Revenue ($1,207.0 million All Funds) related to all other items.

Table 4. Exceptional Item Request.

Method of Financing (millions)							
#	Description	General Revenue	GR-Dedicated	Federal Funds	Other Funds	All Funds	FTE
	Prevent Disruption of Critical Operations and Achieve Efficiencies						
2	Address Critical Workforce Needs	260.4	-	180.4	-	440.7	
14	Ensuring Effective Operations in State Facilities	97.5	-	-	-	97.5	
17	Funding to Support Regulatory Compliance	7.6	0.6	3.0	-	11.3	
18	Maintain Public Facing Offices and Client Supports	58.1	-	13.3	-	71.4	
21	Enhancing Medicaid Enrollment and Contract Management	1.6	-	1.6	-	3.2	18.8
	Improve Access and Delivery of Behavioral Health Services						
3	Improve Mental Health Services	0.0	-	-	-	0.0	
4	Expanding State Hospital Capacity	108.4	-	10.8	-	119.1	
9	Grants Management System for Improving Mental Health Outcomes	24.8	-	8.2	-	33.0	

Method of Financing (millions)							
	Comply with State and Federal Regulations						
8	STAR+PLUS Pilot Program	7.1	0.1	12.5	-	19.6	21.1
16	Comply with State and Federal Regulations	21.5	-	15.2	-	36.7	27.8
	Maintain Access and Improve Outcomes for Essential Client Services						
1	Maintain Client Services Cost Growth	2,334.0	-	3,439.5	-	5,773.6	
5	Better Birth Outcomes	58.5	-	32.9	-	91.4	
6	Support for Community Based Services and Promoting Independence	0.0	-	0.0	-	0.0	
7	Maintain Client Services Base	23.1	-	35.3	-	58.4	
11	ECI Caseload and Method of Finance	56.6	-	9.7	-	66.3	
12	Consolidated Rate Request	0.0	-	-	-	0.0	
15	Increase Access for Deaf and Hard of Hearing Services	2.4	-	-	-	2.4	1.0
	Address IT Infrastructure Needs						
10	Cybersecurity Compliance and Operations Monitoring	30.8	-	15.7	-	46.4	

Method of Financing (millions)							
13	Procurement and Contracting Enhancements	20.6	-	6.9	-	27.5	8.8
19	Application Modernization	33.5	-	27.4	-	60.9	
20	PMAS Cloud Data Analytics Platform	14.0	-	7.1	-	21.0	
	Total HHSC EI	**3,160.3**	**0.8**	**3,819.6**	**-**	**6,98**	**77.5**
	Office of Inspector General EIs	14.1	-	9.4	-	23.5	24.0
	Texas Civil Commitment Office EIs	9.1	-	-	-	9.1	4.0
	Total EI Funding	**3,183.4**	**0.8**	**3,829.0**	**-**	**7,013.1**	**105.5**

HHSC's 21 exceptional item requests are grouped into categories reflective of those needs and are explained individually in Section 4 of the 2024-25 Legislative Appropriations Request.

Prevent Disruption of Critical Operations and Achieve Efficiency

HHSC's top priority for the 88th Legislature is addressing critical workforce needs. Earlier this year, HHSC conducted a market salary analysis for agency employees while also identifying critical, hard-to-fill and retain jobs. Overall, the analysis found that HHSC lags the market when compared to other Texas employers. This request includes funding to increase employee salaries and address salary deficiencies, particularly for critical, hard-to-fill positions such as state facility and eligibility workers. It also includes funding for 31 FTEs the Legislature authorized in 2021 to help HHSC address a backlog of long-term care facility inspections and investigations. The request also includes funding for attorneys, financial forecasting staff and other highly specialized and technical staff for retention and recruitment.

Funding deferred maintenance at state facilities and increased lease costs are also important to the agency's ability to efficiently provide critical services to Texans without disruption.

Improve Access and Delivery of Behavioral Health Services

Continuing the Texas Legislature's significant investments into behavioral health over the last several biennia, the agency is seeking funds to operate 168 new beds at the John. S. Dunn Behavioral Health Center in Houston; complete pre-planning for state hospital construction in Wichita Falls and Terrell; support operations at the planned state hospital in Dallas; and maintain contracted beds to help reduce the state hospital system waitlist. The agency is also requesting funding for a grants management system to aid the process by which organizations apply for grants, receive award notices, and submit financial reports with the ultimate goal to improve mental health outcomes.

Comply with State and Federal Laws and Regulations

Compliance with a complex and dynamic set of state and federal guidelines is one of the most important charges for the agency. These requests seek support to implement several legislative directives, including the STAR+PLUS Pilot program, new residential child-care license types, and continuity of Medicaid for individuals after release from confinement. It also includes funding to support required changes to the nursing facility payment methodology system.

Maintain Access and Improve Outcomes for Essential Client Services

Preserving access to HHSC's client service programs is another major priority for the agency during the 88th Legislature. This includes funding for Medicaid cost growth, maintaining the Medicaid Waiver Program at FY 2023 level and enhancing Medicaid Enrollment and Contract Management. The agency is requesting funding for women's health services to promote better birth outcomes and to maintain client access to the Healthy Texas Women program. Funding would also support projected caseload growth for the Early Childhood Intervention program and expand access to deaf, deaf-blind, and hard of hearing services. It also provides support for community-based services and promoting independence. As part of this request, the agency is seeking funding to increase community attendant base wages. Keeping with traditional practice, this request provides options for the Legislature to consider regarding potential rate adjustments as many providers are impacted by inflation and workforce challenges.

Address IT Infrastructure Needs

Information technology is critically important to ensuring that Texans have secure and efficient access to the services HHSC provides. These requests include funding to strengthen cybersecurity, provide advanced data analytics and improve overall efficiency. It also includes a request to modernize the Texas Integrated Eligibility Redesign System (TIERS), as well as systems that support agency procurement and contracting and financial operations.

Other Items of Interest

Special Provisions, Sec. 9, System Support Services

Special Provisions, Sec. 9 includes an informational listing of appropriations to DFPS, DSHS, and HHSC to support Article II system support services assessments. HHSC has submitted updated assumptions for these amounts.

	FY 2022-23 Sec. 9. System Support Services	Adjusted Baseline Assessment[1]	Transfer of Appropriations for System Support Services (HHSC-2022-N-692)*	Art IX, Sec. 18.09 Contingency Rider 1033 (DSHS)	Howard Lane Building (DSHS)[2]	Data Center Consolidation[3]	Cost Per Adjustments	DSHS Attorney Salary Adjustment[4]	One-time GR HHSC Base reductions[5]	FY 2024-25 Sec. 9. System Support Services[6]
FY 2024										
DFPS	106,399,548	-	5,390,492	-	-	3,116,092	-			114,906,132
DSHS	39,417,058	2,674,309	2,506,237	158,175	985,140	1,099,321	329,074	10,000		47,179,314
HHSC	320,768,415	-	(7,896,729)	-	-	59,111,962	-		(25,015,565)	346,968,083
	466,585,021	**2,674,309**	**-**	**158,175**	**985,140**	**63,327,375**	**329,074**	**10,000**		**509,053,529**
FY 2025										
DFPS	106,302,798	-	4,484,041	-	-	3,116,092	-			113,902,931
DSHS	39,852,206	1,804,017	2,178,236	150,271	985,140	1,099,321	(45,096)	10,000		46,034,095
HHSC	320,768,415	-	(6,662,277)	-	-	59,111,962	-			373,218,100
	466,923,419	**1,804,017**	**-**	**150,271**	**985,140**	**63,327,375**	**(45,096)**	**10,000**		**533,155,126**

Notes:

1 DSHS starting point updated to match agency correspondence dated 05/11/2020

2 FY 2024 is adjusted from FY 2022 to reflect full annual amount.

3 Data Center Consolidation: Adopted HB2, Sec. 35(d)(5) - **HB2 appropriates IAC to HHSC, therefore no GR transfer is assumed as DFPS/DSHS's baseline appropriations were not reduced for this purpose.**

4 Per agency correspondence dated 03/15/2022.

5 One-time GR reductions take at HHSC Pending Allocation to DFPS/DSHS: E-Discovery HB2 Sec 35(a)(9) -2,266,250, SWBEP HB2 Sec 35(c)(5) -3,422,527, EOL/EOS HB2 Sec 35(c)(6) -19,210,692, DCS EI HB2 Sec 35(d)(5) -116,096.

6 One-time increase for Covid projects are excluded from this total.

Several one-time reductions that were included in HHSC's General Revenue and General Revenue-Dedicated Limit for the 2024-25 biennium (see Section 4) included General Revenue that was subsequently reallocated to DFPS and DSHS to support assessment billing of each respective agency. While all of the General Revenue was appropriated to HHSC, it was later allocated among all Article II agencies (DFPS, DSHS, and HHSC). However, the full amount was reduced at HHSC, resulting in a need to allocate a portion of the GR reductions to each agency. The table below illustrates the proposed reallocation.

	System Wide BEP	Modernize EoL/EoS Equipment	Stabilization of Servers	Winters Data Center	Stabilize E-Discovery	DFPS CBC EI[1]	Total
HHSC 2022-23 Appropriated							
General Revenue	8,444,183	26,447,516	3,104,482	755,896	4,853,581	NA	42,849,762
All Funds	13,418,742	36,737,765	5,406,153	755,896	7,150,000	NA	62,712,660
Transfer of Appropriations for System Support Services (HHSC-2022-N-692)							
HHSC	(1,615,763)	(12,322,580)	(490,741)	(184,006)	(1,114,256)	1,168,338	(14,559,008)
DFPS	996,228	9,735,507	118,855	44,566	350,708	(1,371,329)	9,874,535
DSHS	619,534	2,587,073	371,887	139,440	763,549	202,991	4,684,474
2024-25 GR Reductions (GR and GRD Limit)							
HHSC[2]	(3,422,527)	(19,210,692)	(116,096)	-	(2,266,250)	NA	(25,015,565)
DFPS	-	-	-	-	-	NA	-
DSHS	-	-	-	-	-	NA	-
% GR Reduced	40.5%	72.6%	3.7%		46.7%		
Requested Adjustment to Special Provisions, Sec. 9							
HHSC	654,887	8,950,757	18,352	-	520,273	NA	10,144,269
DFPS (DFPS Transfer * % GR Reduced)	(403,783)	(7,071,584)	(4,445)	-	(163,754)	NA	(7,643,565)
DSHS (DSHS Transfer * % GR Reduced)	(251,104)	(1,879,173)	(13,907)	-	(356,519)	NA	(2,500,704)

1 DFPS Community Based Care EI included to tie to total Transfers of Appropriations for System Support Services (HHSC-2022-N-692)
2 One-time GR reductions take at HHSC Pending Allocation to DFPS/DSHS

Exceptional Items to Maintain Base Service Levels

As discussed previously, the standard methodology for requesting baseline funding for the 2024-25 biennium is to maintain 2022-23 base funding and service levels. However, HHSC is requesting several EIs for programs that will not be able to maintain 2022-23 service levels within baseline funding.

HHSC Exceptional Item 7 - Maintain Client Services Base, includes $23.1 million General Revenue ($58.4 million All Funds) for programs impacted by lower federal financial participation due to changes to the federal medical assistance percentage (FMAP) for which HHSC is not able to absorb the additional cost within the baseline request. Impacted programs include State Supported Living Centers (Strategy G.1.1), Behavioral Health Waiver Programs (Strategy D.2.5), and Targeted Case Management (Strategy I.2.1).

Two other EIs have components necessary to maintain base service levels in addition to other subcomponents, including EI 5 - Better Birth Outcomes, for Women's Health Programs, and EI 11 – ECI Caseload and Method of Finance, for the ECI program. For Women's Health and ECI the amounts to maintain base service levels maintain FY 2023 cost per client and then reprojects based on assumed caseload.

Baseline Request by Agency Function (All Funds, in millions)

Agency Function	Restore GR Transfer [1]	One Time GR Reductions	COVID-19	Cost Allocation	Master Lease Purchase Program	Budget Execution	Updated Client Service	Updated projection	One Time Construction Reduction	Biennialize Transfers	Grand Total
Medicaid and CHIP Services	**-**	**-**	**-**	**-**	**-**	**-**	**(10,588.0)**	**-**	**-**	**-**	**(10,588.0)**
Medicaid	-	-	-	-	-	-	(11,368.8)	-	-	-	(11,368.8)
CHIP	-	-	-	-	-	-	780.8	-	-	-	780.8
Non-Medicaid Services	**-**	**(30.3)**	**(127.6)**	**2.5**	**-**	**5.7**	**(10.6)**	**(86.8)**	**-**	**-**	**(247.1)**
Behavioral Health	-	-	(89.6)	0.6	-	5.7	-	(109.0)	-	-	(192.3)
Disaster Assistance	-	(19.0)	-	-	-	-	-	-	-	-	(19.0)
Early Childhood Intervention	-	-	-	-	-	-	(9.0)	(0.4)	-	-	(9.4)
Indigent Health Care	-	-	-	0.0	-	-	-	0.1	-	-	0.1
Long-term Care Services and Coordination	-	-	(26.0)	-	-	-	-	-	-	-	(26.0)
Nutrition Services	-	-	(11.9)	-	-	-	-	27.9	-	-	16.0
Other Community Support Services	-	-	0.7	-	-	-	-	(0.9)	-	-	(0.2)
Other Primary Health and Specialty Care Services	-	(11.3)	(0.7)	1.9	-	-	-	(0.9)	-	-	(10.9)
Rehabilitation Services	-	-	-	-	-	-	-	(0.0)	-	-	(0.0)
TANF	-	-	-	-	-	-	-	(3.6)	-	-	(3.6)
Women's Health Services	-	-	-	-	-	-	(1.6)	-	-	-	(1.6)
Facility-based Services	**-**	**(3.0)**	**(252.8)**	**0.3**	**9.3**	**-**	**-**	**(22.6)**	**(235.1)**	**-**	**(503.9)**
State-owned Facilities	-	(3.0)	(237.8)	0.3	9.3	-	-	(22.6)	(235.1)	-	(488.9)
Mental Health Community Hospitals	-	-	(15.0)	-	-	-	-	-	-	-	(15.0)
Regulatory Services	**-**	**-**	**(0.1)**	**1.5**	**-**	**-**	**-**	**(13.8)**	**-**	**-**	**(12.4)**
Direct Administration	**-**	**(46.8)**	**(164.2)**	**20.6**	**-**	**-**	**-**	**(17.6)**	**-**	**0.3**	**(207.7)**
Indirect Administration	**-**	**(37.2)**	**(0.5)**	**(5.5)**	**-**	**-**	**-**	**(5.9)**	**-**	**-**	**(49.0)**
OIG	**-**	**-**	**-**	**(0.2)**	**-**	**-**	**-**	**-**	**-**	**(0.3)**	**(0.5)**
Total, Baseline Request Adjustments	**-**	**(117.3)**	**(545.1)**	**19.2**	**9.3**	**5.7**	**(10,598.6)**	**(146.7)**	**(235.1)**	**-**	**(11,608.6)**

Notes:

(1) Restores $71.6 million in General Revenue to State-owned Facilities and reduces Federal Coranivirus Relief Funds commensurately. No All Funds impact.

Fiscal Year 2022-23 Appropriation Summary

The Conference Committee Report for Senate Bill 1 (the 2022-23 General Appropriations Bill) adopted the Issue Documents for Senate Bill 1 on May 19th, 2021, and the bill was subsequently passed by the Senate on May 26, 2021 and by the House on May 27, 2021. Information in this document is based upon information available in the Conference Committee Report for Senate Bill 1[61], the Conference Committee Issue Documents for Senate Bill 1[62], and the Senate Committee Substitute for House Bill 2[63].

Appropriations for the Health and Human Services Commission (HHSC) appear in Table 1.

Table 1. Health and Human Services Commission, Conference Committee Report Senate Bill 1 Appropriations

	2022-23 Baseline	2022-23 Exceptional	Total
FY 2023 Full-time Equivalents (FTEs)	37,911.7	499.2	38,410.9
Method of Financing (millions)[64]			
GR and GR-Dedicated Funds	29,557.4	196.0	29,753.4
All Funds	**78,277.7**	**325.6**	**78,603.3**

[61] Senate Bill 1, 87th Legislature, Regular Session, 2021
[62] Article II – Issue Docket Conference Committee on Senate Bill 1 (May 18, 2021). Available at:https://www.lbb.state.tx.us/Documents/Appropriations_Bills/87/Adopted_Decision_Documents/Article02_IssueDoc_05-19-2021.pdf
[63] House Bill 2, 87th Legislature, Regular Session, 2021
[64] Appropriations include $3.2 million in All Funds/$2.8 million in General Revenue related to Special Provisions, Sec. 26 and reflected in the HHSC bill pattern as Supplemental Appropriations Made in Riders.

Table 1A. Health and Human Services Commission, Senate Bill 1 Appropriations – Comparison to Baseline Legislative Appropriations Request

Category	2022-23 Baseline LAR Request	2022-23 Baseline	2022-23 Exceptional Items	2022-23 Conference Committee (SB 1)
FY 2023 Full-time Equivalents (FTEs)	37,296.0	(384.3)	499.2	38,309.9
Method of Financing (millions)				
GR and GR-Dedicated Funds	31,931.9	(2,374.5)	196.0	29,753.4
All Funds	**84,415.9**	**(6,138.2)**	**325.6**	**78,603.3**

The Conference Committee Report for SB 1 includes a net decrease of $5.8 billion in All Funds, including $2.2 billion in General Revenue from HHSC's baseline request in the 2022-23 Legislative Appropriations Request (LAR). The bill provides $325.6 million in All Funds, including $196.0 million in General Revenue and General Revenue-Dedicated Funds, to partially adopt Exceptional Item funding requests.

The decrease is primarily attributable to reductions to the Medicaid program for assumed cost containment ($897.1 million AF / $350.0 million GR) and other Medicaid reductions ($4,740.6 million AF / $1,850.0 million in General Revenue), among other reductions, which are partially offset by Exceptional Item funding.

This section includes:

- Summaries of Exceptional Item funding provided in SB 1, as well as baseline funding adjustments in the bill, including funding decisions as reflected in the Adopted Issue Document for Article II, including Exceptional Item funding, Conference Committee Revisions and Additions, Technical Adjustments, Cost Out Adjustments, and other funding decisions;

- Funding decisions, including Exceptional Item funding provided in Senate Committee Substitute for House Bill 2 (HB 2), the supplemental appropriations bill for the 2020-21 biennium;

- A below-the-line appropriation made in Special Provisions Relating to All Health and Human Services Agencies, Sec. 26, Reimbursement Methodology for Foster Care and Community-Based Care, which is not reflected in the Strategy totals and Method of Financing tables in the General Appropriations Act but is appropriated in addition to those amounts.

This section does not include:

- An exhaustive list of rider decisions made in SB 1;
- Contingent appropriations based on the enactment of certain legislation included in Article IX, Part 19. These contingency riders have historically been moved to the agency bill pattern during Fiscal Size-Up; or
- Decisions impacting the Texas Civil Commitment Office, which is a separate agency administratively attached to HHSC, except where necessary to reconcile total Exceptional Item funding, where it is included as a separate line item from HHSC.

Exceptional Items

HHSC's revised Exceptional Item request of $4,241.8 million All Funds consisted of $2,972.9 million All Funds related to Medicaid and CHIP client services cost growth and $1,268.9 million All Funds related to all other items.

Excluding the request for Medicaid and CHIP client service cost growth, HHSC received Exceptional Item funding equal to approximately 96.5% of its request, $1,224.3 All Funds. Exceptional Item funding was provided through multiple avenues including, in All Funds:

- $325.6 million in SB 1 (the 2022-23 General Appropriations Bill),
- $726.9 million in HB 2 (the supplemental appropriations bill for the 2020-21 biennium), and;
- $171.6 million in SB 1 rider-directed transfer authority.

Table 2 provides a summary of Exceptional Item requests and Exceptional Item funding provided in the Conference Committee Report for Senate Bill 1.

Table 2. Summary of Exceptional Item Funding

	2022-23 Exceptional Item Request[65]	Exceptional Item Funding Included in SB 1	Exceptional Item funding included in HB 2	Over/(Under) Request
FY 2023 Full Time Equivalents (FTEs)	610.4	499.1	1.0	(110.3)
General Revenue Funds (Millions)	2,327.1	196.0[66]	102.4	(2,028.7)
GR-Dedicated Funds	-	-	-	-
Federal Funds	1,867.8	128.8	279.4	(1,459.6)
Other Funds	46.9	0.8	345.1	299.0
All Funds	4,241.8	325.6	726.9	(3,189.3)

[65] Exceptional Item Request reflects updates to requests provided to the Legislative Budget Board in January 2021. Updates include adjustments to reflect Exceptional Item funding provided in HB 1 / SB 1 As Introduced ($31.4 million in All Funds, including $27.2 million in GR and GR-D), as well as a variety of other changes. January 2021 request in this table has been adjusted to reflect the request for funds included in HB 1 / SB 1.
[66] Includes $0.8 million reduction in General Revenue reallocated to DSHS and DFPS for System Exceptional Items and corresponding increase in Other Funds.

Table 3. Exceptional Item Funding Included in Conference Committee Report Senate Bill 1

	Method of Financing (millions)					
Description	General Revenue	GR-Dedicated	Federal Funds	Other Funds	All Funds	FTE
Partially Adopted						
EI #2, Residential Child Care Regulation	29.0	-	-	-	29.0	149.9/153.0
EI #3 – DAA for Hepatitis C No Restrictions	21.3	-	31.2	-	52.5	-
EI #4 – Ensure Access to Medicaid Long-term Services and Supports Waivers	30.0	-	46.9	-	76.9	-
EI #7 – Information Technology (IT) Threat and System Stabilization and Restoration	2.9	-	1.6	-	4.4	17.2/17.2
EI #8 – IDD System Redesign	3.4	-	28.7	-	32.1	15.2/15.2
EI #9 – Community Integration	0.9	-	0.8	-	1.7	0.0/18.0

Method of Financing (millions)						
EI #10 – Maintain Compliance with Federal Data Governance Requirements	-	-	-	-	-	2.0/2.0
EI #11, Complete Construction and Expanded Operations in State Hospitals	69.3	-	-	-	69.6	260.0/260.0
EI #14, Address Long-term Care Regulation Backlogs	0.9	-	5.5	-	6.3	31.7/31.7
EI #16 – Facility Support Services	4.0	-	-	-	4.0	-
Fully Adopted						
EI #6 – Electronic Visit Verification	1.3	-	6.8	-	8.0	-
Not Adopted						
EI #5 – MMIS Modernization	-	-	-	-	-	-
EI #12, Ensure Critical Facility Infrastructure Efficiency and Safety	-	-	-	-	-	-

Method of Financing (millions)						
EI #1, Client Services Cost Growth	-	-	-	-	-	-
EI #13, Stabilize E-Discovery	-	-	-	-	-	-
EI #15, CAPPS Compliance and Stabilization	-	-	-	-	-	-
EI #17 – Article II Assessment Costs	-	-	-	-	-	-
EI Funding Adopted in Introduced Bill						
EI #11, Complete Construction and Expanded Operations in State Hospitals	16.4	-	-	-	16.4	-
EI #15, CAPPS Compliance and Stabilization	10.8	-	4.2	-	15.0	-
Total HHSC EI	**190.4**	**-**	**125.6**	**-**	**316.0**	**476.0/497.1**
Office of Inspector General EIs	2.2	-	3.2	-	5.4	-

Method of Financing (millions)						
Texas Civil Commitment Office EIs	4.2	-	-	-	4.2	2.0/2.0
Total EI Funding	**196.8**	**-**	**128.8**	**-**	**325.6**	**478.0/499.1**
GR Reallocated to DFPS and DSHS for System EIs [67]	(0.8)	-	-	0.8	-	-
HHSC Total	**196.0**	**-**	**128.8**	**0.8**	**325.6**	**478.0/499.1**

[67] See Appendix 1 for a breakout of GR reallocated to DFPS and DSHS for System EIs by Exceptional Item.

Table 4. Exceptional Item Funding Included in Senate Committee Substitute for House Bill 2

	Method of Financing (millions)					
Description	General Revenue	GR-Dedicated	Federal Funds	Other Funds	All Funds	FTE
Partially Adopted						
EI #2, Residential Child Care Regulation	7.3	-	-	-	7.3	-
EI #7 – Information Technology (IT) Threat and System Stabilization and Restoration	38.8	-	18.3	-	57.1	-
EI #10 – Maintain Compliance with Federal Data Governance Requirements	6.0	-	1.8	-	7.8	-
EI #11, Complete Construction and Expanded Operations in State Hospitals	-	-	-	321.4	321.4	1.0/1.0
EI #12, Ensure Critical Facility Infrastructure Efficiency and Safety	11.0	-	-	23.7	34.6	-
Fully Adopted						
EI #5 – MMIS Modernization	34.6	-	257.0	-	291.6	-

	Method of Financing (millions)					
EI #13, Stabilize E-Discovery	4.9	-	2.3	-	7.2	-
Total	102.4	-	279.4	345.1	726.9	1.0/1.0

The following Sections A-Q provide additional details on funding by Exceptional Item and Exceptional Item subcomponent.

Residential Child Care Regulation

EI #2 – Residential Child Care Regulation (RCCR)	General Revenue	All Funds	FTE
Requested			
Respond to Foster Care Litigation	31.0	31.0	140.9/144.0
Migrate RCCR IT Systems from DFPS to HHSC and Perform Upgrades to WebLogic	7.3	7.3	9.0/9.0
Total	38.2	38.2	149.9/153.0
Adopted SB 1			
Respond to Foster Care Litigation	29.0	29.0	140.9/144.0
Migrate RCCR IT Systems from DFPS to HHSC and Perform Upgrades to WebLogic	-	-	9.0/9.0
Total	**29.0**	**29.0**	**149.9/153.0**
Adopted HB 2			
Respond to Foster Care Litigation	-	-	-
Migrate RCCR IT Systems from DFPS to HHSC and Perform Upgrades to WebLogic	7.3	7.3	-
Total	**7.3**	**7.3**	**-**
Total SB 1 and HB 2	36.3	36.3	149.9/153.0
Total EI Funding			
Respond to Foster Care Litigation	29.0	29.0	140.9/144.0

EI #2 – Residential Child Care Regulation (RCCR)	General Revenue	All Funds	FTE
Migrate RCCR IT Systems from DFPS to HHSC and Perform Upgrades to WebLogic	7.3	7.3	9.0/9.0
Total	**36.3**	**36.3**	**149.9/153.0**

Impact: SB 1 provides partial funding to meet the requirements of the ongoing Foster Care Litigation and the remedial orders in M.D. v. Abbott. This item provides critical funding to maintain lower caseload numbers, implement heightened monitoring functions, and complete technology changes required to support these function in response to court orders, and will help ensure a decrease in risk of a finding of contempt of court. The bill does not include funding requested by HHSC to restore the cost of monitor's fees in Strategy L.1.1 which were reduced in the Introduced Bill.

Full funding is provided in HB 2 to migrate certain IT systems from DFPS to HHSC and perform upgrades to the CLASS WebLogic servers.

Direct Acting Antiviral (DAA) Drugs for Hepatitis C with No Restrictions

EI #3 – DAA for Hepatitis C with No	General	All Funds	FTE
Requested			
Medicaid	44.4	112.9	-
State Hospitals	2.9	2.9	-
Total	**47.3**	**115.8**	**-**
Adopted SB 1			
Medicaid	20.0	51.2	-
Transfer Authority (Rider 22 and Rider 122)[68]	24.4	61.7	-
State Hospitals	1.3	1.3	-
Total	**45.7**	**114.2**	**-**
Total EI Funding			
Medicaid	20.0	51.2	
Transfer Authority (Rider 22 and Rider 122)	24.4	61.7	
State Hospitals	1.3	1.3	
Total	**45.7**	**114.2**	

Impact: SB 1 provides partial funding to expand access to drugs used to treat chronic Hepatitis C and direction by rider to transfer additional funds from

[68] Transfer authority provided in HHSC Rider 22 and Rider 122. Any transfers made to provide for costs that exceed the amounts provided would contribute to the Medicaid shortfall.

elsewhere in Goal A, Medicaid Client Services, if the cost of providing DAA to Medicaid enrollees diagnosed with Hepatitis C exceeds the amounts provided. to meet the request for the Medicaid population. This funding will allow HHSC to remove certain prior authorization requirements to align with federal guidance and provide access to treatment of Hepatitis C for approximately 21,000 individuals in Medicaid. Any transfers made to provide for costs that exceed the amounts provided would contribute to the Medicaid shortfall in fiscal year 2023.

While the Senate Committee Substitute for SB 1 included rider language providing transfer authority for HHSC to transfer up to $1.3 million in General Revenue in fiscal year 2022 and $0.3 million in fiscal year 2023 from elsewhere in the agency's budget if the cost of providing DAA to State hospital residents exceeds the amounts provided, that direction has been removed in the Conference Committee version.

Ensure Access to Medicaid Long-term Services and Supports Waivers

EI #4 – Community Care Waiver Slots	General Revenue	All Funds	FTE
Requested			
Community Care Waiver Slots	74.4	191.1	56.4 / 64.5
Total	**74.4**	**191.1**	**56.4 / 64.5**
Adopted SB 1			
Community Care	30.0	76.9	-
Total	**30.0**	**76.9**	-
Total EI Funding			
Community Care	30.0	76.9	-

EI #4 – Community Care Waiver Slots	General Revenue	All Funds	FTE
Total	**30.0**	**76.9**	**-**

Impact: SB 1 provides for 1,549 waiver slots for interest list reduction, but no additional funding for Promoting Independence efforts to transition and divert individuals from institutional settings. A breakout of average slots by fiscal year and total end of biennium waiver slots appears in Table 4. Funding for interest list reduction will allow HHSC to enroll additional individuals into the waiver programs but is unlikely to be sufficient to keep pace with population or interest list growth. Without funding for Promoting Independence transitions and diversions to the community, individuals are at risk for institutionalization or remaining institutionalized for longer periods of time at a higher cost to the state. HHSC would continue using attrition in the HCS waiver program to support Promoting Independence, but it is unknown if sufficient attrition slots would be available to meet the need throughout the biennium.

Table 4. Medicaid Home and Community-based Services (HCBS) Interest List Waiver Slots

Interest List Waiver Slots	Avg. Slots FY 2022	Avg. Slots FY 2023	End of Biennium
CLASS	104	295	381
DBMD	2	5	6
HCS (non-Promoting Independence)	148	419	542
MDCP	13	34	42
STAR+	28	83	107
TxHmL	129	364	471

Interest List Waiver Slots	Avg. Slots FY 2022	Avg. Slots FY 2023	End of Biennium
Total	**425**	**1,199**	**1,549**

Information Technology Threat and System Stabilization and Restoration

EI #7 – IT Threat and System Stabilization and Restoration	General Revenue	All Funds	FTE
Requested			
System-wide Business Enablement Platform	8.4	13.4	15.2/15.2
Modernize End-of-Life/End-of-Support Network Equipment	35.3	49.0	2.0/2.0
Cybersecurity Advancement	2.9	4.4	-
Stabilization of Enterprise Server and Storage	3.1	5.4	-
Winters Data Center Environment Protection Services	0.8	1.5	-
Total	**50.4**	**73.7**	**17.2/17.2**
Adopted SB 1			
System-wide Business Enablement Platform	-	-	15.2/15.2
Modernize End-of-Life/End-of-Support Network Equipment	-	-	2.0/2.0
Cybersecurity Advancement	2.9	4.4	-
Stabilization of Enterprise Server and Storage	-	-	-

EI #7 – IT Threat and System Stabilization and Restoration	General Revenue	All Funds	FTE
Winters Data Center Environment Protection Services	-	-	-
Total	**2.9**	**4.4**	**17.2/17.2**
Adopted HB 2			
System-wide Business Enablement Platform	8.4	13.4	-
Modernize End-of-Life/End-of-Support Network Equipment	26.4	36.7	-
Cybersecurity Advancement	-	-	-
Stabilization of Enterprise Server and Storage	3.1	5.4	-
Winters Data Center Environment Protection Services	0.8	1.5	-
Total	38.8	57.1	-
Total SB 1 and HB 2	**41.6**	**61.5**	**17.2/17.2**
Total EI Funding			
System-wide Business Enablement Platform	8.4	13.4	-
Modernize End-of-Life/End-of-Support Network Equipment	26.4	36.7	-
Cybersecurity Advancement	2.9	4.4	-
Stabilization of Enterprise Server and Storage	3.1	5.4	-

EI #7 – IT Threat and System Stabilization and Restoration	General Revenue	All Funds	FTE
Winters Data Center Environment Protection Services	0.8	1.5	-
Total	**41.6**	**61.5**	**17.2/17.2**

Impact: SB 1 fully funds the Cybersecurity Advancement subcomponent of this EI. HB 2 fully funds the System-wide Business Enablement Platform, Stabilization of Enterprise Server and Storage, and Winters Data Center Environment Protection Services subcomponents of this EI.

The Modernization End-of-Life/End-of-Support Network Equipment component is 75% funded. This approach limits ability to support stakeholder requirements and will result in continuation of production infrastructure operating past manufacturer end of support (EoS) with risks of unpatched security vulnerabilities and risk of failed federal audits for non-compliant equipment.

IDD System Redesign

EI #8 – IDD System Redesign	General Revenue	All Funds	FTE
Requested			
Provide Resources and Technology Changes Necessary to Implement STAR+PLUS Pilot Program	5.0	19.6	2.0/14.0
IDD Systems Migration	3.4	32.1	15.2/15.2
Total	**8.4**	**51.7**	**17.2/29.5**
Adopted SB 1			

EI #8 – IDD System Redesign	General Revenue	All Funds	FTE
Provide Resources and Technology Changes Necessary to Implement STAR+PLUS Pilot Program	-	-	-
Transfer Authority (Rider 25)[69]	5.0	19.6	2.0/14.0
IDD Systems Migration	3.4	32.1	15.2/15.2
Total	**8.4**	**51.7**	**17.2/29.5**
Total EI Funding			
Provide Resources and Technology Changes Necessary to Implement STAR+PLUS Pilot Program			
Transfer Authority (Rider 25)	5.0	19.6	2.0/14.0
IDD Systems Migration	3.4	32.1	15.2/15.2
Total	**8.4**	**51.7**	**17.2/29.5**

Impact: SB 1 fully funds the agency request for IDD Systems Migration, which will support technology enhancements to support IDD providers, LIDDAs, and service coordinators and to prevent gaps in eligibility or services as delivery of long-term supports and services for Individuals with IDD transition to managed care. The bill also includes Rider 25, STAR+PLUS Pilot Program and Medically Fragile Benefit, to authorize HHSC to transfer General Revenue from Goal A, Medicaid Client Services, without approval or notification to implement the STAR+PLUS pilot and the medically fragile benefit. The rider would also increase HHSC's FTE authority by 2.0 FTEs in fiscal year 2022 and 14.0 FTEs in fiscal year 2023. Any transfers made to

[69] Transfer authority provided in HHSC Rider 25. Any transfers made to provide for costs that exceed the amounts provided would contribute to the Medicaid shortfall.

provide for costs that exceed the amounts provided would contribute to the Medicaid shortfall in fiscal year 2023.

Comply with Federal Requirements for Community Integration for Individuals with Disabilities

EI #9 – Community Integration	General Revenue	All Funds	FTE
Requested			
Provide Individualized Skills and Socialization (ISS) Client Services	35.3	90.5	0.0/6.0
Create ISS Registry and Provide Monitoring and Oversight	0.9	1.7	0.0/18.0
Total	**36.2**	**92.2**	**0.0/24.0**
Adopted SB 1			
Provide Individualized Skills and Socialization (ISS) Client Services	-	-	-
Transfer Authority (Rider 23)	35.3	90.5	0.0/6.0
Create ISS Registry and Provide Monitoring and Oversight	0.9	1.7	0.0/18.0
Total	**36.2**	**92.2**	**0.0/18.0**
Total EI Funding			
Provide Individualized Skills and Socialization (ISS) Client Services	-	-	-
Transfer Authority (Rider 23)	35.3	90.5	0.0/6.0

EI #9 – Community Integration	General Revenue	All Funds	FTE
Create ISS Registry and Provide Monitoring and Oversight	0.9	1.7	0.0/18.0
Total	**36.2**	**92.2**	**0.0/18.0**

Impact: SB 1 fully funds the agency request to create an Individualized Skills and Socialization (ISS) Registry and to provide monitoring and oversight, which will fund necessary technology changes and to create a registry for providers of this service and HHSC staff to provide monitoring and oversight of the service and providers.

SB 1 also includes a rider (Rider 23) authorizing HHSC to transfer General Revenue from Goal A, Medicaid Client Services, without approval or notification to provide for reimbursement for the provision of ISS services. Any transfers made to provide for reimbursement for the provision of ISS services would contribute to the Medicaid shortfall in fiscal year 2023. The rider also authorizes HHSC to transfer funds to Strategy I.2.1, Long-Term Care Intake & Access, in fiscal year 2023 to address staffing needs related to the provision of ISS services and increase the agency FTE limitation by 6.0 FTEs.

Maintain Compliance with Federal Data Governance Requirements[70]

EI #10 – Maintain Compliance with Federal Data Governance Requirements	General Revenue	All Funds	FTE
Requested			
Restore Reductions for Certain IT Projects	9.7	12.5	4.1/4.1
Total	**9.7**	**12.5**	**4.1/4.1**
Adopted SB 1			
Restore Reductions for Certain IT Projects	-	-	2.0/2.0
Total	**-**	**-**	**2.0/2.0**
Adopted HB 2			
Restore Reductions for Certain IT Projects	6.0	7.8	-
Total	**6.0**	**7.8**	-
Total SB 1 and HB 2	**6.0**	**7.8**	**2.0/2.0**
Total EI Funding			
Restore Reductions for Certain IT Projects	6.0	7.8	2.0/2.0
Total	**6.0**	**7.8**	**2.0/2.0**

Impact: SB 1 and HB 2 partially fund the agency request to maintain the HHS System's current data governance and performance management capacity and support ongoing data quality, analytics, and performance management workloads, including restoration of proposed cuts to base capital project funding and replacing

[70] This Exceptional Item is titled "Restore Reductions for Certain IT Projects" on Legislative Budget Board Decision Documents.

federal matching funds for data governance and performance initiatives. While approximately $1.4 million in General Revenue in the original request was designated for the Performance Management and Analytics System (PMAS) capital project, HHSC's highest priority for the partial funding is to support Enterprise Data Governance (EDG) data quality needs of approximately $6.0 million in General Revenue.

The partial funding level will allow for HHSC to continue ongoing data quality and management efforts; however, EDG will be unable to bring in new non-Medicaid data sets that could allow HHS to meet data request demands that are continually increasing in number and complexity. The reduced funding amount significantly limits HHS' ongoing efforts and ability to leverage data, manage performance, and increase program leadership's ability to make data-driven decisions that are improving system efficiency and outcomes for individuals served by the HHS System.

For PMAS, only six of the 14 contractors supporting the system will be retained, at the expense of almost all other contingency, training, and technology needs. Any data modifications, enhancements, updates, or linkages within the performance management visualization systems will have to be put on hold indefinitely. With the funding provided HHSC will need to prioritize certain programs and data sets and decommission others, attempting to mitigate degradation of the system over time as much as possible. HHSC would create a backlog of needs and break-fixes that could not be addressed; however, rebuilding those connections to bring them back online at a later date will require significant additional costs and rework. Furthermore, there is no contingency to deal with system changes or problems that arise, creating more risk for the system.

Complete Construction and Expanded Operations in State Hospitals

EI #11 – Complete Construction and Expanded Operations in State Hospitals	General Revenue	All Funds	FTE
Requested			
Staff and Operations	81.4	81.4	260.0/260.0
Complete Construction Projects	276.5	276.5	-
Begin New Construction Projects	-	-	-
Total	357.9	357.9	260.0/260.0
Adopted SB 1			
Staff and Operations	69.6	69.6	260.0/26.0
Complete Construction Projects	-	-	-
Begin New Construction Projects	-	-	-
Staff and Operations for Expanded	16.4	16.4	-
Total	86.0	86.0	-
Adopted HB 2			
Staff and Operations	-	-	-
Complete Construction Projects	-	276.5	-
Begin New Construction Projects	-	44.9	1.0/1.0

[71] This item was included in the Introduced Senate Bill and is therefore not reflected in the requested amounts in this table.

EI #11 – Complete Construction and Expanded Operations in State Hospitals	General Revenue	All Funds	FTE
Total	**-**	**321.4**	**1.0/1.0**
Total SB 1 and HB 2	86.0	407.4	261.0/2
Total EI Funding			
Staff and Operations	69.6	69.6	260.0/2
Complete Construction Projects	-	276.5	-
Begin New Construction Projects	-	44.9	1.0/1.0
Staff and Operations for Expanded	16.4	16.4	-
Total	**86.0**	**407.4**	**261.0/**

Impact: HB 2 fully funds the remaining construction needs at Austin State Hospital and San Antonio State Hospital; however, it only partially funds new construction projects with ESF. HB 2 provides additional direction that funds are for pre-planning and planning efforts for a new state hospital in the Dallas-Fort Worth metropolitan area, including the acquisition of land for that purpose. HB 2 also provides $0.1 million in General Revenue and 1.0 FTE to oversee the construction projects.

SB 1 provides partial funding for expanded capacity operations at Kerrville State Hospital and/or the new Behavioral Sciences Center in Houston. HHSC will be able to operate fewer beds than anticipated with this partial funding amount. The Introduced Bill provided funding to address operational needs at the San Antonio State Hospital.

Address Long-term Care Regulation Backlog

EI #14 – Address Long-term Care Regulatory Backlog	General Revenue	All Funds	FTE
Requested			
Additional Staff	5.3	5.3	31.7/31.7
Automate Survey Scheduling	0.9	1.0	1.0/1.0
Restore Five Percent Reduction – Enforcement and Surveyor Staffing and Travel	1.7	2.1	-
Restore Five Percent Reduction –Data, Complaint, and Incident Intake and Trust Fund Monitoring	2.9	3.3	-
Position Reclassification and Salary Increases	12.3	12.3	-
Contracted Staff	5.0	5.0	-
Total	**28.1**	**29.0**	**32.7/32.7**
Adopted SB 1			
Additional Staff	-	5.3	31.7/31.7
Automate Survey Scheduling	-	-	-
Restore Five Percent Reduction – Enforcement and Surveyor Staffing and Travel	0.8	1.0	-

EI #14 – Address Long-term Care Regulatory Backlog	General Revenue	All Funds	FTE
Restore Five Percent Reduction –Data, Complaint, and Incident Intake and Trust Fund Monitoring	-	-	-
Position Reclassification and Salary Increases	-	-	-
Contracted Staff	-	-	-
Total	**0.8**	**6.3**	**31.7/31.7**
Total EI Funding			
Additional Staff	-	5.3	31.7/31.7
Automate Survey Scheduling	-	-	-
Restore Five Percent Reduction – Enforcement and Surveyor Staffing and Travel	0.8	1.0	-
Restore Five Percent Reduction –Data, Complaint, and Incident Intake and Trust Fund Monitoring	-	-	-
Position Reclassification and Salary Increases	-	-	-
Contracted Staff	-	-	-
Total	**0.8**	**6.3**	**31.7/31.7**

Impact: SB 1 provides $5.3 million in Federal Funds and 31.7 FTEs in each fiscal year for Additional Staff to Address Long-term Care Regulation Backlogs and includes a rider that the funding and FTEs are contingent upon federal funds being made available for that purpose.

SB 1 also partially funds HHSC's request to restore 5 percent reductions included in the Introduced Bill related to enforcement and surveyor staffing and travel. A 5 percent reduction in funding for enforcement and surveyor staff and travel is equivalent to reducing staff by 11 positions. The adopted funding level would limit that reduction to approximately 5.5 FTEs. Other subcomponents of this request were not funded.

Facility Support Services

EI #16 – Facility Support Services	General Revenue	All Funds	FTE
Requested			
Additional Staff	6.1	6.1	-
Total	**6.1**	**6.1**	**-**
Adopted SB 1			
Additional Staff	4.0	4.0	-
Total	**4.0**	**4.0**	**-**
Total EI Funding			
Additional Staff	4.0	4.0	-
Total	**4.0**	**4.0**	**-**

Impact: The Conference Committee version of SB 1 partially funds HHSC's request to reinstate $6.1 million in General Revenue reduced from Strategy G.4.1, Facility Support Services, in SB 1 As Introduced. SB 1 also includes a rider stating that the intent of the Legislature is for the funds to be used to avoid a reduction in force.

To address the reduction, HHSC may be required to cancel or reduce some current high-level priority repair and renovation projects (which include things like roof and HVAC replacement, or anti-ligature projects). Canceling or reducing the scope of

these projects will let HHSC reallocate associated staff costs and potentially avoid a reduction-in-force (RIF).

Strategy G.4.1 includes operating funds for the Facility Support Services (FSS) department. FSS provides general services and supports to the state hospitals and state supported living centers (SSLCs) which, together, serve around 5,000 people each day across 1,400 buildings. FSS provides a full range of logistical, technical, and programmatic assistance to facilitate 24-hour, 365-day operation of our campuses.

Electronic Visit Verification

EI #6 – Electronic Visit Verification	General Revenue	All Funds	FTE
Requested			
Transaction Costs	0.8	3.0	-
Update Claims Administrator Systems	0.2	1.5	-
Update Contracted Vendor Systems	0.4	3.5	-
Total	**1.3**	**8.0**	**-**
Adopted SB 1			
Transaction Costs	0.8	3.0	-
Update Claims Administrator Systems	0.2	1.5	-
Update Contracted Vendor Systems	0.4	3.5	-
Total	**1.3**	**8.0**	**-**
Total EI Funding			
Transaction Costs	0.8	3.0	-
Update Claims Administrator Systems	0.2	1.5	-
Update Contracted Vendor Systems	0.4	3.5	-
Total	**1.3**	**8.0**	**-**

Impact: SB 1 fully funds the request for Electronic Visit Verification (EVV). This funding will provide for federal mandated technology modifications to the EVV claims submission software, EVV Portal, and EVV Vendor Systems that will ensure

accurate processing of claims and data for home health care services and compliance with federal requirements.

MMIS Modernization

EI #5 – MMIS Modernization	General Revenue	All Funds	FTE
Requested			
Procurement and Transition	31.6	266.4	-
Vendor Drug Program Pharmacy Benefits Services Modernization	2.9	25.2	-
Total	**34.6**	**291.6**	**-**
Adopted SB 1			
Procurement and Transition	-	-	-
Vendor Drug Program Pharmacy Benefits Services Modernization	-	-	-
Total	**-**	**-**	**-**
Adopted HB 2			
Procurement and Transition	31.6	266.4	-
Vendor Drug Program Pharmacy Benefits Services Modernization	2.9	25.2	-
Total	**34.6**	**291.6**	**-**
Total SB 1 and HB 2	**34.6**	**291.6**	**-**
Total EI Funding			
Procurement and Transition	31.6	266.4	-

EI #5 – MMIS Modernization	General Revenue	All Funds	FTE
Vendor Drug Program Pharmacy Benefits Services Modernization	2.9	25.2	-
Total	**34.6**	**291.6**	**-**

Impact: HB 2 fully funds the agency request for MMIS Modernization and to transition the current Vendor Drug Program (VDP) system to a VDP Pharmacy Benefits Services Modernization (VPM) solution, which was partially funded by the 86th Legislature. Funding will ensure that HHSC will comply with Centers for Medicare and Medicaid Services (CMS) guidance and will mitigate the risks of possible service disruptions and significant impacts to Medicaid and CHIP members and providers from continuing to utilize the current MMIS structure.

Moving systems into a more standardized, modular environment allows for quicker and more cost-effective enhancements in response to federal and state requirements. In addition, a user friendly, single sign-on portal will standardize and streamline provider logons and accessibility creating efficiencies and greater provider satisfaction. The shift to conform to national standards and discontinue Texas specific claim submission guidelines will lessen provider administrative burden. Additionally, pharmacy providers will no longer need to use two systems to separately enroll the pharmacy (paper-based system) and their durable medical equipment (DME) business in the TMHP system.

VDP includes all covered outpatient drugs administered through fee-for-service and managed care clients within Medicaid, CHIP, Healthy Texas Women, Children with Special Health Care Needs, and Kidney Health Care. Funding will allow HHSC to complete the transition and provide the ability to administer and modernize all aspects of VDP by providing a flexible, integrated, and clinical evidence-based approach to manage drug utilization. The VPM solution will transition four independent Vendor Drug Program Pharmacy Benefit Services contracts to a combined technology and business solution.

Ensure Critical Facility Infrastructure Efficiency and Safety

EI #12 – Ensure Critical Facility Infrastructure Efficiency and Safety	General Revenue	All Funds	FTE
Requested			
Deferred Maintenance	47.8	94.8	4.1/4.1
Laundry Equipment Replacement	2.0	2.0	-
Vehicle Replacement	7.9	7.9	-
IT Infrastructure	3.1	3.1	-
Total	**60.8**	**107.7**	**4.1/4.1**
Adopted SB 1			
Deferred Maintenance	-	-	-
Laundry Equipment Replacement	-	-	-
Vehicle Replacement	-	-	-
IT Infrastructure	-	-	-
Total	**-**	**-**	**-**
Adopted HB 2			
Deferred Maintenance	-	23.7	-
Laundry Equipment Replacement	-	-	-
Vehicle Replacement	7.9	7.9	-
IT Infrastructure	3.1	3.1	-
Total	**11.0**	**34.6**	**-**

EI #12 – Ensure Critical Facility Infrastructure Efficiency and Safety	General Revenue	All Funds	FTE
Total SB 1 and HB 2	**11.0**	**34.6**	**-**
Total EI Funding			
Deferred Maintenance	-	23.7	-
Laundry Equipment Replacement	-	-	-
Vehicle Replacement	7.9	7.9	-
IT Infrastructure	3.1	3.1	-
Total	**11.0**	**34.6**	**-**

Impact: HB 2 includes approximately $23.7 million for critical repair and renovations, to be funded through the Master Lease Purchase Program. This funding will be used to address the most critical needs that emerge during the 2022-23 biennium but may be insufficient to address current known needs. Further, the use of MLPP funds, as opposed to General Revenue or ESF, means the agency will be delayed in accessing these funds. HB 2 fully funds HHSC's request for Vehicle Replacement and IT Infrastructure.

The Conference Committee did not adopt funding for Laundry Equipment Replacement which was previously funded in CSSB 1. HSCS operates under a 10-year plan for replacement of laundry equipment. When replacement is underfunded in a given biennium, critical support failures and challenging situations impact operations for years to come. Current repair projects will need to be suspended, and operational funds may need to be diverted to address repairs on critical items.

The Exceptional Item request was to ensure critical infrastructure at the State Hospitals and SSLCs including vehicles, warehouse and laundry equipment, adequate IT infrastructure and properly repaired and maintained buildings. The request included:

- Repair and renovation: The requested amount includes the two most urgent projects per campus, including critical repairs and renovations for things like

fire systems, HVAC, electrical and plumbing, anti-ligature remediation and roofing. This request includes 4.0 project managers to manage these highly technical projects.

- Regional laundry equipment and fleet: The request is equal to the amount appropriated by the 86th Legislature. This request includes replacement of 197 vehicles, one continuous batch washing system, two dryers and some additional commercial laundry equipment and transport trailers. All items included have already exceeded their expected life.

- Information Technology (IT): The amount requested is the minimum amount required to complete fiber and cabling projects begun this biennium, which allow us to access medical records, building automation and fire systems.

Client Services Cost Growth

EI #1 – Provide for Client Services Cost	General	All Funds	FTE
Requested			
Medicaid Entitlement	1,441.0	2,654.2	-
Medicaid Intensive Behavioral Intervention (IBI) Services	80.5	198.5	-
Medicaid Non-Entitlement	9.9	(27.1)	-
Children's Health Insurance Program (CHIP)	45.9	138.7	-
Temporary Assistance for Needy Families (TANF) Cash Assistance	8.6	8.6	-
Total	**1,585.9**	**2,972.9**	**-**
Adopted			
Medicaid Entitlement	-	-	-
Medicaid Intensive Behavioral Intervention (IBI) Services	-	-	-
Medicaid Non-Entitlement	-	-	-
Children's Health Insurance Program (CHIP)	-	-	-
Temporary Assistance for Needy Families (TANF) Cash Assistance	-	-	-
Total	-	-	-

Impact: SB 1 does not fund HHSC's request for cost growth for Medicaid (entitlement and non-entitlement), Children's Health Insurance Program (CHIP),

and Temporary Assistance for Needy Families (TANF). Because Medicaid is an entitlement program, not receiving funding for this request will increase HHSC's shortfall for the next biennium (FY 2022-23).

Stabilize E-Discovery

EI #13 – Stabilize E-Discovery	General	All Funds	FTE
Requested			
Stabilize E-Discovery	4.9	7.2	-
Total	**4.9**	**7.2**	**-**
Adopted SB 1			
Stabilize E-Discovery	-	-	-
Total	-	-	-
Adopted HB 2			
Stabilize E-Discovery	4.9	7.2	-
Total	**4.9**	**7.2**	**-**
Total SB 1 and HB 2	**4.9**	**7.2**	**-**
Total EI Funding			
Stabilize E-Discovery	4.9	7.2	-
Total	**4.9**	**7.2**	**-**

Impact: HB 2 fully funds HHSC's request to replace the E-Discovery technology with General Revenue and Federal Funds, which would allow the agency to effectively and efficiently produce information required for litigation, public information requests, and investigations.

CAPPS Compliance and Stabilization

EI #15 – CAPPS Compliance and Stabilization	General Revenue	All Funds	FTE
Requested			
Migrate Accounts Receivable Tracking System (ARTS) to CAPPS Financials	5.8	9.6	0.2/3.0
Total	**5.8**	**9.6**	**0.2/3.0**
Adopted			
Migrate Accounts Receivable Tracking System (ARTS) to CAPPS Financials	-	-	-
CAPPS Human Capital Management System	10.8	15.0	
Total	**10.8**	**15.0**	**-**
Total EI Funding			
Migrate Accounts Receivable Tracking System	-	-	-
CAPPS Human Capital Management System	10.8	15.0	
Total	**10.8**	**15.0**	**-**

Impact: SB 1 does not provide additional funding for migrating the Accounts Receivable Tracking System (ARTS) to CAPPS Financials, but adopts capital budget authority only, which will require HHSC to reallocate $9.6 million in existing funds in Strategy L.1.2, IT Oversight & Program Support for this project.

[72] This item was included in the Introduced Senate Bill and is therefore not reflected in the requested amounts in this table.

Funding for updates to the CAPPS Human Capital Management system and CAPPS Financials was provided in the Senate Introduced Bill.

Background: This is a request to replace the current 25-year old Accounts Receivable Tracking System (ARTS) with a solution with functionality, reporting and support to be integrated with the existing PeopleSoft CAPPS Financials - web-based application by enabling and customizing the Accounts Receivable module within PeopleSoft product.

Built in 1995, there is very limited ability to find resources to support the current platform and the fragile system can't support audit finding's security concerns. Without ARTS, HHS would not be able to create or track any receivables for agency programs. HHS Finance could risk non-compliance with the State requirement to deposit State and Federal funds within the 3-day timeframe mandated by Texas Administrative, Section 404.094. In addition, there are federal regulations, related to Medicaid, CHIP and WIC, which require the use of rebates (approximately $2.5 billion) prior to requesting federal grant funds.

Article II Assessment Costs

EI #17 – Article II Assessment Costs	General	All Funds	FTE
Requested			
Article II Assessment Costs	35.3	35.3	-
Total	**35.3**	**35.3**	**-**
Adopted			
Article II Assessment Costs	-	-	-
Total	-	-	-
Total EI Funding			
Article II Assessment Costs	-	-	-
Total	-	-	-

Impact: SB 1 does not fund HHSC's request to support the ongoing cost to HHSC for providing administrative support services to DSHS and DFPS. Interruptions to critical HHS services may occur, as a result.

Background: The Health and Human Services (HHS) system has transformed over the last five years. House Bill 200, 84th Legislature, Regular Session, 2015, took a phased approach to restructuring the health and human services system, including transferring the Department of Assistive and Rehabilitative Services (DARS), Department of Aging and Disability Services (DADS), client services at DSHS; and certain administrative services to HHSC. House Bill 208, 84th Legislature, Regular Session, 2015, transferred the Vocational Rehabilitation Services program to the Texas Workforce Commission (TWC). House Bill 5, 85th Legislature, Regular Session, 2017, established DFPS as a stand-alone agency.

The transfer and consolidation of Article II agencies shifted administrative and support costs both to and between HHSC, DSHS, and DFPS. While abolishing DARS and the subsequent transfer of vocational rehabilitation services to TWC did allow for some reductions to administrative support, certain administrative costs could not be reduced. This transfer meant the costs previously allocated to DARS shifted to the remaining Article II agencies. And although HHSC was appropriated a portion of the necessary funding to address this consolidation, DSHS and DFPS were not appropriated additional funding.

Baseline

HHSC's LAR baseline funding request totaled $84,415.9 million All Funds, including $71,372.1 million All Funds related to Medicaid and CHIP client services and $13,043.8 million All Funds related to other client services and agency operations. Total baseline funding in SB 1 totals $78,208.1 million All Funds, including $65,644.3 million All Funds related to Medicaid and CHIP client services and $12,563.8 related to other client services and agency operations.

Table 7. Significant Changes from the 2022-23 Baseline Request

Method of Financing (millions)						
Description	General Revenue	GR-D	Federal Funds	Other Funds	All Funds	FTE
(1) Notable Baseline Changes	(140.2)	0.0	(96.0)	(14.3)	(250.6)	(385.1/ 385.3)
(2) Additional Funding Not Requested in Exceptional Item	4.6	-	2.7	-	7.4	-
(3) Updated Client Services - Medicaid / CHIP	(2,242.1)	-	(3,460.9)	-	(5,703.0)	-
(4) Updated Client Services - Non-Medicaid/ CHIP	61.3	-	20.1	(0.1)	81.3	-
(5) Updated Revenue Projections	(71.4)	18.7	(2.4)	(5.3)	(72.8)	-
(6) Transfers	(5.0)	-	0.1	4.4	(0.4)	1.0/1.0
(7) Other	(0.6)	-	(3.4)	(208.8)	(212.8)	-
Total	**(2,393.2)**	**18.7**	**(3,539.6)**	**(224.1)**	**(6,138.2)**	**(384.1/ 384.3)**

Section 1. Notable Baseline Changes

A breakdown of funding reductions included in the Introduced Bill that were considered for baseline restoration exceptional items appears in the table below.

	Method of Financing (millions)					
Description	General	General	Federal	Other	All	FTE
(1.1) All Texas Access (Senate Bill	(0.6)	-	(0.0)	-	(0.6)	
(1.2) Behavioral Health Waiver	(14.3)	-	(33.1)	-	(47.4)	
(1.3) General Revenue to Support	(7.0)	-	-	-	(7.0)	
(1.4) Human Trafficking Program	(7.0)	-	-	-	(7.0)	
(1.5) Monitoring Fees	(1.9)	-	-	-	(1.9)	
(1.6) Pediatric Tele-Connectivity Program	(1.1)	-	-	-	(1.1)	
(1.7) Mental Health State Hospitals	(7.2)	-	(0.0)	0.0	(7.2)	
(1.8) State Supported Living	(1.5)	-	(6.3)	(0.9)	(8.7)	10.0/ 10.0
(1.9) Umbilical Cord Blood Bank	(2.0)	-	-	-	(2.0)	
(1.10) Waitlist Avoidance Funding for Mental Health	(23.6)	-	-	-	(23.6)	
(1.11) Facility Support	(5.8)	-	(0.1)	(0.2)	(6.1)	

Method of Financing (millions)						
(1.12) PMAS Capital Project	(1.2)	(0.2)	(3.3)	(0.8)	(5.6)	
(1.13) General Reduction to Information Technology	(5.5)	0.2	0.3	(4.0)	(8.9)	
(1.14) Data Center Services	(64.3)	-	(53.9)	(8.4)	(126.7)	-
(1.15) Reimbursement	2.8	-	0.4	-	3.2	6.1/
(1.16) Other FTE Reductions	-	-	-	-	-	(401.2/ 401.4)
Total	**(140.2)**	**0.0**	**(96.0)**	**(14.3)**	**(250.6)**	**(385.1/**

(1.1) All Texas Access (Senate Bill 633, 86th Legislature, Regular Session)

SB 1 reduces $0.60 million in All Funds, including $0.56 million in General Revenue in Strategy D.2.1, Community Mental Services – Adults.

Funding was originally provided in Article IX, Sec. 18.68, Contingency for SB 633 (2020-21 General Appropriations Act, 86th Legislature, Regular Session, 2019).

(1.2) Behavioral Health Waiver

SB 1 maintains fiscal year 2021 caseloads and costs per client for the Home and Community Based Services - Adult Mental Health Program and Youth Empowerment Services Waiver, resulting in a net decrease of $47.4 million in All Funds, including $14.3 million in General Revenue.

[73] This item is not included in the Strategy and Method of Financing tables in the General Appropriations Bill. It is a below-the-line appropriation in Special Provisions Relating to All Health and Human Services Agencies and is reflected in a separate line item titled Supplemental Appropriations Made in Riders.

Performance Measure Comparison Strategy D.2.5, Behavioral Health Waiver and State Plan Amendment

	Baseline Request		House Bill	
Performance Measure	**FY 2022**	**FY 2023**	**FY 2022**	**FY 2023**
Avg. Monthly Number of Clients	350.6	417.4	271	271
Avg. Monthly Cost Per Client	5,413.78	5,578.16	4,538.42	4,538.42
Average Monthly Number of	1,392.5	1,479.7	1,814	1,814
Avg. Monthly Cost per Client	547.9	572.2	463.74	463.74

(1.3) General Revenue to Support Cost Allocation Changes

SB 1 reduces $7.0 million in General Revenue that was reallocated to Strategy L.1.1, HHS System Supports, from General Revenue made available due to increased federal financial participation in the baseline request.

The General Revenue was reallocated in the baseline request to support cost allocation changes from measuring salary to FTE counts to better represent the relative benefit received by each Article II agency. This was a result of changes in the HHS System cost allocation methodologies.

Cost allocation changes also shifted cost to General Revenue in-lieu of limited federal titles and block grants to avoid exceeding the administrative caps on these titles. This shift was made to avoid projected shortfalls that could create potential interruptions in administrative services required to deliver critical services.

(1.4) Human Trafficking Program

SB 1 reduces $7.0 million in General Revenue that was reallocated to Strategy F.3.1, Family Violence Services, from General Revenue made available due to increased federal financial participation in the baseline request.

The General Revenue was reallocated in the baseline request to implement the requirements of SB 20, 86th Legislature, Regular Session, 2019.

HHSC did not receive additional funding to implement the requirements of the legislation in the 2020-21 General Appropriations Act.[74]

(1.5) Monitoring Fees

SB 1 As Introduced reduced $1.9 million in General Revenue in Strategy L.1.1, Enterprise Oversight and Policy, which was used in the 2020-21 biennium to pay for foster care litigation monitoring fees.

- HHSC did not receive additional funding to pay for these monitoring fees in the 2020-21 General Appropriations Act.

(1.6) Pediatric Tele-Connectivity Program for Rural Texas

SB 1 reduces $1.1 million in General Revenue in Strategy D.1.10, Additional Specialty Care, for lower projections for the Pediatric Tele-Connectivity Program for Rural Texas.

Funding was originally provided in Rider 84, Pediatric Health Tele-Connectivity Resource Program for Rural Texas[75].

(1.7) Mental Health State Hospitals

SB 1 reduces $7.2 million in All Funds to reflect LBB projections for Strategy G.2.1, Mental Health State Hospitals, based on census and other data.

(1.8) State Supported Living Centers

SB 1 reduces $8.7 million in All Funds, including $1.5 million in General Revenue, to reflect LBB projections for Strategy G.1.1, State Supported Living Centers, based on census and other data.

(1.9) Umbilical Cord Blood Bank

SB 1 reduces $2.0 million in General Revenue in Strategy D.1.10, Additional Specialty Care, for the Umbilical Cord Blood Bank.

[74] 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 191).
[75] 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 84).

(1.10) Waitlist Avoidance Funding for Substance Abuse Treatment Services

SB 1 reduces $23.6 million in General Revenue in fiscal year 2022 for the substance abuse waitlist for pregnant women and women with dependent children waiting to receive services.

Funding was provided in the 2020-21 General Appropriations Act[76] and was included in HHSC's baseline LAR request.

This reduction is partially offset by an additional $3.6 million in General Revenue to biennialize funding provided in the 2020-21 General Appropriations Act for a rate increase for substance abuse treatment services provided under Strategy D.2.4, Substance Abuse Services[77].

Funding is provided to maintain the higher fiscal year 2021 appropriated amount through the 2022-23 biennium.

(1.11) Facility Support

SB 1 reduces $6.1 million in All Funds, including $5.8 million in General Revenue, in Strategy G.4.1, Facility Program Support, to align the All Funds appropriation level in each fiscal year to the fiscal year 2021 appropriated amount in Fiscal Size-Up.

The 2020-21 General Appropriations Act included $9.8 million in General Revenue for Vehicle Replacement and Laundry and Equipment Replacement. This General Revenue was removed from HHSC's General Revenue Limit. Restoration of this reduction was requested Exceptional Item 16.

(1.12) Performance Management and Analytics System (PMAS) Capital Project

SB 1 As Introduced reduced $5.6 million in All Funds, including $1.4 million in General Revenue in Strategy L.1.2, IT Oversight and Program Support for the PMAS Capital Project. Restoration of this reduction was requested in EI 10.

[76] 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 64).
[77] Ibid

(1.13) General Reduction to Information Technology

SB 1 includes an additional net reduction of $32.3 million in All Funds, including $17.6 million in General Revenue, in Strategy L.1.2, IT Oversight and Program Support. The net reductions include:

- Increase of $23.4 million in All Funds, including $12.2 million in General Revenue, for the Data Center Services capital project.
- Decreases related to one-time funding not removed in the General Revenue limit, including:
    - Automate National Sex Offender Registry (NSOR) Searches (Exceptional Item 41a [2020-21 LAR])
    - Enhance Long-term Care Background Checks (Exceptional Item 41b [2020-21 LAR])
- Decrease related to assumptions about ongoing operating costs for the System-wide Business Enablement Platform. Restoration of this reduction was requested in EI 10.

(1.14) Data Center Services

Each Chamber's Introduced bill maintained the 2020-21 appropriated level of $126.7 million in All Funds, including $64.3 million in General Revenue for Data Center Services (DCS). The Conference Committee on Senate Bill 1 adopted an item removing funding for Data Center Services from SB 1 and moving it to HB 2, the Senate Committee Substitute for the supplemental appropriations bill for the 2020-21 biennium.

(1.15) Reimbursement Methodology for Foster Care and Community-Based Care

SB 1 includes a new Section in Special Provisions Relating to All Health and Human Services Agencies appropriating additional funds and FTEs to the Department of Family and Protective Services and HHSC in order to establish a proposal for an alternative reimbursement methodology for Foster Care and Community-Based Care.

Strategy	General Revenue	All Funds	FTEs
Department of Family and Protective Services			
B.1.2, CPS Program Support	452,616	455,308	1.0/1.0
Health and Human Services Commission			
L.1.1, HHS System Supports	2,471,043	2,487,256	5.1/5.1
B.1.1, Medicaid Contracts and Administration	339,439	678,878	1.0/1.0
HHSC Total	**2,810,482**	**3,166,134**	**6.1/6.1**

(1.16) Other FTE Reductions

SB 1 includes other FTE reductions totaling 401.2 FTEs in fiscal year 2022 and 401.4 FTEs in fiscal year 2023. Reductions include:

- A reduction of 102.3 FTEs related to proposed 5 percent reduction items which were included in HHSC's baseline LAR request. 32.5 FTEs related to the Office of the Inspector General were reduced in Senate Bill 1 As Introduced. Another 69.8 FTEs were reduced in the Committee Substitute. FTEs were reduced from the strategies in the table below.

Area	FTE Reduction
H.1.1, Facility/Community-Based Regulation	(22.7)
I.1.1, Integrated Eligibility & Enrollment	(2.0)
I.2.1, Long-Term Care Intake & Access	(2.0)
K.1.1, Office of Inspector General	(36.7)
K.1.2, Office of Inspector General Administrative Support	(3.9)
L.1.1, HHS System Supports	(21.0)
L.2.1, Central Program Support	(14.0)
Total	(102.3)

- A reduction of 260.0 FTEs in each fiscal year from HHSC's baseline request related to Kerrville State Hospital expansion. These FTEs were instead reflected as part of the request for Exceptional Item 11, Complete Construction and Expanded Operations in State Hospitals.
- A reduction of 27.7 FTEs in Long-Term Care Intake and Access related to the agency's revised request for monitoring of Area Agencies on Aging;
- A reduction of 12.4 FTEs associated with one-time costs or discontinued programs.

There remains an offsetting increase of approximately 1.0 FTE in each fiscal year for which HHSC will need to work with the Legislative Budget Board to determine intent.

Section 2. Additional Funding Not Requested in an Exceptional Item

Method of Financing (millions)						
Description	General	General	Federal	Other	All Funds	FTE
(2.1) RTE for Electronic Visit Verification	0.8	-	2.5	-	3.3	-
(2.2) Biennialize Substance Abuse	3.6	-	-	-	3.6	-
(2.3) Texas Law Enforcement Peer Network	-	-	-	-	-	-
(2.4) Questionnaire for Long-term	0.2	-	0.2	-	0.5	-
(2.5) Non-contingent	-	-	-	-	-	-
Total	4.6	-	2.7	-	7.4	-

(2.1) Request to Exceed (RTE) for Electronic Visit Verification

SB 1 includes $3.4 million in All Funds, including $2.5 million in General Revenue, to reflect an outstanding Request to Exceed (RTE) for Electronic Visit Verification in Strategy B.1.1, Medicaid Contracts and Administration.

(2.2) Biennialize Substance Abuse Treatment Services Rate Increase

SB 1 includes $3.6 million in General Revenue to biennialize funding provided in the 2020-21 General Appropriations Act for a rate increase for substance abuse

treatment services provided under Strategy D.2.4, Substance Abuse Services[78]. Funding is provided to maintain the higher fiscal year 2021 appropriated amount through the 2022-23 biennium.

(2.3) Texas Law Enforcement Peer Network

SB 1, As Introduced, also added a new Rider 32, Texas Law Enforcement Peer Network, along with $1.1 million in additional General Revenue to establish a mental health peer network for law enforcement officers. Conference Committee decisions transfer the General Revenue and the rider establishing the peer network to the Texas Commission on Law Enforcement.

(2.4) Questionnaire for Long-term Services and Supports Waiver Program Interest List

SB 1 includes an additional $0.5 million in All Funds in Strategy I.2.1, Long-term Care Intake & Access, to revise the Questionnaire for Long-term Services and Supports (LTSS) Waiver Program Interest Lists to capture information necessary to determine the types of services individuals need and when services are needed to ensure the individual's health and safety in the least restrictive setting. HHSC would be required to consult appropriate stakeholders in revising the Questionnaire. Funding also supports administration of the revised questionnaire to individuals on IDD waiver interest lists.

(2.5) Non-contingent Appropriations Included in Article IX

SB 1 includes two provisions in Article IX that provide a total of $10.5 million in additional General Revenue appropriations to HHSC. Because these appropriations are not reflected in HHSC's bill pattern, they are not reflected in SB 1 appropriation amounts in this document. The relevant provisions include:

- **Article IX, Sec. 17.31, Multi-Assistance Demonstration Project.** This provision appropriates $7.5 million in General Revenue in Strategy D.1.10, Additional Specialty Care, to support a demonstration project providing comprehensive medical, therapeutic, and non-medical services to adults and children with special needs. The provision requires a report by August 31, 2023, detailing a review of the demonstration project and outlining best practices to implement the model elsewhere in the state. The rider also provides HHSC with authority to make transfers among strategies in its bill

[78] 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 64).

pattern to efficiently implement these provisions with prior notification to the LBB.

- **Article IX, Sec. 17.32, Rusk State Hospital Building #5 Demolition.** This provision appropriates $3.0 million in General Revenue in fiscal year 2022 and increases HHSC's capital budget authority by a like amount to demolish several buildings on the campus of Rusk State Hospital. While the rider states that the funding is for demolition of building #5, HHSC has received additional direction from legislative leadership stating that the intention was to provide funding for the demolition of 5 different buildings at Rusk State Hospital.

Article IX typically contains General Provisions that are applicable to all state agencies or to multiple agencies that are not within the same Article, and is also historically where contingency riders providing funding to implement legislation contingent on passage of that legislation. In SB 1, Article IX includes several riders appropriating additional funds to several agencies, including HHSC, that are not contingent upon the passage of legislation.

These appropriations are not reflected in the HHSC bill pattern. Historically, appropriations made in this manner are moved to the relevant agency bill pattern during Fiscal Size-Up, when the Legislative Budget Board (LBB) publishes a version of the Conference Committee bill that adjusts appropriation figures to incorporate certain Article IX provisions into agency bill patterns, incorporates other legislation and resolutions enacted by the Legislature which affect appropriations, and makes technical changes and/or reconciling adjustments.

Because these appropriations are not reflected in HHSC's bill pattern, they are not reflected in SB 1 appropriation amounts in this document.

Section 3. Updated Client Services – Medicaid/CHIP

	Method of Financing (millions)					
Description	General	General	Federal	Othe	All Funds	FTE
(3.1) Medicaid Cost Containment	(350.0)	-	(547.1)	-	(897.1)	-
(3.2) Reduce Medicaid Funding	(1,850.0)	-	(2,890.6)	-	(4,740.6)	-
(3.3) Assume Medicaid Eligible	(9.0)	-	19.2	-	10.2	-
(3.4) Intensive Behavioral	(80.5)	-	(118.0)	-	(198.5)	-
(3.5) Rate Increase for Pediatric Long-	1.5	-	2.3	-	3.8	-
(3.6) Increase Reimbursement for	47.6	-	75.9	-	123.5	-
(3.7) Emergency Triage, Treat, and Transport	(1.7)		(2.6)	-	(4.3)	-
Total	**(2,242.1)**	**-**	**(3,460.9)**	**-**	**(5,703.0)**	**-**

(3.1) Medicaid Cost Containment

SB 1 reduces appropriations in Goal A, Medicaid Client Services, to reflect a cost containment target of $350.0 million in General Revenue for the 2022-23 biennium. The bill also includes Rider 112, Health and Human Services Cost Containment, to provide additional direction and reporting requirements related to cost containment initiatives.

Table 5 provides cost containment targets for the previous four biennia. The cost containment targets typically assume some combination of increased fraud, waste,

and abuse prevention and detection activities, increased use of federal flexibility in the Medicaid program, and other programmatic and administrative efficiencies. Appropriation reductions for cost containment are reflected in Medicaid. Variances between the cost containment targets and actual cost containment typically increase the Medicaid supplemental need.

Table 5. Historical Cost Containment Targets.

Biennium	General	Federal Funds
2020-21 General Appropriations Act	(350,000,000)	Not specified
2018-19 General Appropriations Act	(350,000,000)	(480,000,000)
2016-17 General Appropriations	(373,000,000)	(496,570,428)
2014-15 General Appropriations Act	(400,000,000)	(561,602,696)

(3.2) Reduce Medicaid Funding

In addition to cost containment initiatives, SB 1 includes a further reduction of $4,740.6 million in All Funds, including $1,850.0 million in General Revenue to Medicaid. This reduction will significantly impact the supplemental appropriations need in fiscal year 2023.

(3.3) Assume Medicaid Eligible Activities Associated to SB 750 (86R)

SB 1 assumes Medicaid eligible activities in the Women's Health Program associated to SB 750, 86th Legislature, Regular Session, 2019, resulting in a net increase in Federal Funds;

(3.4) Intensive Behavioral Intervention

SB 1 includes a decrease of $198.5 in All Funds, including $77.5 million in General Revenue Funds, which is primarily driven by the assumed implementation of intensive behavioral intervention services for autism in Medicaid beginning in February 2022 instead of in March 2021.

(3.5) Rate Increase for Pediatric Long-term Care Facilities

SB 1 includes an additional $3.8 million in All Funds in Goal A, Medicaid Client Services, for a rate increase to Pediatric Long-term Care Facilities and adds a rider identifying the appropriations. The rider directs that appropriated funds must be used to revise reimbursement methodology for pediatric long-term care facilities to mirror that of Medicare Reimbursement.

This item provides sufficient funding to support 11.0 FTEs at HHSC but only provides authority for 6.1 additional FTEs.

(3.6) Increase Reimbursement for Medicaid Services Provided by Rural Hospitals

SB 1 provides an additional $61.0 million in All Funds, including $23.5 million in General Revenue in fiscal year 2022 and $62.5 million in All Funds, including $24.1 million in General Revenue in fiscal year 2023 to increase reimbursement for Medicaid services provided by rural hospitals. The additional funding is identified in Rider 8, Hospital Payments.

(3.7) Emergency Triage, Treat, and Transport Demonstration Payment Model

SB 1 adds a rider directing the agency to implement an Emergency Triage, Treat, and Transport Model (ET3 Program) and reduces appropriations in Goal A, Medicaid Client Services, by $4.3 million in All Funds related to anticipated cost savings. The rider would require HHSC to implement an ET3 Program or a substantially similar program approved by the Centers for Medicare and Medicaid Services that is designed to improve quality of care and lower costs by reducing avoidable emergency transports and unnecessary hospitalizations.

Section 4. Updated Client Service – Non-Medicaid/CHIP

	Method of Financing (millions)					
Description	General	General	Federal	Other	All Funds	FTE
(4.1) ECI	4.2	-	(4.1)	(0.1)	-	-
(4.2) TANF	(9.1)	-	3.3	-	(5.8)	-
(4.3) Mental Health Community Hospitals	0.2	-	-	-	0.2	-
(4.4) Alternatives to Abortion	26.0	-	(6.0)	-	20.0	-
(4.5) CASA/CAC	10.0	-	13.9	-	23.9	-
(4.6) Mental Health Community Hospital Inpatient Capacity	30.0	-	-	-	30.0	-
(4.7) Family Violence Program	-	-	13.0	-	13.0	-
Total	**61.3**	**-**	**20.1**	**(0.1)**	**81.3**	**-**

(4.1) Early Childhood Intervention (ECI)

SB 1 As Introduced reduced funding for ECI by $24.2 million in All Funds, including $15.4 million in General Revenue Funds from HHSC's LAR requested level. Conference Committee decisions were to adopt the House funding level, which meets the agency's All Funds requested level, with an increase of $4.2 million in

General Revenue offset by a decrease of $4.1 million in Federal Funds and $0.1 million in Other Funds to align with LBB Federal Funds and revenue assumptions.

(4.2) Temporary Assistance for Needy Families (TANF)

SB 1 includes a net reduction of $5.8 million in All Funds (decrease of $9.1 million in General Revenue, increase of $3.3 million in Federal Funds) for TANF.

(4.3) Mental Health Community Hospitals

SB 1 includes a net increase of $0.2 million in General Revenue from the agency's LAR request for Mental Health Community Hospitals.

(4.4) Alternatives to Abortion

SB 1 provides an additional $10.0 million in General Revenue in each fiscal year for the Alternatives to Abortion Program. SB 1 also reduces Temporary Assistance for Needy Families (TANF) Federal Funds in the Alternatives to Abortion strategy by $6.0 million and increases General Revenue by a like amount.

(4.5) Child Advocacy Programs (CASA/CAC)

SB 1 includes an additional $8.0 million in General Revenue Funds and $13.9 million in TANF Federal Funds for Child Advocacy Centers. SB 1 also includes an additional $2.0 million in General Revenue for the Court Appointed Special Advocates Program.

(4.6) Mental Health Community Hospital Inpatient Capacity

SB 1 provides an additional $30.0 million in General Revenue in Strategy G.2.2, Mental Health Community Hospitals, for the 2022-23 biennium for community hospital inpatient capacity in rural and urban areas and an associated rider.

(4.7) Family Violence Program

SB 1 provides a funding increase of $6.5 million in TANF Federal Funds in each fiscal year of the 2022-23 biennium and an associated rider noting that the intent of the Legislature is that the funding should be used to provide enhanced capacity for shelter services and legal, mental health, housing, and economic stability services to victims of family violence.

Section 5. Updated Revenue Projections.

	Method of Financing (millions)					
Description	General	General	Federal	Other	All	FTE
Mental Health Block Grant	0.0	-	-	-	-	-
CHIP	0.3	-	(0.3)	-	-	-
Substance Abuse Prevention and Treatment Block Grant Maintenance of Effort	0.0	-	-	-	-	-
Medicaid	3.8	-	(0.9)	(3.0)	-	-
Social Services Block Grant	(12.2)	-	12.2	-	-	-
Home & Community Support Services Agencies and Freestanding Emergency Medical Care Facility Licensing Fund	(21.0)	18.7	-	2.3	-	-
CSHCN Vendor Drug	-	-	-	-	-	-
Public Health Medicaid Reimbursements	(31.6)	-	-	31.6	-	-
Central Administration Cost Allocation	(0.0)	0.0	-	-	-	-
Subtotal, Method of Finance Swaps	(60.6)	18.7	11.0	30.9	-	-
Child Care Regulation	-	-	(17.5)	-	(17.5)	-
Habilitation Coordination	(4.8)	-	-	-	(4.8)	-

	Method of Financing (millions)					
IAC Aligned with Assessment Amounts	-	-	-	(22.7)	(22.7)	-
Survey and Certification	-	-	0.4	-	0.4	-
Other Federal Funds	-	-	0.3	-	0.3	-
System Support Cost	-	-	(5.5)	-	(5.5)	-
Integrated Eligibility and Enrollment Cost Allocation	0.6	-	26.5	1.1	28.2	-
Medicaid Administrative Claiming	-	-	(30.0)	-	(30.0)	-
Vendor Drug Rebates – Public Health Cost Out Adjustment (GR 8046)	(6.6)	-	-	-	(6.6)	-
Mental Health Block Grant	-	-	12.4	-	-	-
Public Health Medicaid Reimbursements	-	-	-	(14.6)	(14.6)	-
Subtotal, Other Updated Revenue Projections	(10.8)	-	(13.4)	(36.2)	(72.8)	-
Total	**(71.4)**	**18.7**	**(2.4)**	**(5.3)**	**(72.8)**	**-**

5.1 Method of Finance Swaps

SB 1 includes several method of finance swaps across several strategies. These adjustments do not impact All Funds appropriations, but the net impact significantly shifts General Revenue to other fund sources.

Primary shifts include:

- A decrease of $12.2 million in General Revenue and a corresponding increase to Social Services Block Grant Funds in Strategy F.1.2, Non-Medicaid Services.

- A decrease of $21.0 million from General Revenue and a corresponding increase of $18.7 million in General Revenue-Dedicated Home Health Services Account No. 5018 and an increase of $2.3 million in the Freestanding Emergency Medical Care Facility Licensing Fund Account No. 373 (Other Funds).

- A net decrease of $31.6 million in General Revenue and a corresponding increase in Public Health Medicaid Reimbursements Account No. 709 (Other Funds).

    - Assumes a shift of $51.8 million from General Revenue to Public Health Medicaid Reimbursements in Strategy A.1.4, Non-Full Benefit Programs and a shift of $20.2 million from Public Health Medicaid Reimbursements to General Revenue in Strategy G.2.2, Mental Health Community Hospitals.

5.2 Other Updated Revenue Projections

SB 1 reduces $39.0 million in All Funds, including $4.1 million in General Revenue Funds related to other revenue projections.

Primary impacts of these projections include:

- A reduction of $17.5 million in Federal Funds related to Child Care Regulation.

- A reduction of $22.7 million in Interagency Contract Funds (IAC) to align with Assessment amounts.

- A reduction of $30.0 million in Federal Funds for Medicaid Administrative Claiming (MAC) in Strategy B.1.1, Medicaid Contracts and Administration.

- A net increase of $28.2 million in All Funds, including $0.6 million in General Revenue, in Strategy I.1.1, Integrated Eligibility and Enrollment. Changes in I.1.1 include:

    - Reclassification of unmatched General Revenue to other matched General Revenue funds; and

- An increase of $26.5 million in Federal Funds and $1.1 million in Other Funds.

- An assumed increase of $12.4 million in Community Mental Health Block Grant Funds across several behavioral health strategies.

- A reduction of $6.6 million in General Revenue Account No. 8046, Vendor Drug Rebates – Public Health to align with the Comptroller's Biennial Revenue Estimate. Vendor Drug Rebates – Public Health include rebate revenue and related interest for the Healthy Texas Women (HTW) program, Children with Special Health Care Needs (CSHCN), and the Kidney Health Care Program.

- An increase of $12.4 million in federal Mental Health Block Grant funds above HHSC's LAR requested level across several strategies based on assumed federal fiscal year 2021 awards. The funding level represents House Introduced Bill assumptions and include $9.3 million in Strategy D.2.1, Community Mental Health Services Adults; $2.9 million in Strategy D.2.2, Community Mental Health Services – Children; and $0.2 million in Strategy D.2.4, Substance Abuse Services.

- A reduction of Public Health Medicaid Reimbursements (Account No. 709) in Strategy A.4.1, Non-Full Benefit Payments. Special Provisions Sec. 14, Limitation: Expenditure and Transfer of Public Health Medicaid Reimbursements is updated to lower the amount of Public Health Medicaid Reimbursements identified for the Health and Human Services Commission. The adjustment reflects a Conference Committee decision to adopt a House item decreasing the amount of Public Health Medicaid Reimbursements appropriated to HHSC and prioritizing distribution of funds to the Department of State Health Services state laboratory.

Section 6. Transfers.

	Method of Financing (millions)					
Description	General Revenue	General Revenue-Dedicated	Federal Funds	Other Funds	All Funds	FTE
(6.1) Behavioral Health Executive Council	(2.0)	-	-	0.0	(2.0)	-
(6.2) Transfer of 10.0 FTEs from HHSC to DSHS for TCID	-	-	-	-	-	(10.0/10.0)
(6.3) Transfer of APS-Provider Investigations and Child Care Licensing FTEs from DFPS to HHSC	1.4	-	0.1	-	1.6	11.0/11.0
(6.4) Reallocate GR to DSHS and DFPS for CAPPS Compliance Updates	(4.4)	-	-	4.4	-	-
(6.5) Reallocate $10.0 million GR from Strategy D.2.1 to Strategy D.2.3	-	-	-	-	-	
Total	**(5.0)**	**-**	**0.1**	**4.4**	**(0.4)**	**1.0/1.0**

(6.1) Behavioral Health Executive Council

SB 1 reduces $2.0 million in All Funds remaining in the baseline related to the Behavioral Health Executive Council (BHEC). The council was created by the enactment of H.B. 1501, 86th Legislature, Regular Session, 2019. The 2020-21 General Appropriations Act appropriated funding to HHSC in fiscal year 2020 for functions that transferred to BHEC in fiscal year 2021.

This reduction annualizes the reduction in fiscal year 2021 in both years of the 2022-23 biennium.

(6.2) Transfer of 10.0 FTEs from HHSC to the Department of State Health Services for the Texas Center for Infectious Disease

The Conference Committee version of SB 1 transfers 10.0 FTEs allocated to HHSC in SB 1 As Introduced to DSHS related to the Texas Center for Infectious Disease (TCID). The transfer reflects a notification submitted to LBB and the Governor to transfer 10.0 FTEs related to security guard positions at TCID. The transfer impacts FTE authority only and does not include a transfer of funds.

TCID is co-located with the San Antonio State Hospital (SASH). Security guard positions associated with TCID and SASH transferred to HHSC as a result of the consolidation of the health and human services system pursuant to SB 200, 84th Legislature, Regular Session, 2015. However, changes to the transition plan for implementation of consolidation submitted in accordance with Texas Government Code Sec. 531.0204 resulted in TCID remaining at DSHS. DSHS has been reimbursing HHSC for security guard FTEs at TCID. This transfer will align FTE authority with the actual use of these positions by DSHS.

(6.3) Transfer of APS Provider Investigations and Child Care Licensing FTEs from DFPS to HHSC

The Conference Committee version of SB 1 transfers funding and 11.0 FTEs associated to Adult Protective Services Provider Investigations and Child Care Licensing FTEs that were allocated to DFPS in SB 1 As Introduced to HHSC.

(6.4) Reallocate General Revenue to DSHS and DFPS for CAPPS Compliance Updates

SB 1 reallocates General Revenue from HHSC to DSHS and DFPS related to CAPPS Compliance updates and increases Other Funds at HHSC in a like amount to reflect an increase of IAC from those agencies.

(6.5) Reallocate $10.0 million in General Revenue from Strategy D.2.1 to Strategy D.2.3

The Conference Committee version of SB 1 reallocates $10.0 million in General Revenue from Strategy D.2.1, Community Mental Health Services – Adults, to Strategy D.2.3, Community Mental Health Crisis Services, to restore a transfer associated with the Harris County Jail Diversion program that was assumed in SB 1 As Introduced.

The Introduced Bills both reduced Strategy D.2.3 by $5.0 million in each fiscal year to reflect a transfer of the Harris County Jail Diversion program to Strategy D.2.6. However, funding for the program was actually in Strategy D.2.1. Without a correction, this would have resulted in a surplus in Strategy D.2.1 and a decrease in funding for Crisis Services provided under Strategy D.2.3. This adjustment aligns appropriations with legislative intent.

Section 7. Other Changes.

	Method of Financing (millions)					
Description	General	General	Federal	Other	All	FTE
(7.1) CHIP Contracts &	(0.0)	-	(2.1)	-	(2.1)	-
(7.2) Capital	-	-	-	(208.8)	(208.8)	-
(7.3) Capital Projects	(1.3)	-	(1.2)	-	(2.5)	-
(7.4) Master Lease	1.5	-	-	-	1.5	-
(7.5) One-time Funding	(0.5)	-	-	-	(0.5)	-
(7.6) General	(0.3)	-	(0.0)	-	(0.3)	-
Total	**(0.6)**	**-**	**(3.4)**	**(208.8)**	**(212.8)**	**-**

(7.1) CHIP Contracts & Administration

SB 1 reduces Strategy B.1.2, CHIP Contracts & Administration, by $2.1 million in All Funds, including approximately $30k in General Revenue.

This adjustment reflects the fiscal year 2022 baseline request in each fiscal year of the 2022-23 biennium and adjusts Federal matching funds for LBB assumed Enhanced FMAP as identified in Special Provisions, Sec. 4.

(7.2) Capital Construction

SB 1 reduces $208.8 million in Other Funds related to capital construction costs funded by the 86th Legislature that were included in the baseline request.

(7.3) Capital Projects

SB 1 includes a reduction of $2.5 million in All Funds, including $1.3 million in General Revenue, related to other capital projects in Strategies I.3.1, TIERS & Eligibility Support Technology and I.3.2, TIERS Capital Projects.

(7.4) Master Lease Purchase Program

SB 1 provides for an increase of $1.5 million in General Revenue in Strategy G.4.2, Facility Capital Repairs and Renovations, related to debt service for the Master Lease Purchase Program.

(7.5) One-time Funding

SB 1 reduces $0.5 million in General Revenue for other one-time funding items that were not reduced in the agency's General Revenue limit.

(7.6) General Adjustments

SB 1 reduces $0.1 million in General Revenue for Mobile Stroke Units that remained in the baseline request. An additional $0.2 million in General Revenue has also been reduced across Strategies H.1.1, Facility and Community-Based Regulation, and G.3.1, Other Facilities, where the intent is currently unknown.

General Revenue Reallocated to the Department of Family and Protective Services and the Department of State Health Services for System Exceptional Items.

Exceptional Item	Strategy	General Revenue	Other Funds	All Funds
EI #9b, Comply with	L.1.2, IT Capital	(27,126)	27,126	-
EI #7c, Cybersecurity	L.1.2, IT Capital	(748,505)	748,505	-
Total		**(846,325)**	**846,325**	**-**

Comparison of Exceptional Item Requests and Appropriations for the 2020-21 Biennium and 2022-23 Biennium.

Biennium	General Revenue and ESF[79]	All Funds	FTE
Requested			
2020-21 Biennium[80]	3,275.0	6,552.3	2,640.3
2022-23 Biennium[81]	2,327.1	4,241.8	610.4
Adopted			
2020-21 Biennium	545.6	895.5	616.4
2022-23 Biennium[82]	684.5	1,224.3	500.1
Difference (Requested – Adopted)			
2020-21 Biennium	(2,729.4)	(5,656.8)	(2,023.9)
2022-23 Biennium	(1,642.6)	(3,017.5)	(110.3)

[79] Economic Stabilization Funds.
[80] Updated Exceptional Items from January 2019, incorporating funding decisions included in House Bill 1, 86th Legislature, Regular Session, 2019 (2020-21 General Appropriations Act).
[81] Updated Exceptional Items from January 2021, incorporating funding decisions included in Senate Bill 1, 87th Legislature, Regular Session, 2021 (2022-23 General Appropriations Bill).
[82] Includes Exceptional Item funding adopted in SB 1 and HB 2 ($619.8 million in General Revenue and Economic Stabilization Funds / $1,052.5 million All Funds), as well as rider-directed transfer authority ($64.7 million in General Revenue / $171.7 million All Funds).

Exceptional Item Requests and Funding for the 2022-23 Biennium.

	General Revenue and ESF79	All Funds	FTE
Requested			
2022-23 Biennium[81]	2,327.1	4,241.8	610.4
Adopted			
SB 1	196.0	325.6	499.1
Rider Directed Transfer Authority (SB 1)	64.7	171.8	-
HB 2	423.8	726.9	1.0
Total Adopted EI Funding	**684.5**	**1,224.3**	**500.1**
Difference			
Medicaid Entitlement Cost Growth Not	(1,512.9)	(2,793.7)	-
Other EI Request Not Funded	(129.7)	(223.8)	(110.3)
Total Not Funded	**(1,642.6)**	**(3,017.5)**	**(110.3)**

Appendix A. Managed Care Enrollment

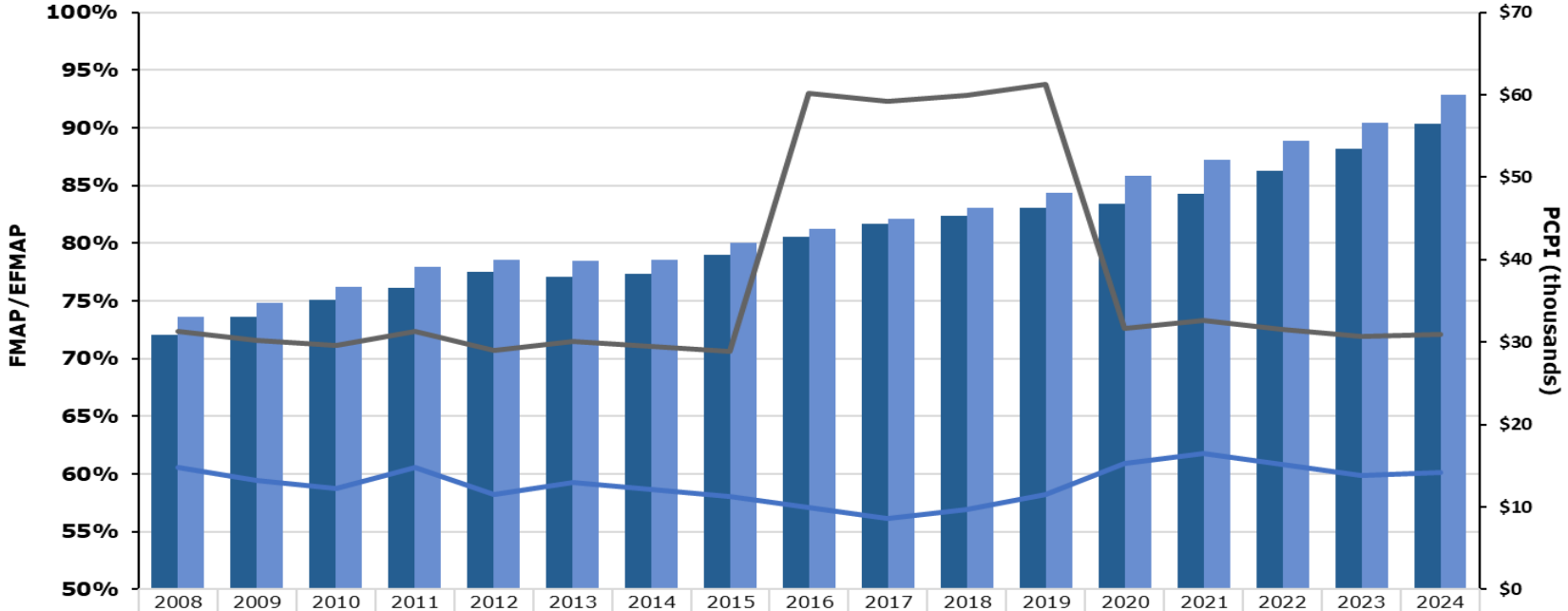
Percentage of Medicaid Clients Enrolled in Managed Care (State Fiscal Year 1994-2021)

SFY	Service Areas and Implementation Dates	Total Medicaid Enrollment	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
1994	STAR implemented in Travis County and	2,033,488	58,243	2.9%
1995	No change	2,069,129	65,388	3.2%
1996	The Tri-county area was expanded to three additional counties and was renamed from Lone STAR Health Initiative to STAR.	2,062,802	71,435	3.5%
1997	STAR expanded to the Bexar, Lubbock, and Tarrant SAs, and the Travis county area was expanded to include surrounding counties.	1,987,547	274,694	13.8%
1998	STAR expanded to the Harris SA, and STAR+PLUS implemented in the Harris SA.	1,863,106	364,336	19.6%
1999	STAR expanded to the Dallas SA.	1,812,393	425,069	23.5%
2000	STAR expanded to the El Paso SA.	1,807,669	523,832	29.0%
2001	No change	1,870,687	623,883	33.4%
2002	No change	2,103,972	755,698	35.9%
2003	No change	2,489,061	988,389	39.7%

SFY	Service Areas and Implementation Dates	Total Medicaid Enrollment	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
2004	No change	2,683,730	1,112,002	41.4%
2005	No change	2,779,936	1,191,139	42.8%
2006	Primary Care Case Management (PCCM)	2,792,597	1,835,390	65.7%
2007	STAR expanded to the Nueces SA, and STAR+PLUS expanded to the Bexar, Travis, Nueces, and Harris Contiguous SAs. STAR replaced PCCM in all urban areas.	2,832,848	1,921,651	67.8%
2008	ICM implemented in the Dallas and Tarrant SAs, and STAR Health implemented statewide.	2,878,126	2,039,340	70.9%
2009	The ICM program was discontinued.	3,005,620	2,127,382	70.8%
2010	No change	3,298,099	2,362,091	71.6%
2011	STAR+PLUS expanded to the Dallas and Tarrant SAs.	3,543,057	2,676,149	75.5%
2012	STAR expanded to Medicaid Rural	3,655,930	2,893,965	79.2%
2013	No change	3,658,629	2,982,923	81.5%
2014	No change	3,746,124	3,012,265	80.4%

SFY	Service Areas and Implementation Dates	Total Medicaid Enrollment	Total Medicaid Managed Care Enrollment	% of Medicaid Population in Managed Care
2015	STAR+PLUS expanded to all areas of the state, non-dual eligible clients in IDD waivers and NF benefits were carved into STAR+PLUS, mental health targeted case management and mental health rehabilitative services were carved into all managed care programs, and the Dual Demonstration program implemented in Bexar, Dallas, El Paso, Harris, Hidalgo, and Tarrant counties.	4,056,702	3,524,581	86.9%
2016	No change	4,060,564	3,570,411	87.9%
2017	STAR Kids implemented statewide.	4,067,380	3,721,646	91.5%
2018	Adoption Assistance and Permanency Care Assistance were carved in to STAR, and the Medicaid for Breast and Cervical Cancer program was carved in to STAR+PLUS.	4,021,686	3,776,096	93.9%
2019	No change	3,915,011	3,676,441	93.9%
2020	No change	3,984,967	3,760,023	94.4%
2021	No change	4,682,819	4,517,225	96.5%

Appendix B. FMAP/EFMAP and Per Capita Personal Income (FFY 2008-2024)

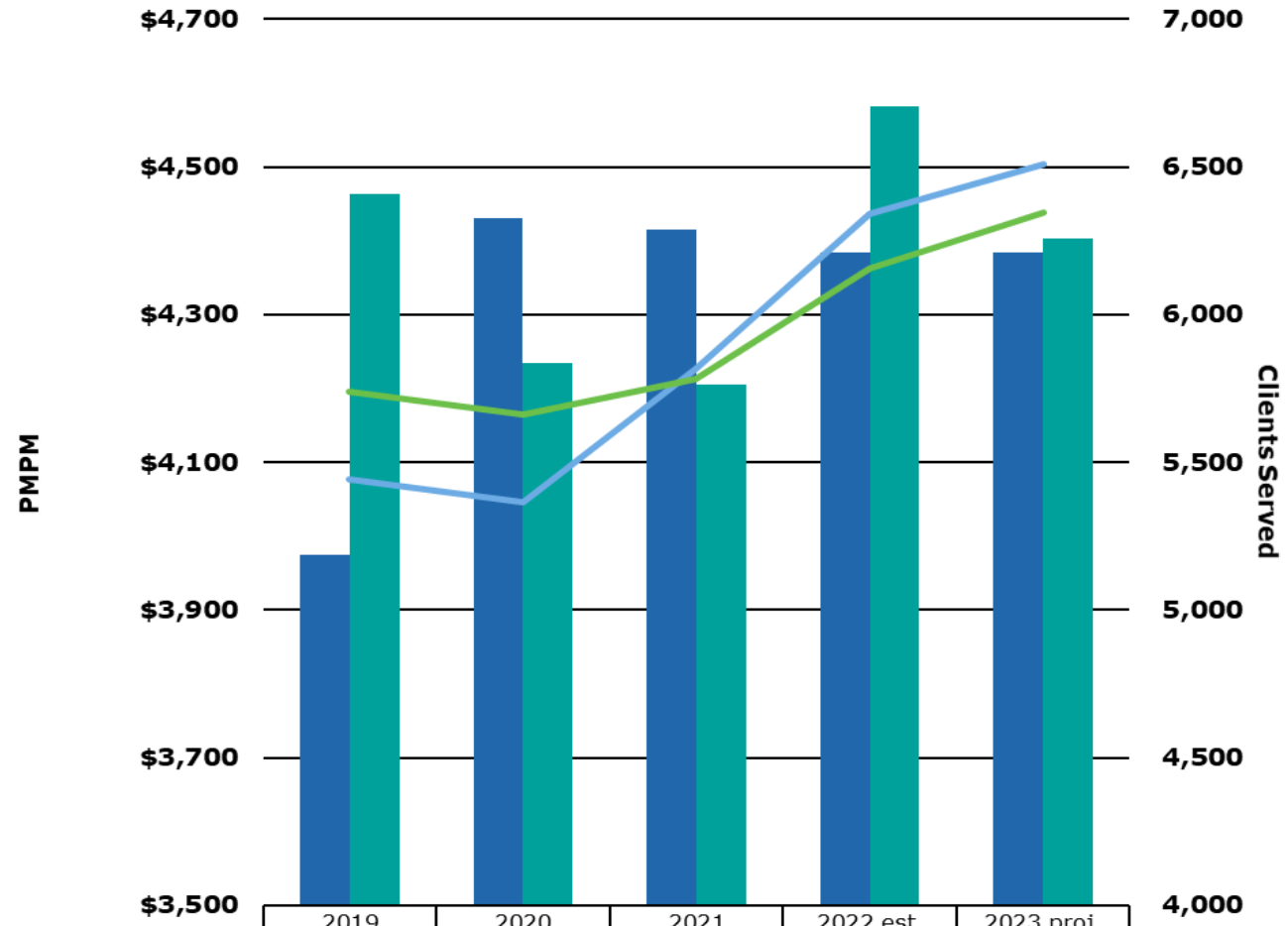


	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Texas	$30.9	$33.0	$35.1	$36.6	$38.5	$38.0	$38.3	$40.6	$42.7	$44.3	$45.4	$46.3	$46.7	$48.0	$50.8	$53.4	$56.5
US	$33.0	$34.8	$36.7	$39.1	$39.9	$39.9	$40.0	$42.1	$43.8	$44.9	$46.3	$48.1	$50.1	$52.1	$54.4	$56.6	$60.1
FMAP	60.56%	59.44%	58.73%	60.56%	58.22%	59.30%	58.69%	58.05%	57.13%	56.18%	56.88%	58.19%	60.89%	61.81%	60.80%	59.87%	60.15%
EFMAP	72.39%	71.61%	71.11%	72.39%	70.75%	71.51%	71.08%	70.64%	92.99%	92.33%	92.82%	93.73%	72.62%	73.27%	72.56%	71.91%	72.11%

Note: Reflects regular FFY FMAPs. Does not reflect stimulus FMAPs related to the American Recovery and Reinvestment Act (ARRA) that applied from the first quarter of FFY 2009 until the third quarter of FFY 2011 or stimulus FMAPs and EFMAPs related to the Families First Coronavirus Response Act (FFCRA) that applied from the second quarter of FFY 2020 until the second quarter of FFY 2023 and may be extended longer. EFMAPs reflect a 23.0 percentage point increase in FFY 2016 through FFY 2019 pursuant to the federal Affordable Care Act and an 11.5 percentage point increase in FFY 2020 pursuant to the federal HEALTHY KIDS Act. Per capita personal income (PCPI) is the average of the most recent three years available at the time each FMAP was calculated and does not include any updates to the data made after that time. For example, FFY 2023 FMAP is based on the average of calendar years 2018

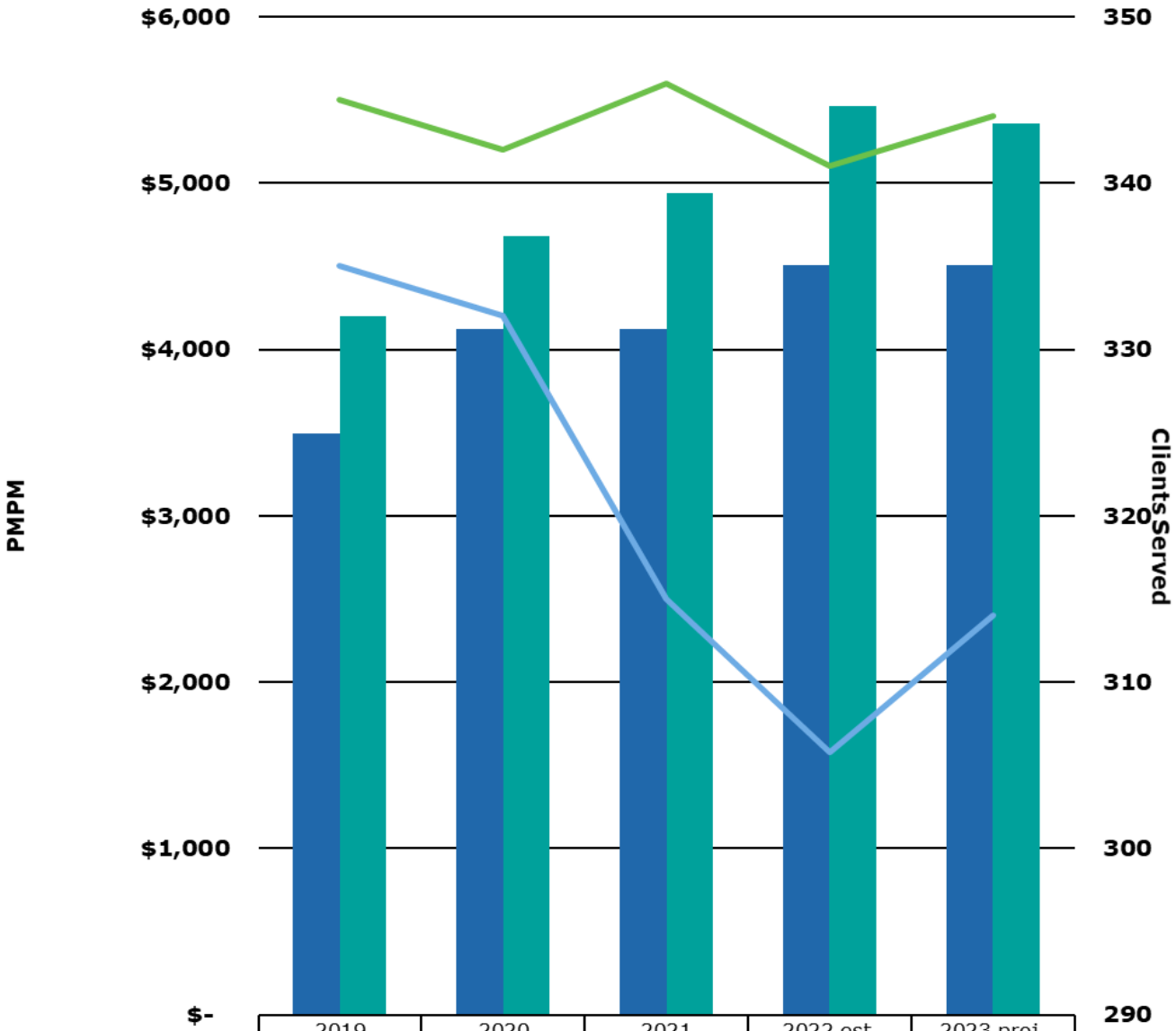
Appendix C. Medicaid

CLASS Waiver Clients Served and PMPM: GAA Targets and Appropriations vs. Actuals



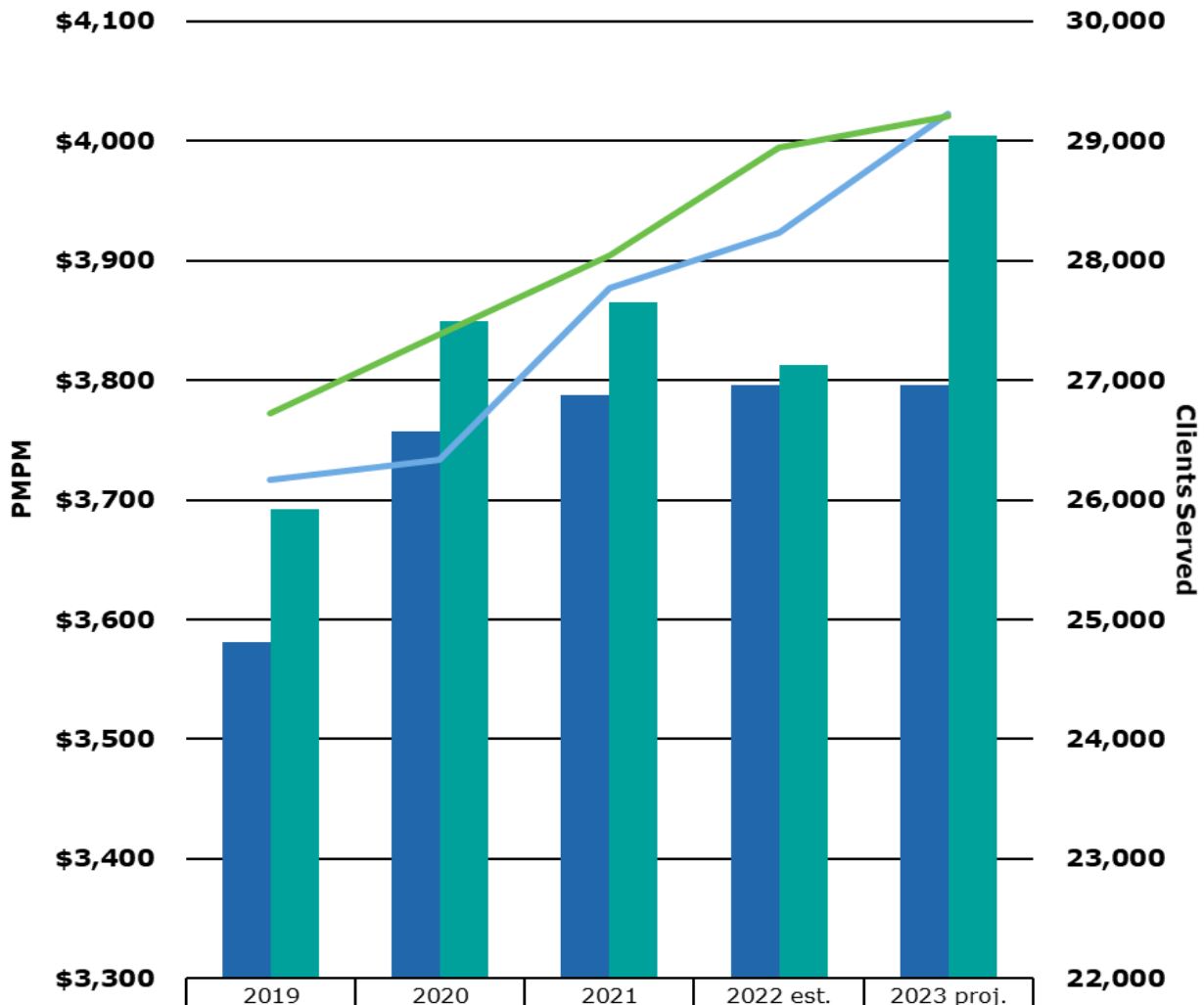
	2019	2020	2021	2022 est.	2023 proj.
Appropriated PMPM	$3,975	$4,431	$4,416	$4,384	$4,384
Actual PMPM	$4,463	$4,235	$4,206	$4,582	$4,403
Actual Clients Served	5,444	5,365	5,818	6,343	6,507
Clients Served Target	5,739	5,663	5,783	6,155	6,344

DBMD Waiver Clients Served and PMPM: GAA Targets and Appropriations vs. Actuals



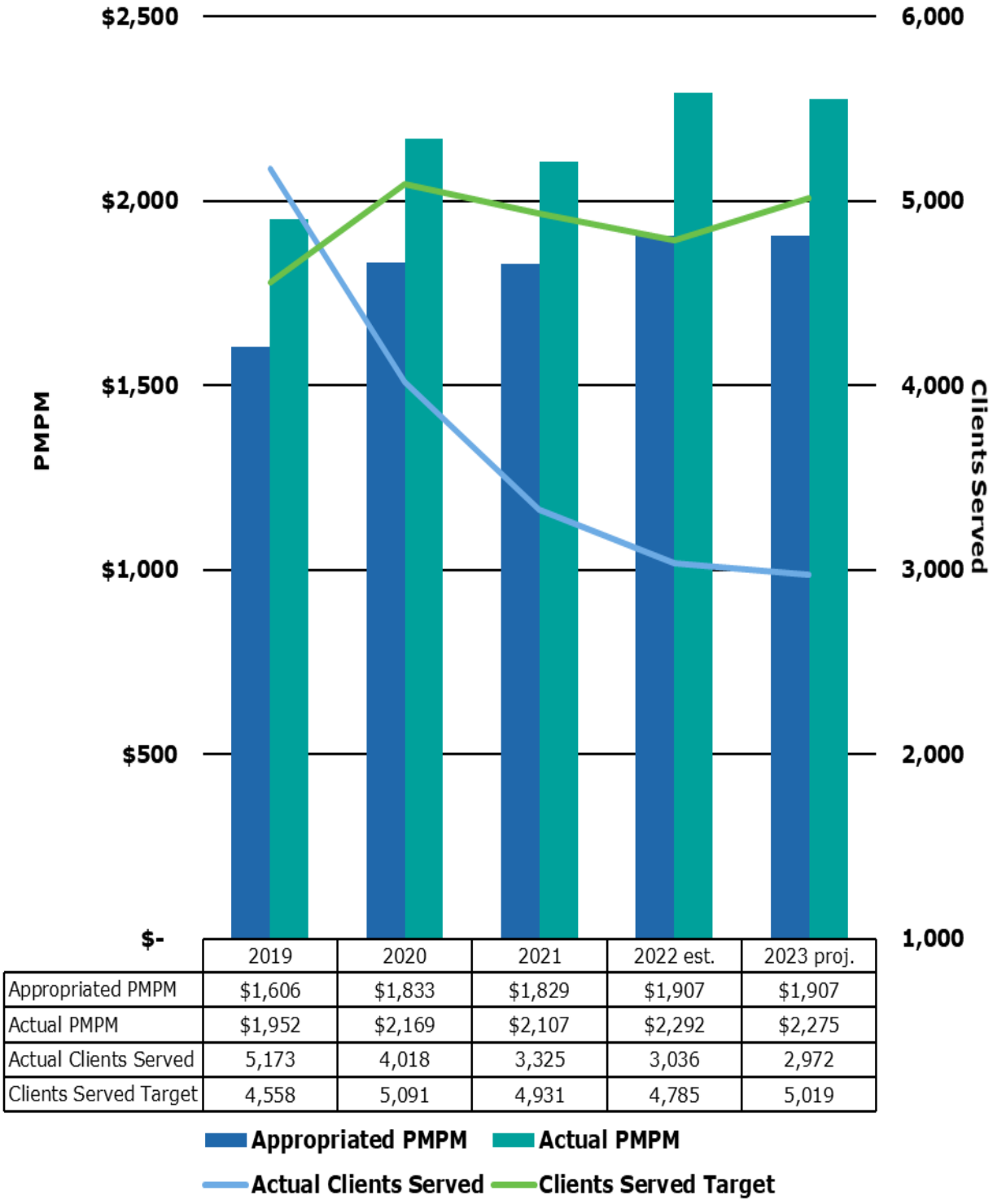
	2019	2020	2021	2022 est.	2023 proj.
Appropriated PMPM	$3,496	$4,122	$4,121	$4,504	$4,504
Actual PMPM	$4,203	$4,682	$4,938	$5,461	$5,358
Actual Clients Served	335	332	315	306	314
Clients Served Target	345	342	346	341	344

HCS Waiver Clients Served and PMPM: GAA Targets and Appropriations vs. Actuals



	2019	2020	2021	2022 est.	2023 proj.
Appropriated PMPM	$3,581	$3,757	$3,787	$3,796	$3,796
Actual PMPM	$3,692	$3,850	$3,865	$3,812	$4,004
Actual Clients Served	26,163	26,340	27,772	28,227	29,230
Clients Served Target	26,723	27,383	28,043	28,941	29,211

TxHmL Waiver Clients Served and PMPM: GAA Targets and Appropriations vs. Actuals



	2019	2020	2021	2022 est.	2023 proj.
Appropriated PMPM	$1,606	$1,833	$1,829	$1,907	$1,907
Actual PMPM	$1,952	$2,169	$2,107	$2,292	$2,275
Actual Clients Served	5,173	4,018	3,325	3,036	2,972
Clients Served Target	4,558	5,091	4,931	4,785	5,019

Total Medicaid Expenditures Detail

FFY		DSH	UC	DSRIP	Directed Payment Programs	UC-PHPCCP	SHARS	GME	All Other Client Services	Administration	Clawback	Total Medicaid
2023	FED	1,170,714,762	2,024,005,203	111,807,225	4,891,051,798	299,350,000	661,936,426	78,032,400	21,824,378,067	1,045,473,408	-	32,106,749,289
2023	NONFED	784,713,268	1,356,661,579	74,942,775	3,274,379,634	200,650,000	443,686,467	52,303,993	14,232,518,603	672,990,139	394,951,273	21,487,797,731
2023	TOTAL	1,955,428,030	3,380,666,781	186,750,000	8,165,431,432	500,000,000	1,105,622,893	130,336,393	36,056,896,670	1,718,463,547	394,951,273	53,594,547,019
2022	FED	1,290,775,152	2,282,502,392	1,530,784,219	6,265,193,881	335,000,000	828,020,170	78,312,524	23,617,008,291	1,055,081,412	-	37,282,678,040
2022	NONFED	635,754,927	1,124,275,157	753,968,347	3,079,125,755	165,000,000	405,892,868	45,009,255	10,845,375,451	691,613,532	420,949,308	18,166,964,600
2022	TOTAL	1,926,530,079	3,406,777,549	2,284,752,566	9,344,319,636	500,000,000	1,233,913,038	123,321,779	34,462,383,742	1,746,694,943	420,949,308	55,449,642,640
2021	FED	1,245,393,706	1,067,564,249	2,030,037,908	3,240,205,949	-	571,264,907	79,054,516	23,277,769,037	995,200,511	-	32,506,490,783
2021	NONFED	585,343,759	517,017,707	954,826,982	1,506,233,565	-	507,508,898	37,276,485	10,577,360,968	630,175,367	395,729,425	15,711,473,157
2021	TOTAL	1,830,737,465	1,584,581,956	2,984,864,890	4,746,439,514	-	1,078,773,805	116,331,001	33,855,130,005	1,625,375,878	395,729,425	48,217,963,940
2020	FED	1,261,052,794	2,551,032,787	1,939,292,724	1,875,540,426	-	640,001,403	75,417,317	19,708,181,401	942,745,356	-	28,993,264,208
2020	NONFED	704,874,796	1,406,065,048	1,002,620,058	956,877,546	-	450,375,685	42,714,394	9,776,763,066	598,331,575	388,870,566	15,327,492,733
2020	TOTAL	1,965,927,590	3,957,097,835	2,941,912,782	2,832,417,972	-	1,090,377,088	118,131,711	29,484,944,466	1,541,076,931	388,870,566	44,320,756,941
2019	FED	1,135,454,021	2,087,928,703	1,489,493,368	1,222,737,870	-	1,132,939,031	71,107,358	16,749,189,335	927,733,044	-	24,816,582,730
2019	NONFED	815,280,033	1,517,288,370	1,070,166,468	847,293,049	-	815,638,214	51,347,824	11,582,709,517	578,858,538	481,830,280	17,760,412,293
2019	TOTAL	1,950,734,054	3,605,217,073	2,559,659,836	2,070,030,919	-	1,948,577,245	122,455,182	28,331,898,852	1,506,591,582	481,830,280	42,576,995,023
2018	FED	1,081,579,027	1,540,814,930	1,754,634,974	808,618,588	-	691,563,284	17,694,672	16,096,009,259	873,748,199	-	22,864,662,933
2018	NONFED	819,932,090	1,174,000,086	1,330,166,318	585,545,616	-	525,079,853	13,540,915	11,693,016,984	542,616,304	489,795,321	17,173,693,487
2018	TOTAL	1,901,511,117	2,714,815,016	3,084,801,292	1,394,164,204	-	1,216,643,137	31,235,587	27,789,026,243	1,416,364,503	489,795,321	40,038,356,420

Appendix D. Full Time Equivalents

The Legislature establishes state employment level limitations on full-time equivalent employees (FTEs) in the General Appropriations Act (GAA), known as the FTE cap. HHSC's FTE cap for fiscal year 2023, as established by the 2022-23 General Appropriations Act, SB 1, 87th Legislature, Regular Session, 2021, is 38,430.3[83].

Some adjustments to the FTE cap can occur per other authority granted by the GAA. HHSC's FTE cap for fiscal year 2023 has been adjusted to reflect a net increase of 42.0 FTEs due to adjustments made per GAA authority, resulting in a total of 38,472.3 FTEs.

Health and Human Services Commission, Fiscal Year 2023 FTEs

	FTEs
Conference Committee FTE Limitation[84]	38,373.9
Net FTE adjustments to incorporate certain Article IX provisions into	56.4
Fiscal Size-Up FTE Limitation	38,430.3
Net FTE adjustments pursuant to authority from 2022-23 GAA	42.0
Total FTEs	38,472.3

[83] Represents the HHSC and OIG portion of the FTE limitation established in the 2022-23 General Appropriations Act. Pursuant to Rider 116, Administrative Attachment: Texas Civil Commitment Office, the Texas Civil Commitment Office (TCCO) is allocated 37.0 FTEs in each fiscal year of the 2022-23 biennium. TCCO is an independent agency which is administratively attached to HHSC.
[84] Includes 6.1 FTEs appropriated in Special Provisions Relating to All Health and Human Services Agencies, Sec. 26 and included in the Conference Committee Report as "Number of FTE in Riders".

FTEs by Major Function

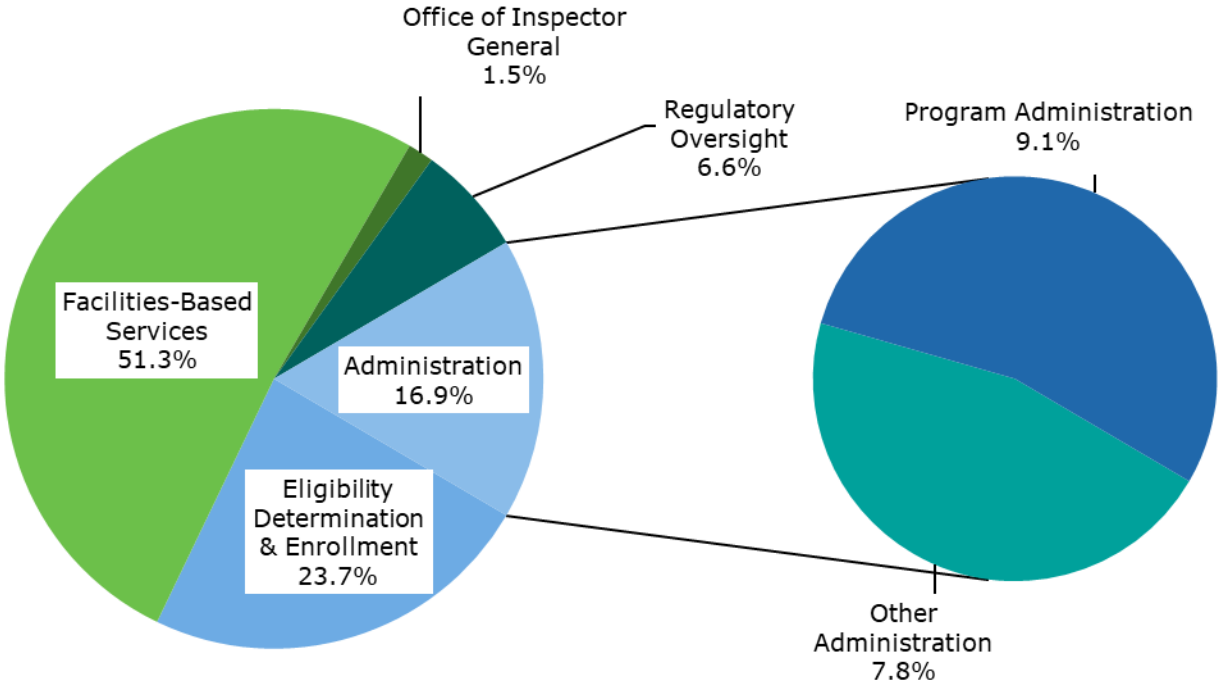
Summary of FTEs by Major Agency Function

FTEs are allocated between major agency functions as shown in the next table.

FTE Allocation by Major Agency Function – FY 2023 Appropriated

Major Agency Function	FY 2023 FTE Allocation	Percentage of FTE Limitation
Facilities-Based Services	19,721.3	51.3%
Eligibility Determination	9,119.8	23.7%
Regulatory Oversight	2,543.1	6.6%
Subtotal, Non-Administration	31,384.2	81.6%
Program Administration	3,507.2	9.1%
Other Administration	2,987.1	7.8%
Subtotal, Administration	6,494.3	16.9%
Total	**37,878.5**	**98.5%**
Office of Inspector General	593.9	1.5%
Disaster Assistance FTEs[85]	0.0	0.0%
Total with Disaster Assistance	**38,472.4**	**100.00%**

[85] FTEs associated with Disaster Assistance in Strategy E.1.3.



Facilities-Based Services[86]

State Operated Facilities, including the State Supported Living Centers and State Mental Health Facilities, comprise about 51.3 percent of HHSC's FTE cap. FTEs are located throughout the state, with 18,727.1 in regions outside of Austin and 994.2 in Austin.

[86] FTEs associated with Strategy G.4.1, Facility Program Support, are included in the Program Administration category.

Facilities-based Services FTEs – Regional/State

Facilities	Regional	Region 00 State Offices	Total
State Supported Living Centers	11,710.7	83.7	11,794.4
State Hospitals	6,949.7	908.5	7,858.1
Mental Health Community Hospitals	0	1.0	1.0
Other State Operated Facilities	66.8	1.0	67.7
Total	**18,727.1**	**994.2**	**19,721.3**

Eligibility Determination and Enrollment

Eligibility Determination functions comprise about 23.7 percent of HHSC's FTE cap. FTEs are located throughout the state, with 8,352.5 in the regions and 767.3 in Austin.

Eligibility Determination and Enrollment FTEs – Regional/State

Function	Regional	Region 00 State Offices	Total
Integrated Eligibility and Enrollment	7,423.5	438.5	7,862.0
Long-term Care Intake and Access	929.0	328.8	1,257.8
Total	**8,352.5**	**767.3**	**9,119.8**

Regulatory Services

Regulatory Oversight functions comprise about 6.6 percent of HHSC's FTE cap. FTEs are located throughout the state, with 1,961.0 in the regions and 582.1 in Austin.

Regulatory Services FTEs – Regional/State

Program	Regional	Region 00 State Offices	Total
Facility and Community Based Regulation[87]	1,311.0	363.8	1,674.8
Child Care Regulation	648.0	177.1	825.1
Health Care Professionals and Others	2.0	41.2	43.2
Total	**1,961.0**	**582.1**	**2,543.1**

Administration

Administrative functions comprise about 16.9 percent of HHSC's FTE authority. Program administration directly supports client services programs, while other administration supports overall agency operations.

Program Administration

Program Administration includes FTEs that directly support client services programs, including Medicaid and CHIP, Community Mental Health and Substance Use Disorder Services, Women's Health Programs, and other client services. Program Administration also includes FTEs related to Facility Program Support.

While Regulatory Services and Eligibility Determination and Enrollment functions have been broken out separately due to the relatively large number of FTEs

[87] Includes 63.0 FTEs allocated to Strategy H.1.2, Long-term Care Quality Outreach in the 2022-23 biennium. Strategy H.1.2 is consolidated with Strategy H.1.1, Facility and Community Based Regulation, in the 2024-25 LAR due to an LBB and OOG approved budget structure change for the 2024-25 strategic planning process.

associated with each, both functions could also be considered Program Administration directly supporting client service programs.

Program administration functions comprise about 9.1 percent of HHSC's FTE cap. FTEs are located throughout the state, with 552.5 in the regions and 2,954.7 in Austin.

Program Administration FTEs – Regional/State

Program	Regional	Region 00	Total
Medicaid and CHIP Contracts &	206.0	810.9	1,016.9
Disability Determination Services	6.0	824.2	830.2
Behavioral Health Administration	50.0	490.7	540.7
TIERS	41.0	267.9	308.9
WIC	1.0	203.9	204.9
Primary Health & Specialty Care	2.0	165.4	167.4
Guardianship	112.0	12.7	124.7
Facility Program Support	17.0	103.9	120.9
Children's Blindness Services	71.5	6.0	77.5
Comprehensive Rehabilitation (CRS)	23.0	14.0	37.0
Independent Living Services	23.0	1.0	24.0
Deaf and Hard of Hearing Services	-	23.6	23.6
Family Violence Services	-	12.0	12.0
Prescription Drug Savings Program	-	8.5	8.5
Additional Advocacy Programs	-	7.0	7.0

Program	Regional	Region 00	Total
County Indigent Health Care Services	-	2.0	2.0
BEST Program	-	1.0	1.0
Total	**552.5**	**2,954.7**	**3,507.2**

Other Administration

Other Administration includes IT Oversight, Central and Regional Program Support, and HHS System Supports. Functions include both system support functions that HHSC performs for the benefit of the HHS system and in some instances for the Department of Family and Protective Services (HHS System Supports) and indirect administration functions supporting only HHSC (HHSC Program Supports).

Other administration functions comprise about 7.8 percent of HHSC's FTE cap. FTEs are located throughout the state, with 561.9 in the regions and 2,425.2 in Austin.

Other Administration FTEs – Regional/State

Function	Regional	Region 00	Total
HHS System Supports			
Enterprise Oversight & Policy			
IT Oversight & Program Support			
HHSC Program Support			
Central Program Support			
Regional Program Support			
Total	**561.9**	**2,425.2**	**2,987.1**

HHS System Support functions include: 1) Information Technology Oversight and Program Support, including IT Resource Planning and Management, Application

Support, Network Support, User Support and other functions; and 2) Enterprise Oversight and Policy including Human Resources, Civil Rights Office, Procurement, Ombudsman, Executive Leadership and Policy, and the Office of Chief Counsel.

HHSC Program Support includes: 1) Central Program Support functions that benefit HHSC including Accounting, Budget, Communications, Government Relations, and other general administrative support; and 2) Regional Program Support functions including invoice processing, building and property management, and other general administrative support[88].

[88] Regional Program Support functions also benefit the HHS system and DFS and includes regional indirect supports for those agencies that are administered by HHSC.

Organizational Structure FTEs by Region[89]

Organizational Structure - Chief and DEC/Department Level	Region 00 State Offices	Region 01 High Plains	Region 02/09 Northwest and West Texas	Region 03 Metroplex	Region 04/05 East Texas	Region 06 Gulf Coast	Region 07 Central Texas	Region 08 Upper South Texas	Region 10 Upper Rio Grande	Region 11 Lower South Texas
Executive Commissioner	**70.0**									
Chief of Staff	7.0									
Executive Commissioner	1.0									
Internal Audit	62.0									
Chief Counsel	**231.0**	**12.0**	**5.0**	**20.0**	**7.0**		**1.0**	**16.0**	**3.0**	**11.0**
Appeals	33.0	9.0	3.0	9.0			1.0	9.0		3.0
Chief Counsel	13.0									
Chief Ethics Officer	1.0									
Legal Services	173.0	3.0	2.0	11.0				7.0	3.0	8.0
Privacy	11.0									
Chief Financial Officer	**649.0**	**3.0**	**11.0**	**13.0**	**4.0**		**6.0**	**14.0**	**2.0**	**7.0**
Accounting	230.0									
Actuarial Analysis	10.0									
Budget Management	78.0									
Chief Financial Officer	20.0									
Deputy CFO	33.0									
Fiscal Program Coordination	6.0									
Forecasting	19.0									
Payroll, Time, Labor & Leave	31.0	2.0	9.0	5.0			5.0	7.0	2.0	4.0
Provider Finance	222.0	1.0	2.0	8.0			1.0	7.0		3.0
Chief Medicaid & CHIP Services Officer	**859.3**	**6.0**	**20.0**	**58.0**	**44.0**		**35.0**	**37.0**	**5.0**	**72.0**
Chief Medicaid & CHIP Services Officer	125.4	1.0	2.0	4.0			12.0	8.0		4.0
Chief Medical Director	111.0	3.0	11.0	20.0	24.0		16.0	13.0	2.0	27.0
Deputy State Medicaid Director	150.0									1.0
Managed Care	210.0	2.0	7.0	29.0	14.0		7.0	10.0	3.0	40.0
Operations	263.0			5.0				6.0		
Chief Operating Officer	**1,736.1**	**41.4**	**71.4**	**79.4**	**76.8**		**72.4**	**75.4**	**45.4**	**68.9**
Chief Operating Officer	4.0									
Information Technology Svcs	1,173.5	16.4	35.4	21.4	28.8		28.4	27.4	24.4	23.9
Procurement & Contracting Svcs	229.0		2.0	1.0				1.0		
System Support Svcs	329.6	25.0	34.0	57.0	47.0		44.0	47.0	21.0	45.0
Chief Policy & Regulatory Officer	**760.1**	**103.0**	**140.0**	**430.0**	**199.0**		**255.0**	**247.0**	**41.0**	**156.0**
Chief Policy & Regulatory Officer	4.0									
Compliance & Quality Control	42.0			1.0						
Performance	140.0									
Policy & Rules	-									
Regulatory Svcs	543.1	103.0	140.0	429.0	199.0		255.0	247.0	41.0	156.0
Transformation & Innovation	31.0									
Chief Program & Services Officer	**3,222.2**	**1,158.5**	**4,984.2**	**3,368.1**	**2,742.9**		**4,149.2**	**3,542.6**	**1,474.6**	**3,033.2**
Access & Eligibility Svcs	1,307.7	316.5	408.0	1,105.0	814.0		806.5	1,016.5	754.5	1,640.0
Chief Program & Services Officer	31.0									
Deputy CPSO	11.0									
Health & Specialty Care Svcs	1,081.1	825.0	4,553.7	2,191.1	1,910.9		3,321.7	2,496.1	715.1	1,379.2
Health Developmental & Independence Svcs	418.1	17.0	22.5	55.0	16.0		21.0	28.0	5.0	13.0
IDD & Behavioral Health Svcs	373.3			17.0				2.0		1.0
Chief Public Affairs Officer	**196.8**	**1.0**	**2.0**	**1.0**	**1.0**		**3.0**	**1.0**	**1.0**	**2.0**
Chief Public Affairs Officer	4.0									
Communications	53.0									
DFPS Rider 42 , Office of the Ombudsman	5.0									
Government & Stakeholder Relations	18.0									
HHS Ombudsman	116.8	1.0	2.0	1.0			3.0	1.0	1.0	2.0
Total by Region	**7,724.5**	**1,324.9**	**5,233.6**	**3,969.5**	**3,074.7**		**4,521.6**	**3,933.0**	**1,572.0**	**3,350.1**

[89] Does not include Full-time Equivalents associated with the Office of Inspector General (593.9) or the Texas Civil Commitment Office (37.0).

Appendix E. Changelog

Date	Page	Summary of Changes
1/25/23	190	Corrected typo in table to show full entry; Re-ordered table of contents