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I. EXECUTIVE SUMMARY

The five agencies comprising the Texas Health and Human Services System (the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of Family and Protective Services, the Department of State Health Services, and the Health and Human Services Commission) have individually submitted their requests for legislative appropriations (LARs) for the two year budget period FY 2010-2011. Each agency's request provides strategy level detail, sources of funding, anticipated performance, and baseline and "exceptional item" requests. This Consolidated Budget for FY 2010-2011:

- *summarizes the requests* for legislative appropriations for all five Texas health and human service agencies;
- *highlights critical funding needs across the agencies and categorizes* the requests to assist decision makers and the public in their analysis of the service and operational needs to maintain and improve the delivery of health and human services in our state;
- *provides supporting information* on elements contributing to funding needs;
- *describes major federal funding issues;*
- *estimates the cost impact* of two additional major issues for legislative consideration, *recruitment and retention of non-medical clients service staff and provider rate increases*; and
- fulfills several statutory reporting requirements.

Summary of the HHS System LAR Requests

The HHS System agencies request a total of $65.6 billion from all fund sources for the two year period of fiscal years 2010-2011, an increase of $9.9 billion (17.8 percent) over the 2008-2009 biennium. The 2008-2009 biennium assumes supplemental funding of $2.6 billion all funds ($1.4 billion general revenue). The general revenue portion of the FY 2010-2011 request totals $27.9 billion, an increase of $5.7 billion (25.8 percent) over the same time period. Federal funds would provide the majority (55.6 percent) of the total funding, but would not grow at the rate of total funding needs for a variety of reasons described in this Consolidated Budget. Chapter VI provides additional summary information of the system agencies' requests.

Highlights and Categorization of Critical Funding Needs

In addition to the "baseline" level of funding, prepared according to required budget guidance, the Consolidated Budget briefly highlights agency requests above the baseline budget (Chapter II) and categorizes this nearly $6.4 billion all funds ($3.1 billion general revenue) of exceptional items into five groupings:

- Funding needed to Maintain Current Services and Cost Trends in Medicaid and CHIP.
- Maintain FY 2008-2009 Legislative Initiatives and Non-Medicaid Services.
- Major Initiatives to Increase Service Capacity and Improve Service Quality.

- Critical Operating Needs and System Improvements.
- Additional Program Enhancements.

Supporting Information on Elements Contributing to Funding Needs

Chapter III provides information on some of the "drivers" of the increased need for resources such as historical and forecasts for caseload, trends in cost of services and needs caused by recent major natural disasters.

Major Federal Funding Issues

Federal funds provide nearly 60 percent of all funding for Texas health and human services. Federal policy issues are contained in several chapters of this Consolidated Budget document, including Chapter IV which highlights many policy issues with significant fiscal impact including promulgation of selected Medicaid regulations and changes in federal matching percentages. A graphical representation of the history of the Federal Medicaid Assistance Percentage (FMAP) is provided in Chapter II.

Two Additional Issues not Included in Agency LARs

The Consolidated Budget also addresses two additional fiscal issues, which are not included in agency LAR submissions:

- a proposal to improve the recruitment and retention of critical non-medical client services staff (Chapter V).
- the cost of increasing various provider rates (presented in one percent increments) (Chapter VII, Table VII.1 and Appendices A1–A3).

Other Supplemental Information Provided

In addition, this Consolidated Budget provides a status report on Texas Medicaid Reform activities (Chapter IV) and recent information on two major Medicaid provider supplemental payment systems, DSH and UPL (Chapter VIII, Appendix E). The document also provides tabular information on the Ten Percent Biennial Base Reduction Options Schedule (Chapter VIII, Appendix F).

Statutory Requirements Fulfilled

Submission of the Consolidated Budget fulfills several statutory requirements including:

- the Biennial Consolidated Budget Recommendation for the HHS System;
- the Annual Federal Funds Report (Chapter IV); and
- the Long-term Care Plan for Persons with Mental Retardation, which is provided in Chapter VIII, Appendix D.

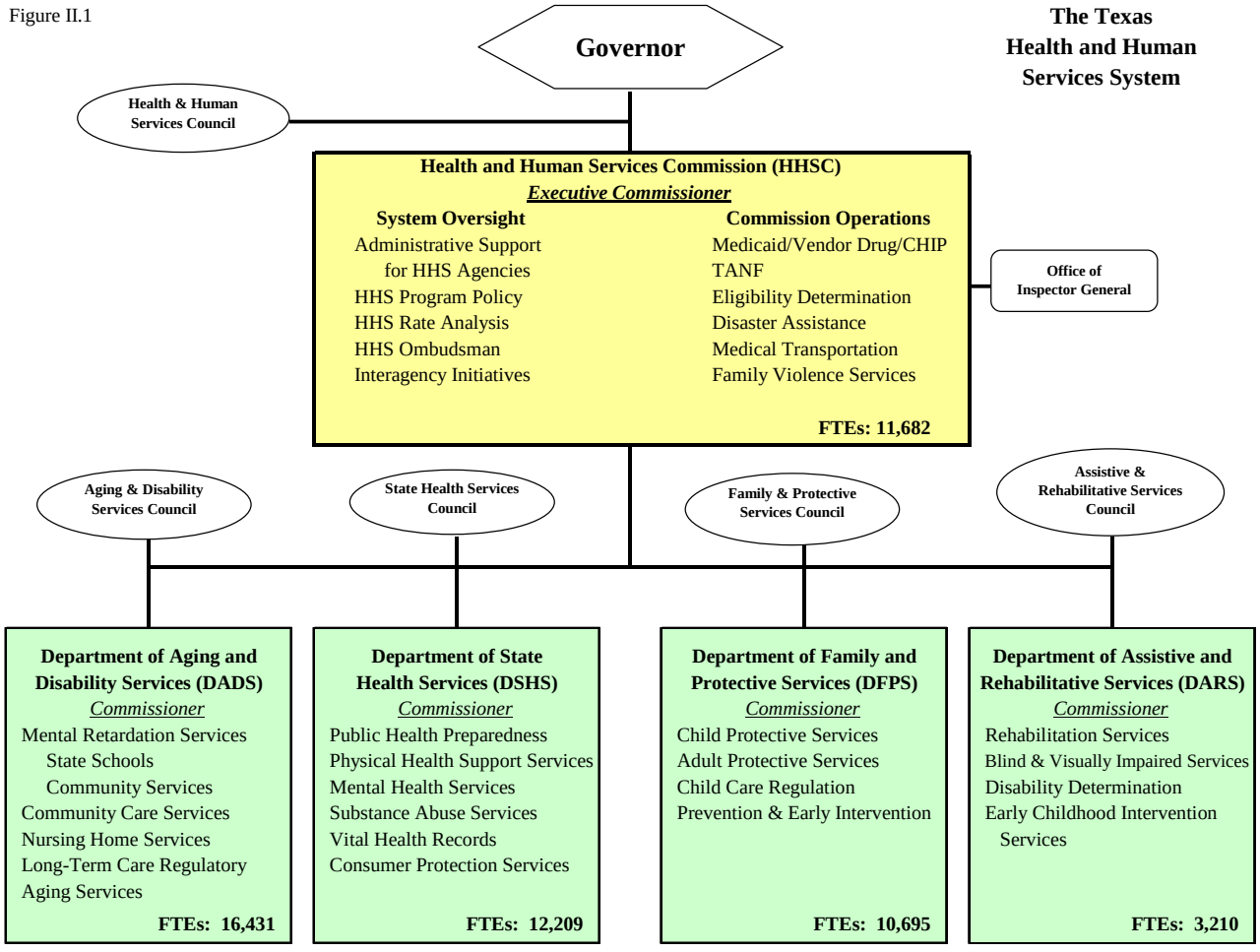
For further information, the document includes contact information for executives of the five Health and Human service agencies in Chapter VIII, Appendix G.

II. CONSOLIDATED BUDGET OVERVIEW

Health and Human Services System Overview

The Texas Health and Human Services (HHS) System is dedicated to developing client-focused program and policy initiatives that are solution-oriented and fiscally responsible. The HHS system advocates client-choice, appropriate funding, and streamlined service delivery. Reflecting a unified philosophy and approach to delivering health and human services, the HHS system agencies operate with similar organizational structures. Organizational structures reflect an emphasis on efficiency, service delivery, accountability, and providing visible and accessible agency resources for stakeholders. The following chart depicts the HHS system organizational structure in FY 2009 and identifies services provided by the HHS agencies.

Figure II.1



Note: The Full Time Equivalent (FTE's) positions are the budgeted level for FY 2009.

As of: 09-01-2008

HHS System FY 2010–2011 Legislative Appropriations Request

The FY 2010–2011 Legislative Appropriations Request (LAR) base request combined with the exceptional items for all HHS agencies totals $65.6 billion, an increase of $9.9 billion all funds from the 2008-2009 biennium (17.8 percent increase).

Figure II.2 presents the allocation of requested funds among HHS agencies.

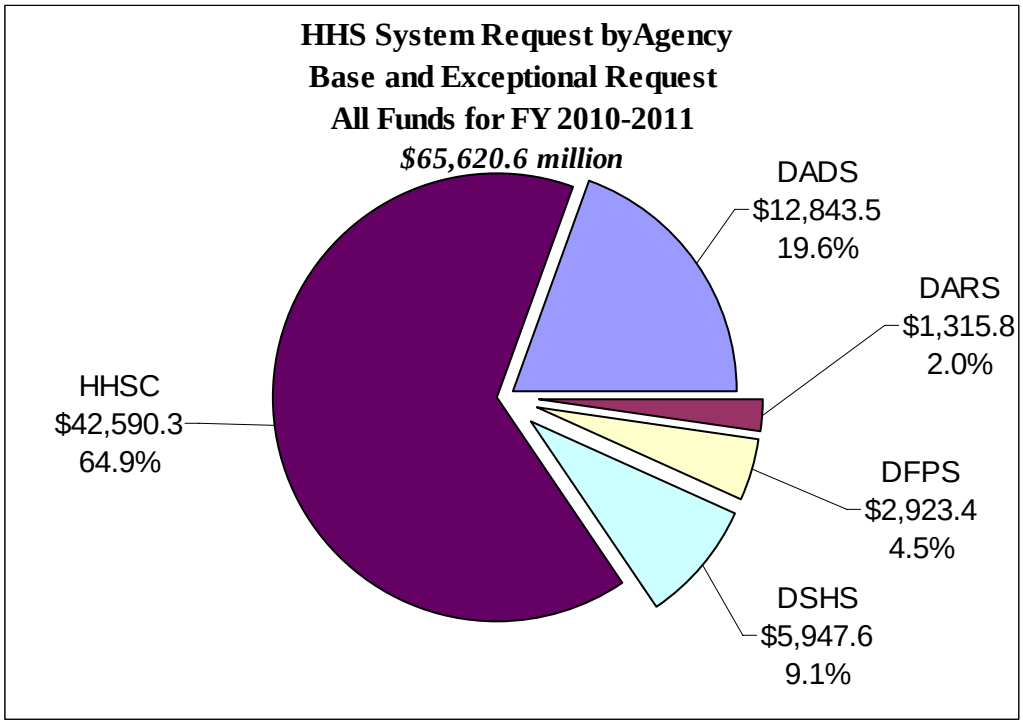
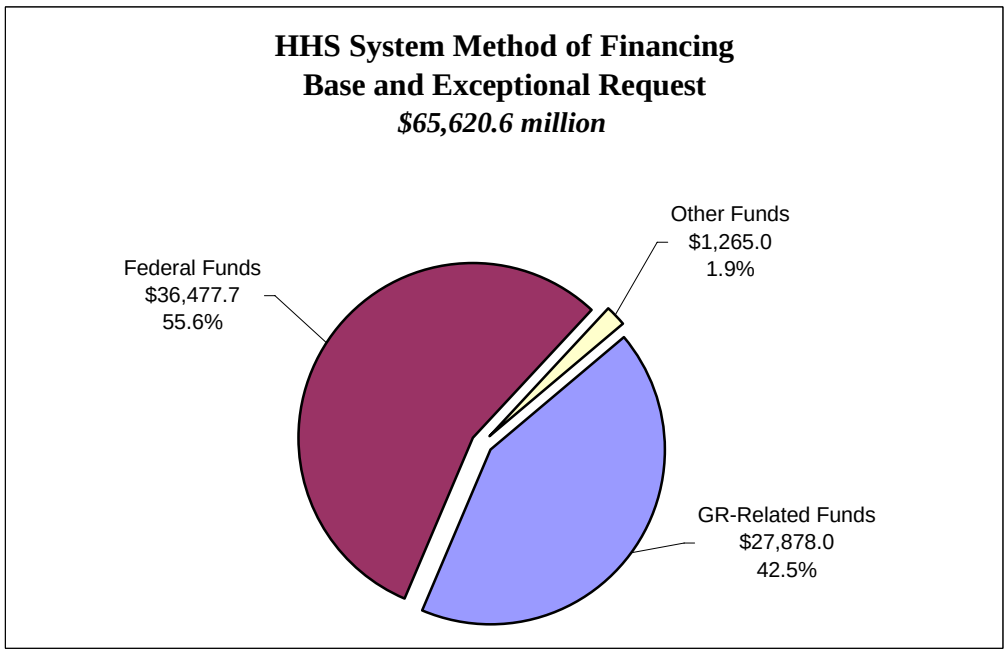
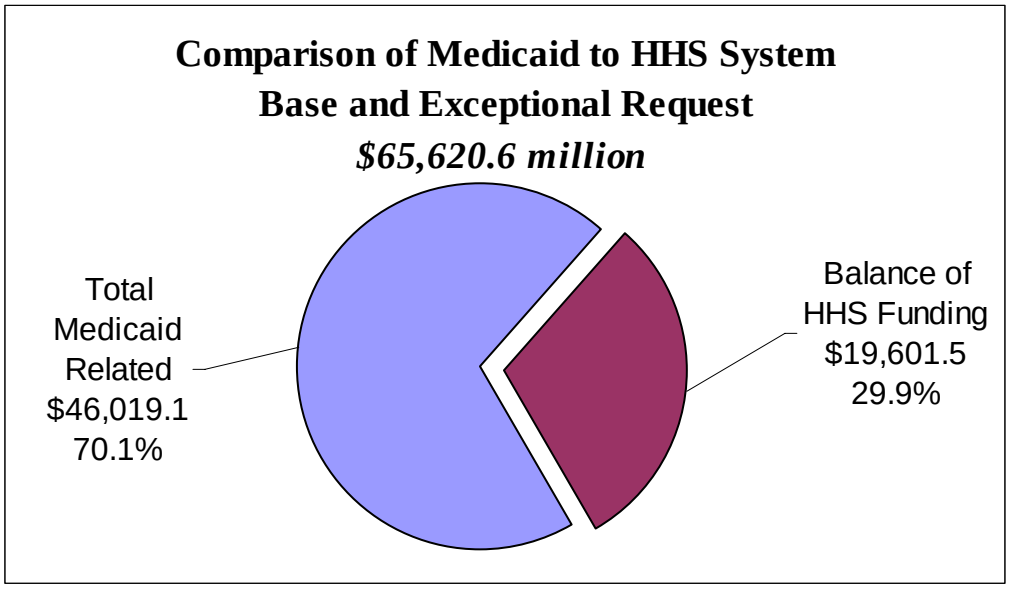


Figure II.3 presents the comparison of funding sources for the HHS System.



Exceptional items represent $6.4 billion all funds of the total FY 2010-2011 biennial request. The GR-related base and exceptional item request for 2010-2011 biennium totals $27.9 billion, representing a $5.7 billion increase (25.8 percent) from the 2008-2009 biennium. Total requested base and exceptional federal funds for the HHS System for the biennium is $36.5 billion, representing a $4.1 billion increase over 2008-2009 biennium federal funds.

Figure II.4 presents the comparison of Medicaid to the HHS System.



As the chart indicates, Medicaid related funding, accounts for $46 billion, or 70.1 percent, of the total HHS funding requested in the 2010-2011 biennium. Using state and federal funding, Texas' Medicaid program provides acute care and long term services and support to millions of low income Texans each year (Reference Figure III.1-4 for Medicaid caseload forecasts).

Legislative Appropriation Request Guidance and Baseline Funding

Baseline Policy and HHS Assumptions

The General Revenue (GR) and GR-related baseline request must not exceed the sum of the amounts expended in fiscal year 2008 and budgeted in fiscal year 2009 plus an amount equal to the GR-related allocation for the two percent/$50 employee raise in fiscal year 2009, plus caseload growth for federal entitlement services. Agencies must also submit a supplemental schedule detailing how they would reduce the baseline request by 10 percent, or down to 90 percent, in general revenue funding. (Reference Chapter VIII, Appendix F) A summary of each agency's baseline request is provided below.

Health and Human Services Commission

The baseline request for FY 2010-2011 totals $37,782.1 million, of which $15,553 million is GR. This request represents an increase of $2,150.2 million in GR or about 16 percent more than is projected to be expended in the 2008-2009 biennium. This increase is associated with Medicaid entitlement caseload growth.

The CHIP program is not considered an entitlement program. By assuming the elimination of the CHIP Perinate program and including the Perinates as Medicaid entitlement, the funding for the remaining CHIP Program at projected caseloads and costs is fully maintained in the FY 2010-2011 base request. Because of this shift of Perinates to Medicaid, HHSC is purposely submitting the FY 2010-2011 base request related to non-entitlement GR, at $116.6 million less than the non-entitlement GR amount in the FY 2008-2009 base funding; therefore, there is no CHIP Perinatal Program assumed in the FY 2010-2011 baseline request and it is restored in an exceptional item request. The remaining CHIP program is funded in the baseline request at projected caseloads and projected cost levels. CHIP caseloads are projected to increase to 483,358 in FY 2010 and to 485,706 in FY 2011. Medicaid caseloads are projected to increase to 3,056,383 in FY 2010 and to 3,141,452 recipients in FY 2011 and reflect the Medicaid caseload growth associated with the elimination of the CHIP Perinatal Initiative in the baseline request.

The LAR assumes a Medicaid match rate (FMAP) of 60.56 percent in FFY 2008 and 59.44 percent in FFY 2009. The match rate projections for FY 2010-2011 are anticipated to continue their decline as the Texas economy is expected to fare better when compared with the national economy. The LAR assumes a Medicaid FMAP of 58.59 percent in FFY 2010 and 58.10 percent in FFY 2011. The CHIP match rate is 72.39 percent in FFY 2008 and 71.61 percent FFY 2009 and projected to decline to 71.01 percent in FFY 2010 and 70.67 percent in FFY 2011. The base request for Medicaid and CHIP services includes $350 million GR associated with declining federal match changes. Historical trends in FMAP are included on page 9.

Average TANF caseloads are anticipated to remain steady in FY 2010-2011 after having significant decreases from FY 2008-09 levels. Because of the biennial decrease, the TANF programs are fully funded in the FY 2010-2011 base request at projected caseloads of 114,344 in FY 2010 and 114,344 in FY 2011. The current TANF caseload projections total 125,480 in

FY 2008 and 114,746 in FY 2009. The portion of the federal TANF maintenance of effort (MOE) requirement in HHSC's request is met in the base request.

Aging and Disability Services

The Department of Aging and Disability Services (DADS) FY 2010-2011 baseline request totals $12,184.8 million in all funds for the biennium, with $5,051.2 million being GR-related funds. The baseline request will serve an estimated average monthly caseload of 296,000 with an average monthly caseload of 214,000 or 72.3 percent of these individuals being served in the community. This level of funding is an increase of $351.9 million in all funds from the 2008-2009 biennial amount of $11,832.8 million. The GR difference between the two biennia is $316.9 million (6.7 percent).

Family and Protective Services

The Texas Department of Family and Protective Services (DFPS) baseline request totals $1,258.1 million ($517.7 million GR-related) and $1,281.1 million ($532.4 million GR-related) in fiscal years 2010 and 2011 respectively. DFPS is not able to include more funds in the baseline request due to timing difficulties associated with seeking approval to spend additional available funds for ongoing operating costs in FY 2008-2009.

State Health Services

The Department of State Health Services (DSHS) FY 2010-2011 baseline request totals $5,502.2 million ($2,806.4 million GR-related). This level of funding is a decrease of $79.8 million AF from the FY 2008-2009 biennial amount of $5,582.0 million, but a $6.1 million or 0.2 percent increase GR-related funds.

Assistive and Rehabilitative Services

The Department of Assistive and Rehabilitative Services (DARS) baseline request totals $603.3 million ($133.8 million GR-related) and $617.8 million ($141.8 million GR-related) in fiscal years 2010 and 2011 respectively. The FY 2010-2011 baseline request is an increase of $14.9 million in all funds over the estimated and budgeted amounts in FY 2008 and FY 2009, but the GR request is $45.4 million (19.7 percent) higher due primarily to a reduction in available special education grants for early childhood intervention.

Summary Tables of Agency Requests

Table II.1 illustrates a comparison, by agency, of the FY 2010-2011 requests to the FY 2008-2009 appropriation, and summarizes the FY 2010-2011 baseline request and exceptional items amounts.

Table II.1

Comparison of HHS Agency Baseline Request
FY 2008 - 2009 and FY 2010 - 2011
(in millions)

Agency	FY 08 Expended - FY 09 Budgeted		FY 10-11 Baseline		Biennial Change		GR / GRD % Change
	GR / GRD	All Funds	GR / GRD	All Funds	GR / GRD	All Funds	
DADS	4,734.4	11,832.8	5,051.2	12,184.8	316.9	351.9	6.7%
DARS	230.2	1,206.3	275.6	1,221.2	45.4	14.9	19.7%
DFPS	985.8	2,481.4	1,050.2	2,539.2	64.4	57.8	6.5%
DSHS	2,800.3	5,582.0	2,806.4	5,502.2	6.1	(79.8)	0.2%
HHSC	13,402.8	34,621.9	15,553.0	37,782.1	2,150.2	3,160.3	16.0%
Total, HHS	**$ 22,153.5**	**$ 55,724.4**	**$ 24,736.4**	**$ 59,229.5**	**$ 2,583.0**	**$ 3,505.1**	**11.7%**

HHS Agency Baseline and Exceptional Request
FY 2010 - 2011
(in millions)

Agency	Baseline Request		Exceptional Item Request		Total Request	
	GR / GRD	All Funds	GR / GRD	All Funds	GR / GRD	All Funds
DADS	5,051.2	12,184.8	282.2	658.8	5,333.4	12,843.5
DARS	275.6	1,221.2	70.3	94.7	345.9	1,315.8
DFPS	1,050.2	2,539.2	332.0	384.1	1,382.2	2,923.4
DSHS	2,806.4	5,502.2	359.1	445.4	3,165.5	5,947.6
HHSC	15,553.0	37,782.1	2,098.0	4,808.2	17,651.0	42,590.3
Total, HHS	**$ 24,736.4**	**$ 59,229.5**	**$ 3,141.6**	**$ 6,391.2**	**$ 27,878.0**	**$ 65,620.6**

HHS Agency Biennial Funding Comparison (Baseline & Exceptional Items)
FY 2008 - 2009 and FY 2010 - 2011
(in millions)

Agency	FY 08 Expended - FY 09 Budgeted		FY 10 - 11 Requested [1]		Biennial Change		GR / GRD % Change
	GR / GRD	All Funds	GR / GRD	All Funds	GR / GRD	All Funds	
DADS	4,734.4	11,832.8	5,333.4	12,843.5	599.1	1,010.7	12.7%
DARS	230.2	1,206.3	345.9	1,315.8	115.7	109.6	50.3%
DFPS	985.8	2,481.4	1,382.2	2,923.4	396.4	441.9	40.2%
DSHS	2,800.3	5,582.0	3,165.5	5,947.6	365.2	365.7	13.0%
HHSC	13,402.8	34,621.9	17,651.0	42,590.3	4,248.2	7,968.4	31.7%
Total, HHS	**$ 22,153.5**	**$ 55,724.4**	**$ 27,878.0**	**$ 65,620.6**	**$ 5,724.5**	**$ 9,896.3**	**25.8%**

Note: Totals may not add due to rounding.

HHSC Exceptional Items include enterprise items such as interest list, staff retention, vehicles, and IT.

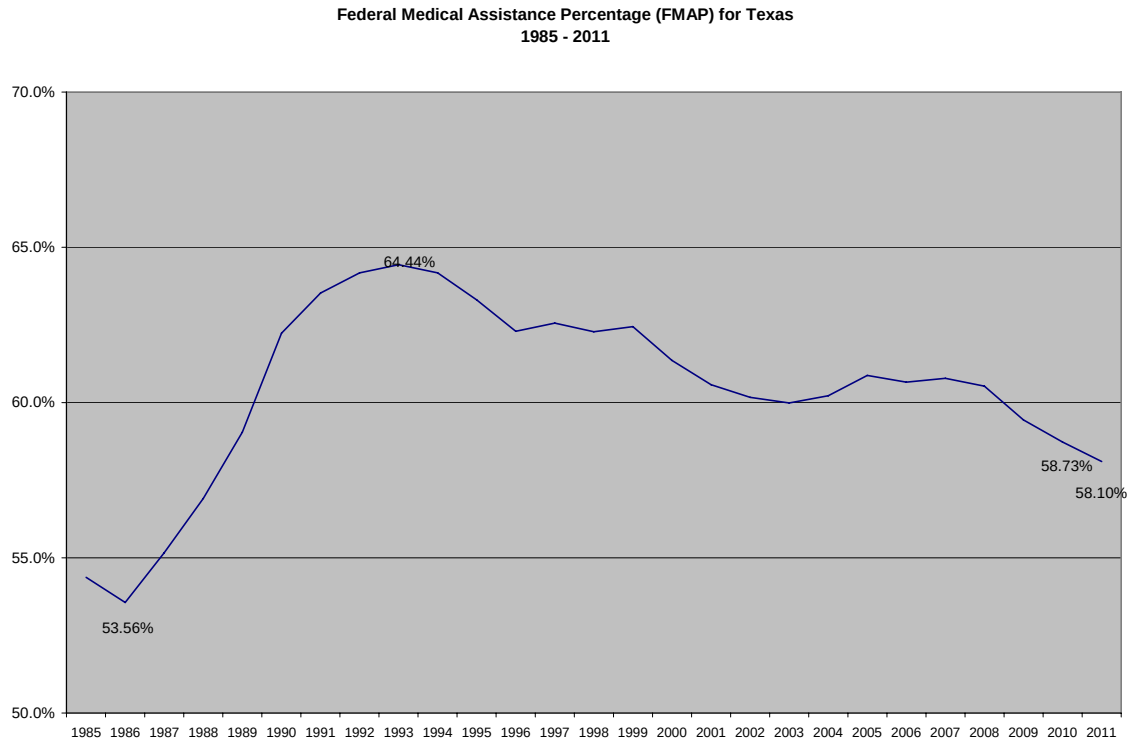
[1] Requested includes baseline and exceptional items.

Federal Medical Assistance Percentage (FMAP)

Medicaid is financed by both the federal and state governments. The federal government's share of the Medicaid program is known as the Federal Medical Assistance Percentage (FMAP). The formula that determines FMAP compares a state's average per capita income level with the national average. As a result, states with lower incomes pay a lower portion of Medicaid expenses. Texas' 2009 FMAP is 59.44 percent, which places the state at about the 50th percentile. Federal law prohibits the FMAP from being less than 50 percent or greater than 83 percent.

Changes in the FMAP can have significant cost implications for the state budget. In fiscal years 2008 and 2009 in Texas, Health and Human Services agencies were appropriated nearly $23 billion for the federal portion of Medicaid. Each one-tenth percent decline in the FMAP will shift approximately $50 million of costs to general revenue for the 2010-2011 biennium or $25 million per year. The FMAP is also tied to Title IV-E funds for foster care and to the state's Children's Health Insurance Program. Figure II.5 below shows the changes in FMAP since 1985.

Figure II.5



Note: 1) Based on federal fiscal year.
2) The FFY 2010 rate of 58.73% was determined after the agency LARs were submitted. The LARs used a projected rate of 58.59%.
3) The FFY 2011 rate will be published in November, 2009.

Summary of HHS Agency Exceptional Item Request

HHS agencies have requested a total of 64 exceptional items totaling more than $3.1 billion in general revenue (19 percent less than the 2008-09 request), including six that are enterprise wide. Table II.2 divides the exceptional items into categories to better highlight the areas of funding needs. While the categories are listed in priority order, the exceptional items within each category are not listed by priority.

Maintain Current Services and Cost Trends for Medicaid/CHIP

The exceptional items in this category would continue the current level of services provided in the Medicaid program by funding increased costs due to rising caseloads and cost trends in acute care, as well as maintaining those Frew strategic initiatives began in 2008-09. The DADS request seeks to maintain funding in waiver and non-waiver programs. Also included is the request to restore the CHIP Perinate program.

Maintain Non-Medicaid Services and 2008-09 Legislative Initiatives

This category captures those exceptional items required to annualize the costs of legislatively mandated programs that were "ramped up" during the 2008-2009 biennium. These exceptional items also seek to maintain non-Medicaid services in multiple programs across the enterprise that are experiencing unavoidable costs in areas such as leases, utilities, and other operating expenses.

The two categories above identify those exceptional items that maintain current services in FY 2010-2011.

Major Initiatives to Increase Service Capacity and Improve Quality

These exceptional items seek funding to increase the capacity for serving clients in existing programs, including community care services to decrease the size of waiting/interest lists. In addition there are several major new initiatives developed to respond to ongoing needs in the HHS system, such as improving retention and recruitment of direct care staff and creating a Medicaid Buy-In program for children.

Critical Improvements in System Operations

This category identifies those exceptional items related to the critical infrastructure needs of the agencies. These items include IT system support and enhancements, building repair and replacement, and vehicle replacement.

Additional Program Enhancements

The final category lists a number of exceptional items that seek funding to enhance services, increase prevention efforts and expand oversight. These items have been identified as critical to building each agency's capacity to fulfill its mission.

Table II.2

HHS Enterprise Exceptional Item GR Request Breakout

Agency	Exceptional Item		GR/GRD		All Funds
Total Exceptional Item Request		**$**	**3,141,575,791**	**$**	**6,391,164,995**
Maintain Current Services and Cost Trends for Medicaid/CHIP					
DADS	Maintain FY09 Caseloads	$	190,682,690	$	440,495,003
HHSC	Maintain Medicaid Cost	$	1,263,435,002	$	2,948,888,056
HHSC	Frew Corrective Actions	$	25,000,000	$	49,887,527
HHSC	Frew Strategic Initiative	$	150,000,000	$	293,838,682
HHSC	Maintain CHIP Perinate Program	$	(68,135,540)	$	82,984,072
	subtotal	**$**	**1,560,982,152**	**$**	**3,816,093,340**
Maintain Non-Medicaid Services and 2008-09 Legislative Initiatives					
DFPS	Required Funding for Base FTEs	$	82,989,550	$	97,835,596
DFPS	Maintain Phased-In Staff and Initiatives	$	34,516,864	$	39,785,413
DFPS	Replace Non Recurring Federal Revenue	$	43,353,154	$	51,155,652
DFPS	Direct Delivery Staff to Maintain Investigation Caseloads	$	5,853,880	$	6,575,496
DFPS	Direct Delivery Staff to Meet Federal Standards for 95% Contacts	$	21,221,391	$	25,033,241
DFPS	Add'l Purchased Client Services & Program Support for Caseload Growth	$	20,682,709	$	22,728,952
DARS	Request to Maintain Services (BCVDDP/Autism)	$	4,327,470	$	4,908,462
DSHS	Maintain Current Operating Capacity	$	75,813,170	$	76,732,123
HHSC	Maintain Current Operating Levels	$	151,351,124	$	287,778,593
	subtotal	**$**	**440,109,312**	**$**	**612,533,528**
Major Initiatives to Increase Service Capacity and Improve Quality					
DFPS	Address Recruitment and Retention	$	40,078,688	$	46,916,531
DARS	VR Growth to Maintain Services and Serve General Population Growth	$	6,434,505	$	30,208,942
DARS	Growth to Serve More Clients	$	4,786,549	$	4,786,549
DADS	Promoting Independence	$	16,326,222	$	35,636,700
DADS	MR Safety Net	$	31,306,800	$	31,306,800
DADS	Hospital Level of Care	$	15,146,232	$	36,475,888
DSHS	Stipends for Psychology and Medical Residents	$	2,736,795	$	2,736,795
DSHS	Substance Abuse	$	66,246,178	$	81,669,715
DSHS	Community Mental Health Services	$	88,336,497	$	88,336,497
HHSC	Increase Eligibility Resources	$	56,689,165	$	124,925,999
HHSC	Medicaid Buy-In for Children	$	22,713,550	$	45,926,770
Enterprise	Increase HHS Community Services	$	224,049,666	$	474,415,281
Enterprise	HHS Targeted Staff Retention	$	45,877,230	$	66,834,186
Enterprise*	Retention and Recruitment of Service Delivery Staff		-		-
	subtotal	**$**	**620,728,077**	**$**	**1,070,176,653**

Critical Improvements in System Operations					
DFPS	Mobile Caseworker Enhancements	$	11,927,954	$	12,530,106
DFPS	IT and Data Management Initiatives	$	8,712,975	$	9,823,851
DARS	Accessibility	$	4,336,221	$	4,336,221
DADS	State Schools (Equipment Needs)	$	8,499,781	$	80,137,880
DADS	IT - Automation/ System Modification	$	7,103,744	$	8,349,600
DSHS	Regulatory Capacity	$	18,786,207	$	18,786,207
DSHS	Health Data Collection and Analysis	$	12,460,837	$	12,467,749
DSHS	Vital Statistics	$	6,655,044	$	6,655,044
DSHS	Information Technology Support	$	30,290,109	$	30,290,109
DSHS	Disaster Recovery and Public Health Prep	$	13,511,006	$	14,091,630
DSHS	Building and Equipment Repair and Replacement	$	3,663,479	$	70,854,048
Enterprise	Maintain Data Center Services	$	38,755,399	$	46,913,305
Enterprise	Maintain HHS Transportation	$	11,300,070	$	11,300,070
Enterprise	Maintain and Improve HHS Technology	$	32,878,377	$	45,131,170
	subtotal	**$**	**208,881,203**	**$**	**371,666,990**
Additional Program Enhancements					
DFPS	Address Caseload Growth for Kinship Caregiver Program	$	10,852,637	$	10,852,637
DFPS	CPS Capped Caseload Pilot	$	2,851,483	$	3,360,591
DFPS	Increase Funding for Prevention Services	$	6,200,172	$	6,200,172
DFPS	Strengthen CPS Services to Families	$	14,407,832	$	16,936,103
DFPS	Strengthen Services to Youth Transitioning from Foster Care	$	7,732,092	$	7,803,502
DFPS	Create Higher Adoption Subsidy Ceilings for Certain Children	$	2,850,913	$	5,328,809
DFPS	Address Pending and Projected Appeals Hearings	$	4,290,854	$	4,587,000
DFPS	Enhance CPS Risk Management	$	3,344,460	$	3,898,372
DFPS	Strengthen APS and Day Care Licensing Program Oversight	$	10,118,683	$	12,783,656
DARS	Increase Number of Service Hours	$	50,412,058	$	50,412,058
DADS	Prevention of Institutionalization	$	4,622,648	$	11,078,900
DADS	AAA - Benefits Counseling	$	3,000,000	$	3,000,000
DADS	PACE Expansion	$	3,195,186	$	7,674,907
DADS	Survey and Certification FTEs	$	2,312,866	$	4,625,731
DSHS	Chronic Disease Prevention	$	23,771,702	$	25,914,095
DSHS	Infectious Disease Prevention	$	16,839,705	$	16,906,613
HHSC	Improve Staffing for OIG	$	8,143,882	$	16,892,957
HHSC	Increase Family Violence Services	$	2,482,659	$	2,482,659
HHSC	Increase 2-1-1 Information Center Support	$	982,000	$	2,000,000
HHSC	Critical Health/Family Support	$	7,463,215	$	7,463,215
HHSC	Increase Children Hospital UPL	$	25,000,000	$	60,098,501
HHSC	Restore State Supported GME	$	100,000,000	$	240,394,006
	subtotal	**$**	**310,875,047**	**$**	**520,694,484**
	Total HHS Exceptional Item Request	**$**	**3,141,575,791**	**$**	**6,391,164,995**

* Additional request not in agencies' LARs. See page 39.

III. ELEMENTS CONTRIBUTING TO FUND NEEDS

Caseloads and Cost

Medicaid caseloads are projected to average over 3.1 million recipients in FY 2011, with an average of 2.14 million in the children's risk groups (non-disabled children aged 0-18, and TANF recipients through age 18). The caseload shown in FY 2008-2011 for both Medicaid and CHIP is the caseload with CHIP Perinatal clients removed from the Medicaid caseload and reflected in CHIP, although the LAR base request shows CHIP Perinatal clients in Medicaid. The combined Medicaid children and CHIP caseload for FY 2008 was 2.5 million and is projected to be 2.6 million in FY 2009. The regular CHIP caseload is projected to average approximately 486,000 in FY 2011.

Table III.1

Medicaid Acute Care Caseload

Caseload by Group	FY 2008	FY 2009	FY 2010	FY 2011
Total Medicaid	**2,879,770**	**2,943,527**	**3,021,181**	**3,105,401**
Aged and Disability-Related	**666,428**	**692,280**	**714,758**	**739,466**
Aged & Medicare Related	338,866	342,810	349,723	359,578
Disabled & Blind *(including Children)*	327,561	349,470	365,034	379,888
Other Adults, Non-Aged or Disabled	**208,223**	**210,709**	**216,163**	**222,086**
Pregnant Women	126,256	128,148	131,649	135,548
TANF Adult	43,672	44,054	44,799	45,558
TANF Non-Cash Adult	38,295	38,507	39,715	40,980
Medicaid Children Ages 0-18, Non-Disabled	**2,005,118**	**2,040,538**	**2,090,260**	**2,143,850**
Ages 0-18, Cash Grant (TANF)*	221,308	203,841	204,737	208,302
Ages 0 - 21, Foster Care STARHealth	12,162	29,097	30,086	31,489
Ages 0-12 months, Newborns**	168,786	201,132	217,533	226,422
*Perinate Infants (numbers in base request only)****			*35,202*	*36,051*
Ages 0 - 6 years	743,302	731,294	750,210	781,064
Ages 6 - 18 years	859,560	875,174	887,695	896,572

** TANF Child includes all Foster Care Clients through FY 2007, and non-STAR Health Foster Care Clients through 2011*

*** Caseload shifts between the Newborns and Children 0-6 in FY 2009, with clients moving to the Newborns.*

**** Newborn perinate infants are in the base request of the LAR, but not included in this table. In FY 2010 there are 35,202 additional infants in the base (as Newborns) and 36,051 in FY 2011. These infants are included in the CHIP table here, reflecting the total agency request.*

Table III. 2

CHIP Caseload				
Group	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**
Federally Funded Children	362,779	448,047	451,101	453,113
Perinatal (Federally Funded)	*53,628*	*63,001*	*64,504*	*66,045*
Legal Permanent Resident Children	16,226	20,093	20,230	20,328
Eligible Children of School Employees	10,057	11,946	12,028	12,265
Group Total, No Perinatal	**389,062**	**480,085**	**483,358**	**485,706**
Group Total, With Perinates	**442,689**	**543,086**	**547,862**	**551,750**

** Perinatal Caseload includes Newborns from the Base Request of the LAR (35,202 in FY 2010 and 36,051 in FY 2011), plus unborn Perinates and Infants and Perinates with incomes greater than 185% FPL*

In forecasting the Medicaid program for the LAR, the base forecast held costs at the FY 2009 level. The base caseload includes Medicaid clients who are part of the CHIP Perinatal program. Cost growth was projected through the end of the 2010-2011 biennium for the cost exceptional item request, and the LAR caseload was adjusted to remove the CHIP Perinatal clients from Medicaid, showing a general revenue savings due to the higher match rate received in CHIP. Both caseload and cost trends are determined by time-series analyses of historical data, with consideration of external factors such as policy impacts (for example, the CHIP Perinatal program).

Table III.3

Long-Term Care Caseload				
Group	**FY 2008**	**FY 2009**	**FY 2010**	**FY 2011**
Residential LTC	80,633	81,436	81,982	82,593
Promoting Independence	4,751	5,298	5,679	6,088
Community Care (includes Exceptional Items)	157,372	163,093	169,193	174,604
Entitlement: Base	*110,924*	*113,410*	*117,882*	*122,731*
Non-Entitlement: Base	*46,448*	*49,683*	*45,417*	*45,527*
Non-Entitlement: Base + Exceptional Items			*51,311*	*51,873*

Source: DADS LAR FY 2010-2011

Residential Long-Term Care includes caseload from the Nursing Facility, Hospice, Skilled Nursing Facility, Intermediate Care Facilities - Mental Retardation and State School Services programs. Community Care Entitlement includes caseload from the Primary Home Care, Community Attendant Services, Day Activity and Health Services Title XIX programs. Community Care Non-Entitlement includes caseload from the Community Based Alternatives, Home and Community Services, Community Living Assistance and Support Services, Deaf-Blind Multiple Disability, Medically Dependent Children, Consolidated Waiver and Texas Home Living waiver programs.

Residential long-term care caseloads are projected to reach approximately 82,600 clients by FY 2011, an increase of less than one percent each year of the biennium. Foster care caseloads are

projected to increase by close to three percent each year of the biennium, and adoption subsidy caseloads are projected to increase by about nine percent each year of the 2010-2011 biennium, with a daily average of just over 18,800 children in paid foster care in FY 2011. Early childhood intervention caseload increases by between six and seven percent each year. Temporary Assistance to Needy Families (TANF) is projected to stabilize, at approximately 114,000.

Table III.4

Other HHS Caseloads

Agency/Program	FY 2008	FY 2009	FY 2010	FY 2011
Department of Family & Protective Services				
Foster Care	17,318	17,856	18,365	18,863
Adoption Subsidy	24,956	27,729	30,275	32,889
Department of Rehabilitative Services				
Early Childhood Intervention	27,559	29,358	31,245	33,132
Health and Human Services Commission				
Temporary Assistance to Needy Families	125,480	114,746	114,344	114,344

Cost Allocated Support Services

The Health and Human Services Commission (HHSC) is responsible for the equitable allocation of costs related to co-location of human services and support functions among the HHS agencies. These costs are allocated to the five agencies by methodologies approved by the Federal Division of Cost Allocation as part of the HHSC Public Assistance Cost Allocation Plan. Examples of methodologies used to allocate and bill these costs include total salaries by agency, computer usage by agency, purchase order line counts by agency, metered postage by agency, number of email accounts by agency, etc. Billings are based on actual costs as recorded in HHSC's accounting system. Although the HHS agencies did not have adequate historical data to estimate and budget these costs, they were able to make payments for their share of the FY 2006-2007 co-location and support functions. As fiscal year 2008 progressed and cost allocated support services increased, a structural shortfall became apparent. The major factors contributing to the increase in cost include:

- Costs not captured in FY 2008-09 Appropriations Request
  The timing of the consolidation of regional space has contributed to this issue; actual consolidation of some agency personnel did not take place until March 2007, which was after the FY 2008-2009 LARs were developed and submitted. Sufficient historical expenditure data was not available for legislative consideration in FY 2007.
- Change in Federal Cost Allocation Methodology
  Factor 1 is the HHSC oversight factor that has been used since the consolidation of the five agencies under the Enterprise. Its methodology was based on an equal combination of total Enterprise FTEs and total Enterprise expenditures, excluding payroll related costs. The federal Division of Cost Allocation did not accept this methodology and required HHSC to change to a methodology based upon total salaries by agency within the Enterprise. Factor 1 is also imbedded in another 24 HHSC factors in the public assistance cost allocation Plan (PACAP). The change in methodology resulted in a decrease in the allocation to HHSC and an increase the allocation to the other four agencies in the Enterprise. In the aggregate, this resulted in an increase in the general revenue related share of expenses.
- Regional Operations: Change in Underlying Costs
  The initial assumption for the 2008-09 biennium regarding FTEs related to regional costs was that positions would be eliminated related to outsourcing integrated eligibility. This assumption did not materialize affecting not only salaries budgeted for those FTEs, but other associated costs such as leases, utilities, supplies, and equipment. In order to remain co-located with a significantly larger workforce, new office space was needed and relocation costs were incurred.
- Information Technology: Change in Assumptions
  The original assumption included retirement of mainframe by FY 2008 upon implementation of TIERS. However, delays in TIERS implementation has impacted IT costs related to the maintenance of the enterprise mainframe and all the related servers, causing increased costs to be allocated to all agencies.

In anticipation of the impact these factors would have on each agency's budget, an analysis of projected cost allocated support services billings by HHSC and available appropriations at the recipient agencies revealed significant funding gaps in FY 2008 and FY 2009 for each agency. HHSC assisted the HHS agencies with the funding gap created by cost allocated services by transferring general revenue in the amounts of $16.2 million and $1.7 million to the Department of State Health Services (DSHS) and Department of Assistive Rehabilitative Services (DARS), respectively. Although the Department of Aging and Disability Services (DADS) also experienced an increase in costs, their appropriations level was able to absorb the increase. The Department of Family and Protective Services (DFPS) requested approval to address this funding issue by internal transfers. The FY 2008 portion of the request was substantially approved in September 2008. Resolution of the FY 2009 request remains pending.

The lack of historical data available to project the initial appropriation requests for HHS co-location and support services costs, changes in budget assumptions, change in the allocation methodology, and timing of the development of the FY 2008-2009 requests created funding needs for costs related to co-location and support services at all HHS agencies. While the transfer of general revenue from HHSC to DSHS and DARS and the requested approval of the internal transfers at DFPS will resolve the funding needs in FY 2008 and FY 2009, the issue will continue to emerge until appropriation levels for co-location and support costs are increased to reflect spending needs. The agency LARs for FY 2010-2011 benefit both from longer historical data and better tracking systems to estimate the impact of allocated costs among agencies. A methodology has also been developed to include the impact on support services when additional staff are requested in exceptional items. As additional staff resources are requested by an HHS agency, an average cost for each FTE requested has been developed for the support services provided by HHSC. This methodology allows for a variance in the calculation of average cost per FTE whether the new employee is to be located in a State School or Hospital, in a local or regional office, or in an Austin office since the costs differ by location.

2008 Disasters

Two federally declared "major" disasters will impact the need for health and human services in Texas: Hurricanes Dolly and Ike. In addition, Hurricane Gustav and Tropical Storm Edouard required pre and post disaster responses from health and human service agencies. While the majority of affected individuals from Hurricane Katrina repatriated to Louisiana, the storms of 2008 had a greater effect on the health, income, and need for social services of Texans. As of October 31, 2008, projected health and human service needs from disasters which occurred this year are estimated to be:

Table III.5

Projected Health and Human Services 2008/2009 Disasters Needs
($ in millions)

Disaster	General Revenue	All Funds
Hurricane Dolly	$ 3.4	$ 13.4
Hurricane Ike*	163.3**	498.0
Other Disasters***	9.8	14.6
Total	$ 176.5	$ 526.0

* Twelve Month projection Method of Finance does not reflect an allocation from September, 2008 federal appropriation.

** Texas requests the $163.3 million estimated state share from the Federal government.

*** Includes Hurricane Gustav and Tropical Storm Edouard

Congress provided supplemental funding for disaster response, including $600 million to be shared by at least 32 states which experienced presidentially declared major disasters in 2008. Texas will receive a portion of this funding from the Social Services Block Grant (Title XX) to be used for social service needs and for health care, including mental health services and uncompensated health care. A process will be developed to indentify eligible reimbursement from this new financing source. While the Texas allocation from this new appropriation has not been determined, as a point of reference, our state allocation of $550 million appropriated for Hurricanes Katrina and Rita was $88 million.

The Texas Health and Human Service system, along with many state, federal, and local agencies, has stepped forward to respond to these two "major disasters" in addition to other natural disasters, which occurred in 2008. Staff provided medical, public health, social service, and financial assistance while employees and state agencies faced many of the same problems themselves such as property loss, office damage, and lack of utilities.

HHSC will continue to estimate the impact on agency budgets for disaster assistance and our federal resources when possible to help Texans in affected regions recover from these devastating events.

Frew v. Hawkins

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are health benefits for children enrolled in Medicaid under the age of 21 and are subject to Title XIX of the Social Security Act. The EPSDT service is known as the Texas Health steps (THSteps) program in Texas, which includes the Comprehensive Care Program (CCP) and the Medical Transportation Program (MTP).

In 1993, a class action lawsuit, now commonly known as *Frew v. Hawkins,* was filed against the State of Texas alleging that Texas did not adequately provide Medicaid EPSDT services. The lawsuit was filed by Texas Legal Rural Aid on behalf of more than 1.5 million Medicaid enrolled children entitled to health benefits through EPSDT services. The main allegations in the lawsuit include:

- Medical and dental screenings (check-ups) were not provided to children in accordance with recognized periodicity schedules.
- Texas did not meet the federal screening goals for children.
- Texas did not provide adequate case management services for children.
- The MTP failed to meet the needs of recipients.
- Program access was denied because of an inadequate supply of providers, which was the result of inadequate reimbursement rates, red tape, and providers' lack of knowledge of the program.

In 1996, the state and the plaintiffs' attorneys entered into a consent decree to resolve many of the issues in the suit. The plaintiffs filed motions to enforce the consent decree in 1998 and in 2000. After hearing evidence on the motion, the court found the state to be in violation of the consent decree and ordered corrective action. After the state exhausted all avenues for appeal, a hearing for corrective action was scheduled for April 2007. Prior to this hearing, the parties negotiated a set of 11 corrective actions that the federal court found fair, reasonable, and adequate.

House Bill 15, 80th Legislature, Regular Session, 2007, appropriated an estimated $1.8 billion for the 2008-2009 biennium to support state responsibilities and efforts in response to the agreed corrective action orders. H.B. 15 appropriations related to *Frew* were provided for three general purposes:

- $1.3 billion all funds (AF) for the biennium to increase medical and dental provider payments for services to children enrolled in Medicaid under the age of 21;
- $91.6 million AF for the biennium to implement the eleven corrective action orders; and
- $150 million GR to finance various strategic initiatives related to health care services provided to children enrolled in Medicaid. This funding is intended to augment and further enhance efforts to ensure access to care and increased participation rates in THSteps.

HHSC implemented the rate increases for medical and dental providers in September 1, 2007, and is on target to spend the $91.6 million to implement the eleven corrective action orders.

In order to ensure cost effective and accountable use of the $150 million in strategic initiative funds, HHSC established an external advisory committee, Frew Advisory Committee, to:

- assess the feasibility and efficacy of proposed initiatives;
- identify the initiatives most likely to result in long-term, fundamental improvements in the Medicaid program; and
- increase access to services and providers for children under the age of 21.

The Frew Advisory Committee includes representatives from the medical, dental, advocacy, and academic communities. In its deliberations, the Frew Advisory Committee considers:

- the research support for each proposal;
- other state Medicaid program's experience with similar initiatives;
- comparisons to current Medicaid policy; and
- operational challenges in implementing the initiative.

This deliberate, open, analytical, and evidence-based approach provides HHSC with critical information to aid in determining which initiatives HHSC will put forward for funding consideration.

As of September 2008, HHSC had requested and received expenditure authority from the Legislative Budget Board (LBB) and the Governor's Office for five projects for an estimated $30 million general revenue ($59.3 million all funds) for the 2008-2009 biennium. HHSC, with the assistance of the Frew Advisory Committee, continues to review proposals for funding using FY 2008-2009 appropriations. The fiscal impact of currently approved, pending, and new projects carry-over into the 2010-2011 biennium. The five projects will have a key role in improving access to care and participation by children under the age of 21 enrolled in Medicaid. Below is a brief summary of each project and its current status:

First Dental Home

HHSC implemented the First Dental Home project in March 2008 for pediatric dentists and in May 2008 for general dentists. The First Dental Home provides an oral evaluation, parental education, and application of fluoride varnish for Medicaid-enrolled children starting at 6 months of age. As of July 1, 2008, a total of 6,119 unduplicated children, all under the age of three, have received First Dental Home services.

HHSC projects the First Dental Home will provide dental care to an estimated 130,000 children during the 2008-2009 biennium.

The successful implementation of this project was due to continuous feedback from experts in the field and stakeholder interaction in developing the materials for distribution to dentists' offices months in advance of formally implementing this initiative.

Oral Evaluation and Fluoride Varnish in the Medical Home

HHSC implemented the Oral Evaluation and Fluoride Varnish in the Medical Home in September 2008. This project intentionally was scheduled for implementation *after* the First Dental Home project in order to allow the state to recruit and train enough pediatric and general dentists to accept referrals from physicians for a permanent dental home.

HHSC projects the Oral Evaluation and Fluoride Varnish in the Medical Home will provide care to an estimated 63,272 children.

Mobile Dental Unit in the Rio Grande Valley

HHSC finalized negotiations with the University of Texas Health Science Center in San Antonio (UTHSC-SA) Dental School (Dental School) to operate a mobile dental unit (MDU) in the Rio Grande Valley. HHSC has provided funding for FY 2008 to the Dental School to purchase the MDU and dental equipment, and to cover staffing costs and expenses incurred for developing a dental home in the City of Laredo for Medicaid children and young adults without a dental home.

The Dental School's MDU will provide dental services to Medicaid-enrolled children in three counties in Texas, which may include Zapata, Starr, Duval or Webb counties. Those children with a dental home will be connected to their regular source of care. Children without a dental home will be directed for follow-up care to the dental home being developed by the City of Laredo.

The Dental School's pediatric dental team on the MDU is expected to provide 3,500 patient visits in the MDU and follow-up care in the 15 dental clinics in the City of Laredo per year, assuming a full year of operations with the MDU.

Integrated Pediatric and Mental Health Proposal

This proposal has been re-named Services Uniting Pediatrics and Psychiatry Outreaching to Texas (SUPPORT). This project addresses access to mental health care for Medicaid-enrolled children, giving special consideration to the challenges of identification and treatment of childhood and adolescent behavioral and emotional problems in pediatric primary care. HHSC contracted with the University of Texas Health Science Center in San Antonio (UTHSC-SA) School of Psychiatry to manage and operationalize pilots throughout the state that would test the effectiveness of integrating pediatric and mental health benefits.

Six pilot sites were selected; two urban (Cook Children's Non-Profit Children's Hospital Health System and Parkland Hospital); two rural (Rio Grande Valley private, group, and community health center locations, and Lubbock Community Health Center); and two academic sites (UTHSC-SA and Texas Tech in El Paso Pediatric Clinics).

The UTHSC-SA School of Psychiatry plans to enroll 200 Medicaid children per Licensed Professional of the Healing Arts (LPHA) per year. Full enrollment per full state fiscal year is anticipated to be 6,000 children. The first enrollment occurred September 2008.

Increased Access to Pediatric Subspecialty Care

- Telephone Consultations for Pediatric Subspecialists: HHSC is revising its benefit policy and programming the necessary changes to the Medicaid claims payment system to allow reimbursement of telephone consults between specialists and primary care providers who are providing clinician-directed care coordination. Implementation for this new benefit is expected in early FY 2009 after system changes have been completed.

- Referral Guidelines for Primary Care Providers Referring to Pediatric Subspecialists: HHSC is planning to develop referral guidelines with supporting online training modules for up to ten health conditions. The guidelines will include early referral, common symptoms, and simple lab tests to rule out diagnoses. HHSC will begin rolling out the referral guidelines in FY 2009.

HHSC is requesting $150 million in GR to continue funding these strategic initiatives and additional projects for the 2010-2011 biennium.

IV. FEDERAL FUNDS: CURRENT ISSUES

For the 2010-2011 biennium, the legislative appropriations baseline request and exceptional items include $36.5 billion in federal funds or 55.6 percent of the total requested appropriations. Issues such as a decline in the Federal Medical Assistance Percentage (FMAP), formula and program changes that occurred in the reauthorization of major grants such as the Ryan White program (HIV) and Children's Health Insurance Program (CHIP), as well as significant funding changes in federal appropriations levels or regulatory changes can impact the state's ability to continue or improve services to clients.

Federal Budget Outlook

Concern about federal deficit projections and the growth in entitlement programs is expected to result in action to tighten federal expenditures in both discretionary and entitlement programs during fiscal years 2009-2011. To keep the federal government "running" Congress must pass appropriations bills by the end of the federal fiscal year, September 30, or pass a continuing resolution (CR) that continues federal funding at the current rate. The practice of enacting CRs in lieu of appropriations bills is increasingly common. The recently passed CR funds FY 2009 appropriations for discretionary spending at the FY 2008 level through March 6, 2009. If an appropriations bill (such as Labor-Health and Human Services-Education) is signed by the President before March 6, the earlier date would prevail. The CR also serves as the legal authority for allowing mandatory spending (Medicaid, Food Stamps, Title IV-E & F, CHIP, TANF, and SSBG) to proceed under the general authorizing law.

Related to the ongoing expenses of homeland security, including bioterrorism, Congress and the Administration added state-local matching funds and maintenance of effort provisions. Federal support for preparedness activities has been decreasing for several years, and additional reductions are anticipated in the future.

Selected Medicaid Regulations

Regulatory action by federal agencies can impact federal funding and result in significant health and human services financial and program variations and issues. The Centers for Medicare and Medicaid Services (CMS) has taken a number of administration actions that will shift billions of dollars in Medicaid costs from the federal government to states, local governments, and school districts. These new federal regulations impose significant cost shifting to states while limiting states' flexibility to pursue innovative approaches to providing cost-effective and quality health care to Medicaid clients. Congress has enacted a moratorium until April 1, 2009 on implementation of six CMS regulations, which are described below.

- **Government Provider Cost Limit Regulation** – Imposes new restrictions on payments to providers operated by units of government and clarifies that those entities involved in the

financing of the non-federal share of Medicaid payments must meet a restrictive new definition of unit of government. This rule will have serious consequences for public hospitals and safety net providers in Texas. The state estimates a potential impact to hospitals and other Medicaid providers of more than $480 million annually in lost federal revenue due to the provisions in this rule.

- **Targeted Case Management** – CMS published an interim final rule on December 4, 2007, that clarifies the definition of targeted case management services (TCM) as required by Section 6052 of the Deficit Reduction Act (DRA). CMS included additional provisions in the rule that were not addressed in the DRA. This rule eliminates targeted case management for children in state conservatorship and would require programmatic and rate changes for the various Medicaid case management services. The moratorium suspends the rule except the portion that adopts the DRA definition of TCM, but only to the extent these definitions are not more restrictive than the policies set forth in the State Medicaid Director letter on case management issued on January 19, 2001 (SMDL #01-013), and with respect to community transition case management, the State Medicaid Director letter issued on July 25, 2000 (Olmstead Update 3).

- **Eliminating Medicaid Reimbursement for Graduate Medical Education** (GME) – CMS maintains that GME is not within the scope of medical assistance that is authorized for payment by Medicaid and would no longer allow Medicaid funding to be used for GME. Texas has supported teaching hospitals in the past through the use of GME dollars. While the state does not currently have an active GME program, teaching hospitals play an important role in the training of doctors. Further, Texas may elect to implement a GME program in the future.

- **School-based Medicaid Services – Administration and Transportation** – CMS is proposing to eliminate funding for school-based administration and transportation activities covered by Medicaid. Texas independent school districts receive approximately $12.6 million in annual federal funding for school-based administrative services. In addition, specialized transportation is the third largest claim total of all school-based medical services in Texas. Texas will lose a significant amount of federal funding for these programs with the implementation of this rule. This could affect the ability of the ECI providers, who are also Independent School Districts, to participate in the Medicaid Administrative Claiming program.

- **Rehabilitation Services** – CMS seeks to redefine rehabilitative services and to determine the difference between habilitative and rehabilitative services. This rule would no longer allow reimbursement for a number of currently reimbursable Medicaid rehabilitative services.

- **Provider Taxes –** The moratorium suspends the rule except the portions that implement the Congressionally mandated change that limits the tax from 6 percent to 5.5 percent until 2011 and the new definition of managed care services class of providers that can be taxed as amended by section 6051 of the Deficit Reduction Act of 2005 (Public Law 109-171).

Current Federal Issues

Federal Medical Assistance Percentage (FMAP)

The amount of federal Medicaid funds Texas receives is based on the federal medical assistance percentage (FMAP) or Medicaid matching rate. The federal Department of Health and Human Services annually updates this rate, derived from each state's average per capita income. Consequently, the percentage of total Medicaid spending that is paid with federal funds also changes annually.

Since the final FMAP rate for FY 2010 is published in November, after the LARs are submitted, HHSC uses the best available information to develop the LARs. To ensure consistency across the enterprise, all the HHS agencies use the same FMAP rate. For FY 2010, the Medicaid FMAP assumed for LAR development was 58.59 percent; in FY 2011, the FMAP assumed was 58.10 percent. The most recent FMAP information indicates that final FY 2010 FMAP will be 58.73 percent, a positive .14 difference that will result in decreased general revenue demand of approximately $30 million from the request.

Due to the size of the Medicaid program, even small changes in the FMAP can result in federal funding fluctuations worth millions of dollars. For example, the federal Deficit Reduction Act of 2005 contained language instructing the Secretary of Health and Human Services to disregard Hurricane Katrina evacuees and their income when calculating the FMAP for states that received a significant number of evacuees. This language was intended to ameliorate the impact of a mismatch between a population count that occurred prior to the hurricane and income data collected after the hurricane, factors that are used to calculate state per capita income in determining a state's FMAP. Texas FMAP for FY 2008 was adjusted from 60.53 to 60.56 percent. While this adjustment resulted in approximately $6 million in additional federal funding, the amount was minimal given the size of the Texas Medicaid program and the needs of the Katrina evacuees. In FY 2009, Texas FMAP was 59.44. Congress considered legislation to increase the federal share of FMAP in order to ease the strain on state budgets, but as of November 1, 2008, legislation has not been enacted.

Targeted Case Management (TCM): Impact of Deficit Reduction Act (DRA) and Interim Final Rule at DFPS

Child Welfare Funding

The DRA Targeted Case Management (TCM) provision makes Medicaid the payer of last resort if case management services are reimbursable from other federal funding sources and alters the TCM definition to exclude provision of direct services. This DRA provision significantly impacts DFPS' ability to fund a portion of Child Protective Services (CPS) case management with Medicaid. DFPS provided case management services to Medicaid recipients aged 0-20 who have been placed in foster care, who were receiving in-home services as the result of having been found to be in a state of or at risk of abuse or neglect, who were receiving adoption assistance and services, and Medicaid recipients who were elderly or disabled and receiving protective services as the result of being determined to be in a state of abuse, exploitation, or neglect.

The Interim Final Rule on TCM prohibits states from claiming Medicaid reimbursement for services provided by employees of State child welfare agencies or contractors of the state child welfare agency. In Texas, the provider base is limited to DFPS Child Protective Services (CPS) caseworkers; therefore DFPS discontinued Medicaid claiming for TCM services delivered by CPS caseworkers effective July 1, 2008. Federal reimbursement at that time was $12 million monthly and was maintained longer than anticipated when the Legislature enacted FY 2008-2009 appropriations. While the rule moratorium may positively affect some states, due to a settlement agreement reached between HHSC and CMS in 2005, TCM can no longer be claimed under Medicaid for CPS in foster care and in-home services. The DFPS LAR request assumes that Title IV-E will partially offset the loss of Title XIX. Case management activities that are not allocable to Title IV-E will be borne by TANF federal funds, Title IV-B federal funds, or state general revenue in lieu of TANF or Title IV-B.

Adult Protective Services Funding Impact

The DRA TCM provision also impacts Adult Protective Services (APS) since the provider base is limited to DFPS APS caseworkers. Due to the single case manager and provider choice provisions included in the regulations, DFPS discontinued claiming for targeted case management delivered by APS caseworkers effective July 1, 2008. The DFPS LAR request assumes that APS case management activities are reimbursable as Medicaid administrative case management as costs that are necessary for the efficient administration of the Medicaid State Plan. The reimbursement under Medicaid administrative case management will partially offset the loss of TCM.

Transitional Medical Assistance

The 1988 Family Support Act (FSA) required states to offer Medicaid coverage for up to 12 months to families who lost their Aid to Families with Dependent Children (AFDC) eligibility due to increased earnings.

Transitional Medical Assistance (TMA) was created to assist former welfare recipients by providing transitional Medicaid coverage after they enter the workforce. Welfare recipients may enter low-wage jobs that do not offer health insurance or that offer insurance that is unaffordable to individuals transitioning off TANF. Since not having access to affordable health insurance is a potential disincentive for seeking employment, states were required to provide at least four and up to nine months of transitional Medicaid benefits for qualifying individuals.

Twelve months coverage was set to expire after December 2005. However, the DRA extended 12 months coverage through December 2006. Transitional Medicaid was again extended through June 30, 2009 by HR 6331 (PL-110-275 Medicare Improvements for Patients and Providers Act of 2008).

If 12 months transitional coverage is not extended beyond June 2009 the anticipated effects are:

- individuals who lose Medicaid would have only four months of transitional Medicaid, rather than the 12 months currently provided. This will reduce coverage and member months; and
- additional administrative costs related to eligibility system changes. In Texas, the change would likely be implemented so that individuals who lose Medicaid coverage after June 2009 would receive only four months transitional Medicaid, while those who lost prior to that date would keep their 12 months. Administratively, Texas would have to maintain systems for each of these two groups until all the 12 month-eligibles lose coverage. As of September 2008, there were 48,140 individuals on transitional Medicaid coverage.

TANF/Work Requirements

The DRA maintained TANF federal work participation rate standards, but revised the caseload reduction credit calculation. The two work standards require 50 percent of all families and 90 percent of two-parent families to meet work participation. Texas was able to meet the standards in previous years because of significant caseload reduction credits. The revised caseload reduction calculation gives states credit for caseload declines that occur from fiscal year 2005 forward.

The work participation rate denominator (the number of TANF families that include a work eligible adult or minor head of household) has been expanded to include non-recipient parents living with a child receiving TANF and families in TANF MOE separate state programs. Federal penalties will be assessed for failure to meet federal work participation requirements. The non-adjusted State Family Assistance Grant (SFAG) for fiscal year 2008 is $538.9 million. The federal penalty for failure to meet the all families rate is five percent of the SFAG, increased by two percent for each consecutive year to a maximum of 21 percent. The penalty for failure to meet the two-parent rate is five percent of the SFAG multiplied by the percentage of the state's caseload that are two-parents.

A federal participation rate penalty results not only in the loss of TANF federal funds but the state is required to expend state funds in an amount equal to the penalty amount. In addition, the TANF MOE requirement will be 80 percent, rather than 75 percent of the historical state expenditures under the former Aid to Families with Dependent Children (AFDC) program in fiscal year 1994. The potential total penalty for failure to meet participation requirements for fiscal year 2008 is $70.4 million.

HHSC provides eligibility determination and cash assistance for TANF while the Texas Workforce Commission (TWC) provides employment training and child care services. The TANF block grant is distributed across four of the health and human services agencies and TWC.

TANF Supplemental Funds

TANF supplemental grants were extended through FY 2009 by HR 6331 (PL-110-275 Medicare Improvements for Patients and Providers Act of 2008). Texas currently receives $52 million in TANF supplemental funds annually. Congressional action for FY 2010 supplemental funds is not expected until mid-year, 2009.

Farm Bill

Policy changes enacted in 2008 in the farm bill reauthorization included Food Stamps dependent care deductions, exemptions for retirement accounts and education tuition savings accounts. The new law required changes to policy manuals, training, and automation. State options are available in this new law, such as expansion of streamlined reporting that will require automation changes and some additional cost in the short-term, but will result in workload reductions over the long term. The reauthorization will also result in a small increase in the number of persons eligible for Food Stamps and in the average size of award per family. The reauthorization bill also renamed the Food Stamp Program to be known as Supplemental Nutrition Assistance Program (SNAP)

Preventive Health and Health Services Block Grant (PHHSBG)

Texas has been the recipient of the PHHSBG for the past 26 years. This block grant is the "glue" that keeps public health programs together in Texas. The grant allows the state to address some of the high priority public health issues as determined by mortality, morbidity, and economic cost data for the state. For instance, the PHHSBG in Texas supports activities dealing with cardiovascular disease (the leading killer in the state) and border health issues that are unique to Texas. These and other health problems that exist in Texas would fall between the cracks if only the current categorical programs existed. The PHHSBG has been zeroed out of the President's budget for the past seven years but restored by Congress each year; however, the grant suffered a 28% decrease during this time span. Maintaining support for this grant is critical in allowing Texas to focus funds on prevention measures that yield clear benefits in terms of quality of life and savings. Grant amount in FY 2008 was $24 million.

Ryan White HIV/AIDS Treatment Modernization Act

The reauthorization of the Ryan White HIV/AIDS Treatment Modernization Act made substantial changes in funding methodology, program emphasis, and requirements for HIV/AIDS services. Two of these changes that affect programming in Texas are described below.

- Three of the former Ryan White Title I Eligible Metropolitan Areas (EMAs) lost this designation under the new law. These areas (San Antonio, Fort Worth, and Austin) became Transitional Grant Areas (TGAs) under the new Part A (formerly Title I) of the Act. The Dallas and Houston areas remain as EMAs. TGAs do not have the same hold harmless protections as EMAs and are thus subject to potentially large funding reductions. If these areas do lose significant funds, they will likely request financial assistance from the state.
- A new requirement is now in existence that 75 percent of funds must be spent on core medical services, thereby de-emphasizing supportive services. Historically, a significant percentage of Ryan White funds in Texas have been spent on psychosocial case management. This change has required evolution of these case management services to a medical case management model, which is a time consuming and challenging process.

Children's Health Insurance Program (CHIP)

After several unsuccessful attempts to enact a comprehensive SCHIP reauthorization bill, Congress passed the Medicare, Medicaid, and SCHIP Extension Act in December 2007, which extends SCHIP funding to the states through March 2009. The Act maintains the current $5 billion baseline SCHIP budget for FFY 2008 and FFY 2009 and continues to allow states up to three years to use unspent funds from previous allotments. After three years, a state's unspent funds are made available for redistribution to shortfall states. The Act also appropriates an additional $1.6 billion for FFY 2008 and $275 million for the first two quarters of FFY 2009 for shortfall states. While the Texas CHIP program is not currently experiencing a shortfall, future reauthorization legislation could change the SCHIP allocation formula or other provisions that may impact Texas' SCHIP allotment. Congress is expected to resume discussions on SCHIP in the coming months, but it is unknown when a comprehensive reauthorization bill will be passed. The Texas FY 2008 CHIP allocation was $500 million.

International Classification of Diseases (ICD-10) Project

New initiatives are being proposed at a national level that will continue to improve health care claim technology and medical information. Along with these efforts is the proposal to implement the International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM). Most health care claim systems require a medical diagnosis for a patient and those diagnosis codes are currently provided through use of ICD-9. The implementation of these new medical diagnosis and inpatient procedural coding methods will require changes to information technology systems throughout the state. Texas Medicaid must be able to accept these new codes by the mandated date, anticipated to be October 2011. The original proposed legislation specified that file format changes to facilitate the new codes would implement with the code sets; however, CMS recently released draft regulation for the upgrade to transactions set (to version 5010) separately from the ICD-10 regulation. The Version 5010 Update is tentatively set for October 2010.

Public Assistance Cost Allocation Plans (PACAPs)

The federal Division of Cost Allocation (DCA) has approved the HHSC Cost Allocation Plans and is now concentrating their efforts on the Department of Family and Protective Services' (DFPS) PACAPs that have been submitted for approval. Although DFPS has submitted their PACAPs in accordance with federal regulations, they are operating under unapproved PACAPs and will continue operating without approved PACAPs until a formal approval is received from DCA. Since DFPS' 2004 submission, two PACAPs revisions have been submitted and most recently a third revision was submitted before September 30, 2008, which incorporated all the methodology changes required per the Deficit Reduction Act.

Bi-national Health Problems

Texas faces bi-national health problems present in Texas that are not experienced by other non-border states. Texas serves in a capacity that not only protects Texans but other U.S. citizens. The awarding of grant monies based on Texas population and demographics rarely recognizes or considers the dynamic characteristics of our border. For example, additional federal support is needed for the treatment of persons who are inflicted with tuberculosis (TB) who make numerous

crossings into the U.S. along the 1,200-mile Texas/Mexico border. Although these individuals are not U.S. citizens, they are entering and working in Texas with a highly communicable disease that necessitates treatment to prevent and control transmission of TB disease from Mexico into Texas and into other states. In addition, Texas stretches limited federal support in meeting priority health objectives to increase our ability to detect, investigate, and control foodborne, respiratory, and new or unusual infectious disease threats to Texas, and in turn to the U.S., whether man-made or natural.

Federal Audits, Disallowances, Deferrals and Reviews

A national trend has emerged in which CMS is allocating more resources to review many aspects of state Medicaid operations for cost-containment opportunities and increased efficiencies. The Texas Medicaid Program generally has several deferrals and disallowances at any given time around which it is negotiating with CMS. When CMS imposes deferrals and disallowances, the availability of federal financial participation (FFP) for the Medicaid program is impacted. The difference between a deferral and a disallowance is explained below.

Deferral: When CMS determines that a state is out of compliance with federal reporting requirements, future grant awards are reduced by the amount of FFP that CMS estimates is attributable to improper reporting. CMS withholds funds until it determines the state is in compliance with reporting requirements or until the state provides additional information to support the allowability of the claim.

Disallowance: CMS can also recoup or not pay federal funds when it alleges a claim is not allowable, but the state has the option to appeal the CMS determination.

CMS often imposes deferrals or disallowances following a federal audit or a change to the Medicaid State Plan, the state's contract with CMS. A deferral or disallowance may be imposed for the federal fiscal quarter(s) for which CMS asserts that the state has failed to report properly, and in the case of a disallowance, may retroactively encompass several years of claims.
To alleviate cash flow issues related to CMS deferrals and disallowances and the length of time required to obtain resolution, HHSC has requested a cash flow rider in the event that access to funding is needed to maintain timely payments to employees, clients, and vendors.

Child and Family Services Review

The Child and Family Services Review (CFSR) is a federal-state collaborative effort designed to ensure that state child welfare systems provide quality services to children and families. The U.S. Department of Health and Human Services, Administration for Children and Families (ACF), Children's Bureau administers the review. The CFSR identifies strengths and deficiencies in state programs and systems, focusing on outcomes for children and families in the areas of safety, permanency, and child and family well-being. Following a review, states develop and implement Program Improvement Plans (PIPs) as needed. All states have completed one CFSR, and each state was required to complete a PIP to improve outcomes and systemic factors. After the first CFSR of DFPS, Texas was assessed a financial penalty of over $4 million dollars for not meeting one targeted outcome. The penalty continues to accrue until the outcome is found to be in

substantial conformity. A reasonable estimate of the earliest date that this outcome will achieve substantial conformity is late in 2011. DFPS completed a second CFSR in February 2008. As a result of the review, a new PIP is in the process of being developed.

IV-E Administrative Cost Review

A title IV-E pilot Administrative Cost Review (ACR) was conducted by the Administration for Children and Families (ACF) in September 2007 for DFPS administrative claims. The primary purpose was to test the recently developed ACR Guide and data collection instruments. The ACR Guide and data collection instruments were developed in response to a GAO report that determined ACF did not have tools/methods in place to adequately assess states' IV-E administrative claims. It is anticipated that it will be between four to five years until these tools receive approval to be used nationwide. Also, a review of the DFPS and Texas Juvenile Probation Commission (on behalf of the county juvenile probation departments) processes to claim title IV-E for administrative costs for foster care candidates was conducted. A candidate for foster care is defined as a child who is at imminent risk of removal to foster care due to risks to the child.

DFPS received official notice from ACF on December 28, 2007 regarding the findings of this review. ACF determined that DFPS and Texas Juvenile Probation Commission (TJPC) were improperly claiming reimbursement for administrative costs associated with foster care candidates and directed DFPS and TJPC to cease claiming title IV-E administrative candidate costs effective January 1, 2008. ACF noted several changes would be necessary to policies and practices of DFPS and TJPC to meet federal regulations in order to resume claiming. Based on the changes made by DFPS regarding foster care candidates, ACF approved DFPS resuming claiming effective April 27, 2008. ACF has not approved TJPC to resume claiming to date.

Revenue and Federal Funds Enhancement Initiatives

The state and the HHS agencies work diligently to ensure all federal tax dollars that are available to the state come to the state to support programs benefiting the citizens of Texas, consistent with state and federal policy objectives, in accordance with Sec. 531.028, Government Code. Congressional or regulatory action by federal agencies can impact federal funding; therefore, active monitoring of legislative and regulatory measures are critical functions.

Reviewing federal funding formulas for equity is necessary to ensure that formulas fairly reflect Texas' unique demographics, border health issues, and recently, support and hosting of Katrina evacuees. For example, Texas requested an adjustment to the Federal Medical Assistance Percentage (FMAP) and thirteen other population based grant allocations to include the Katrina evacuees residing in Texas. Due to timing of the population estimates used in these federal funding formulas, the Katrina evacuees living in Texas were not included in the funding allocations. As previously mentioned, Texas received an FMAP adjustment in FY 2008 that totaled approximately $6 million.

In addition to monitoring federal funding information and working with the HHSC Washington-based federal liaison staff and Office of State Federal Relations on pending federal legislation, HHSC and enterprise agencies have sought to increase federal funding for health care expenditures through a variety of initiatives as shown below.

Pursuit of Federal Grants

DSHS was awarded fourteen new grants in FY 2008. DSHS uses a variety of techniques to fund the state match, including requiring subcontractors to provide a local match as a condition of an award, as well as utilizing state-paid benefits as a source of calculated match. Federally Qualified Health Centers (FQHCs) in Texas have increased from 32 to 58 centers. State Incubator Grant funds are used to prepare FQHCs to operate, provide services, and submit competitive and fundable applications for federal funding. The investment of state funds awarded through this program has increased federal funding for FQHCs to the extent that each $1 actually brings in close to $5 federal funding.

Disproportionate Share Hospital (DSH) Programs

Federal law requires that state Medicaid programs make special payments to hospitals that serve a disproportionately large number of Medicaid and low-income patients. Such hospitals are called disproportionate share hospitals and receive disproportionate share funding under the program commonly known as "DSH." DSH funds differ from all other Medicaid payments in that they are not tied to specific services for Medicaid-eligible patients. These hospitals are reimbursed up to 100 percent of the sum of their un-insured costs and non-reimbursed Medicaid costs. Hospitals may use DSH payments to cover the costs of uncompensated care for indigent or low-income patients.

As shown on the table below, Texas has three active DSH programs. DSH programs have generated $6.2 billion in federal funding since fiscal year 2002. In fiscal year 2008, DSHS programs are expected to generate approximately $869.2 million in federal funding. Under section 1923(f)(3) of the Social Security Act, as amended by Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173) the fiscal year 2009 federal DSH allotment will be $936.7 million. This was a net increase in federal DSH funds of $36 million from the FY 2008 Texas DSH allotment of $900.7 million. HHSC plans to use these increased DSH funds in the Health Opportunity Pool (HOP) to fund insurance subsidies for uninsured Texans as directed in the Texas Medicaid Reform Waiver. If the waiver is not approved by the Centers for Medicare and Medicaid Services (CMS), these funds will be allocated to DSH eligible hospitals based on published DSH distribution methodologies.

CMS has proposed an amendment to its administrative rule governing the DSH program. This CMS proposed rule would implement Section 1001 of the MMA, which establishes new reporting and auditing requirements for states with Medicaid Disproportionate Share Hospital (DSH) programs. As proposed, the rule includes a number of new administrative and reporting requirements as well as policy directives that could affect Texas by reducing the dollars available to safety net hospitals participating in both the DSH and UPL programs. The publication date of the final rule is unknown at this time. For further details on DSH programs, see Appendix E.

Table IV.1

Disproportionate Share Hospital (DSH) Programs: Active, FY 2002-2008 Federal Funds ($ in millions)								
	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY02-08 Total
DSH Programs								
Non-State Hospitals	566.3	504.3	516.5	540.9	701.2	616.8	594.3	4,040.3
State-Owned Teaching Hospitals	123.1	117.9	193.9	181.7	81.5	109.8	85.6	893.5
Other State-Owned Hospitals	166.6	170.2	162.2	183.9	193.4	149.6	189.3	1,215.2
Total	**$856.0**	**$792.4**	**$872.6**	**$906.5**	**$976.1**	**$876.2**	**$869.2**	**$6,149.0**

Active Upper Payment Limit (UPL) Initiatives

UPL is the federal limit on Medicaid payments to a group of hospitals and is determined under Federal regulations as a reasonable estimate of the amount that would be paid for Medicaid services or similar services using Medicare payment principles. Supplemental payments are made to certain hospitals to make up the difference between what Medicaid actually paid for their Medicaid clients and what Medicare would have paid for the same services.

As shown on the table below, Texas has seven active UPLs. Active UPLs have generated $4.6 billion in federal funding since fiscal year 2002. In fiscal year 2008, UPLs are expected to generate approximately $1.2 billion in federal funding. For further details on Active UPLs, see Chapter VIII, Appendix E.

Table IV.2

Upper Payment Limit (UPL) Programs: Active, FY 2002-2008 Federal Funds ($ in millions)								
	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY02-08 Total
Active UPL Programs								
Large Urban Public Hospital UPL	170.2	216.9	410.9	497.4	442.4	547.4	588.6	2,873.8
State-Owned Hospital UPL	-	-	29.4	39.7	49.4	87.8	87.8	294.1
Rural Hospital UPL	14.1	20.1	29.1	41.4	46.1	46.3	41.2	238.3
Private Hospital UPL	-	-	-	5.2	143.5	334.2	423.9	906.8
State Physician Practice Plan UPL	-	-	28.1	69.4	56.9	57.0	56.8	268.2
Tarrant County Physician UPL*	-	-	-	0.5	2.2	2.2	2.2	7.1
Children's Hospital UPL	-	-	-	-	19.3	19.4	19.2	57.9
Total	***$184.3***	***$237.0***	***$497.5***	***$653.6***	***$759.8***	***$1,094.3***	***$1,219.7***	***$4,646.2***

* This UPL program was recently approved by CMS, therefore the amounts are estimates.

Initiatives Completed with an Outside Contractor

TANF Delinking Revenue Claiming: This project identified additional costs that qualified for reimbursement through a special Medicaid eligibility allocation. The initiative is complete and Texas has drawn all of the funds available.

Developmental Rehabilitation Services: This project identified retroactive Medicaid claims related to the Developmental Rehabilitation Services state plan amendment for Early Childhood Intervention services.

School Health and Related Services (SHARS): Retroactive corrections were made to direct service and transportation rates for SHARS and direct service and transportation rates were developed for FY 2004 and FY 2005. The requirement that the referral for SHARS speech therapy must be provided by a physician was eliminated. This increased SHARS units of service by also allowing the referral to be provided by a licensed speech-language pathologist.

State-Owned Hospital Upper Payment Limit: Supplemental reimbursement amounts are paid to state-owned hospitals up to applicable limits, increasing overall reimbursements.

State Hospital Physician Practice Plan Upper Payment Limit: Supplemental reimbursements are paid to physician practice plans associated with state-operated hospitals.

Review of Laboratory Claims: To ensure that Texas is receiving full reimbursement, an initiative to review state laboratory claims is underway at the Department of State Health Services.

Change in the Methodology Used to Allocate Ombudsman Costs

On June 11, 2008, HHSC submitted a revision to the PACAP to change the way Ombudsman Costs are allocated. Previously, these costs were allocated to all agencies by HHSC's factor 1. The HEARTS (HHS Enterprise Administrative Reporting and Tracking System) is now used as the basis for allocating these costs. The HEARTS systems tracks the type of contact received. Due to documentation that most contacts received benefit Medicaid, the state will receive substantially more federal matching funds for Ombudsman services.

Revised DSHS Clinical Laboratory Fees

HHSC plans to submit a state plan amendment that would increase DSHS laboratory fees based on the Medicare fee schedule. This initiative could potentially generate up to $30 million in additional federal funds annually and requires approximately $20 million in general revenue match.

Medicaid Reform

There are 2.1 million low-income adults who lack insurance in Texas today. Most of these men and women work, yet they cannot afford to buy into their employer's health plan, or their job does not offer insurance.

When the working poor neglect their health care needs, health issues that could have been treated in a doctor's office can get worse and require more costly care later. Those without insurance do not have sufficient access to a regular doctor to help them manage chronic illnesses such as diabetes, asthma and heart disease. The result is crowded emergency rooms, escalating uncompensated care charges, higher insurance premiums for other Texans and their employers, and poorer health outcomes.

Senate Bill 10 passed by the 80th Texas Legislature and signed by Governor Perry, gives Texas the tools to create new health coverage options for the working poor. Under this legislation, low income Texans will be able to use premium subsidies to choose from a range of affordable health plans or buy into employer-sponsored coverage. They will be able to choose their own doctor and have a medical home to manage their health issues in a more comfortable and less costly setting.

The Texas proposal includes a comprehensive package of health care reforms that will provide more people with insurance, reduce reliance on expensive emergency room visits for basic care, and make it easier for the working poor to buy into employer-sponsored health coverage. The reforms protect funding for our safety-net hospitals, reward innovative local efforts to reduce uncompensated care, and establish greater accountability and transparency in the reporting of uncompensated care costs. The Texas Legislature appropriated $150 million in additional state general revenue to serve as the financial catalyst for these reforms.

The goals of the Texas reform effort are to:

- Focus on keeping Texans healthy by providing premium subsidies for low-income uninsured citizens to buy in to employer-sponsored plans, or purchase market-based insurance or other coverage options. The state will emphasize providing people with easy access to primary and preventive care.
- Restructure current federal funding to gain flexibility in federal fund expenditures, optimize investments in health care, and reduce the number of uninsured Texans.
- Establish an improved, more integrated health care infrastructure to enhance quality and value with better data and information, increased coordination, better care management, and incentives to reduce uncompensated care and improve health care efficiency and effectiveness.

Texas has the highest uninsured rate in the nation. Compared to other states, Texas has lower wages, higher premiums, and fewer employers offering insurance. For a variety of reasons, Texas' current health care investment strategy too often focuses on uncoordinated care provided in the costliest settings, when undiagnosed diseases are more complicated and costly to treat. Uncompensated care costs in Texas are among the highest in the nation and lead to higher premiums for those with private insurance to help pay for the uninsured. When businesses drop group coverage because of rising costs, this means more uninsured people in our emergency rooms, which leads to even higher costs for those who can pay. Working within the framework of Senate Bill 10 and federal policy objectives for health care financing, Texas proposes to transform its health care system.

The cornerstone of the Texas plan is the creation of the Texas Health Opportunity Pool (HOP) trust fund that will serve as the funding source for targeted investments in our health care system. The Health Opportunity Pool will be funded through a variety of federal and state sources and will be used to:

- Provide premium subsidies to low-income Texans.
- Develop a catastrophic coverage program for parents and caretakers.
- Reward hospitals for innovative efforts to reduce uncompensated care.
- Award grants to improve coordination, provide services and/or support the infrastructure for a more effective and efficient health care system.
- Increase family coverage by blending funds from the Medicaid Health Insurance Premium Payment (HIPP) program, HOP and the State Child Health Insurance Program (SCHIP) to enable families to buy into employer-sponsored coverage.

Uncompensated care charges, as reported by Texas hospitals, went from $5.5 billion in 2001 to $11.6 billion in 2006. This trend will not change until we fundamentally reform the Texas health care system. Today, care for uninsured Texans too often takes place in hospitals and crowded emergency rooms – the most expensive points in the health care system.

HHSC submitted a waiver request to Centers for Medicare and Medicaid Services (CMS) and is currently in negotiations. The agencies LARs do not include funding impact as the proposal is neither complete nor approved by CMS.

V. ENTERPRISE INITIATIVES

Increase HHS Community Services (Waiting/Interest Lists)

The 80th Legislature, Regular Session, 2007, continued the commitment made by 79th Legislature to increase capacity of funded community services by appropriating $237.5 million (all funds) in H.B. 1, General Appropriations Act.

This increase will provide services during the FY 2008-2009 for almost 9,966 Texans currently on waiting/interest lists for services. This effort is part of a long-term plan to increase capacity for community services that help Texans live more independently, receive mental health treatment and care for children with chronic medical conditions. Although the FY 2008-2009 appropriation will not eliminate waiting/interest lists, the increased capacity will reduce the number of individuals waiting and/or the length of the wait for services:

- At Department of Assistive and Rehabilitative Services (DARS), the FY 2008-2009 funding will increase the program capacity for Comprehensive Rehabilitation Services (CRS) and Independent Living Services (ILS) by serving 183 and 173 individuals, respectively. The wait time for CRS has been reduced from eight months to 12 weeks.
- The FY 2008-2009 funding will increase program capacity at Department of Aging and Disability Services (DADS) by nearly 10 percent for long-term care community programs that have interest lists, including Community Based Alternatives, Community Living Assistance and Support Services, Medically Dependent Children's Program, Consolidated Waiver Program, Deaf-blind with Multiple Disabilities, Home and Community-Based Services, Non-Medicaid Services, and In-Home and Family Support.
- Department of State Health Services (DSHS) FY 2008-2009 funding will increase capacity for the Child and Adolescent Community Mental Health and Children with Special Health Care Needs programs, thus preventing the waiting list from growing.

By the end of the 2008-2009 biennium, all affected programs are expected to increase program capacity by serving a total of 9,966 clients. Of these clients, an estimated 8,902 additional persons will receive services through DADS programs.

Interest List Improvements to Date

- The additional funding to increase capacity over the past two sessions has allowed DARS to serve record numbers in CRS program – an increase of over 50 percent from 419 in FY 2005 to 629 in FY 2008.
- The goal for the additional funding for the ILS waiting list was to reduce the impact of demographic growth in the program – to keep the waiting list count constant and minimize the growth. In addition to waiting list funds, DARS also received new funding in HB1, 80th Legislature, RS, Article II, Rider 30 ($800,000 per year for this

program) to serve ILS clients with Adaptive Technology needs. DARS used some of Rider 30 funds for clients on the waiting list. The end of FY 2007, ILS waiting list was 1,089. At the end of FY 2008 the waiting list was projected to be 996. Thus, not only was the growth of the waiting list reduced but DARS was actually able to reduce the number of clients on the ILS waiting list compared to the start of 2008-2009 biennium.

- DARS has added more monthly reports for CRS and ILS waiting lists that are submitted to the LBB.
- In the 2008-2009 biennium, changes made to DSHS riders have enabled the agency to improve the timeliness for removing clients from the Children with Special Health Care Waiting list.

Further improvements in progress or planned:

- DARS will continue to maximize the use of Rider 30 funds along with the waiting list funding to reduce the ILS waiting list in FY 2009.

Increase HHS Community Services (Waiting/Interest Lists)

The Health and Human Services Commission (HHSC) supports funding additional waiver slots in all community-based services programs in order to provide more timely service and give clients greater choice in the type of service they may access. HHSC included an exceptional item request to continue efforts to increase capacity in community services (reduce/eliminate waiting/interest lists) at DADS, DARS, and DSHS. This exceptional item would serve 16,200 individuals by end of FY 2010 and cost $224 million general revenue (GR) for the biennium. Most programs would receive federal matching funds.

The HHSC LAR includes an exceptional item requesting approximately $224 million GR on behalf of DADS, DARS, and DSHS to increase capacity in community service programs. Each agency's portion of the request is detailed below:

- DADS, approximately $152 million GR (almost 68 percent of the request) would serve an additional 13,719 individuals by the end of the biennium (a 13.9 percent increase in capacity) for Community Based Alternatives, Community Living Assistance and Support Services, Medically Dependent Children's Program, Consolidated Waiver Program, Deaf-blind with Multiple Disabilities, Home and Community-Based Services, Non-Medicaid Services, and the In-Home and Family Support program.
- DSHS, approximately $28 million GR would serve 606 individuals from Child and Adolescent Community Mental Health, and Children with Special Health Care Needs (CSHCN) waiting lists.
- DARS, approximately $8 million GR is requested to remove 1,212 individuals from the waiting list for Comprehensive Rehabilitative Services and Independent Living Services.

Appendix B contains additional detail on the amount of funding being requested and the applicable programs at DADS, DSHS, and DARS for the increasing capacity for community services.

Retention and Recruitment of Critical Client Service Staff

The foundation of the Health and Human Services System in Texas is the staff that provides direct care for vulnerable Texans. The competition for qualified health professionals and front line client services staff throughout the state has a direct impact on HHS agencies' ability to maintain a high level of quality services in several critical areas, such as state mental health hospitals, state schools, protective services, and eligibility determination.

Increased turnover, high vacancy rates, and the inability to fill positions with qualified applicants have the potential to diminish the quality of services and delay client access to services. Together these conditions heighten the risk to consumers by increasing the burden on existing staff, resulting in long hours, weekend shifts, and ultimately high staff dissatisfaction and burnout. In addition, the cost of turnover related to recruitment, training, and loss of productivity associated with frequently hiring new employees creates an additional strain on funding health and human services.

Structure of Funding Requests:
The FY 2010-2011 appropriations request to move HHS agency staff compensation closer to market rates is divided into two main categories. The first is a request that has been incorporated into the HHSC Legislative Appropriations Request (LAR) to increase salaries for nurses, physicians and psychiatrists in four HHS agencies. The second request, which is not included in an individual agency LAR, is a broad request to solidify the front line staff in state operated mental health and mental retardation facilities, the child and adult protective services system and the eligibility determination function. Both of these requests are based on increasing salaries by a specified percentage, but would not be implemented with an across the board salary adjustment. Instead, a targeted approach to implementation would be used to provide the flexibility to address the areas of greatest need.

In addition to these two main requests, which are detailed below, individual agency LARs have included specific requests for targeted groups that are difficult to hire and retain, such as salary increases for sanitarians, epidemiologists, microbiologists, chemists, and medical technologists at DSHS and recruitment and retention bonuses and educational stipends for caseworkers at DFPS. If approved, these additional appropriations would assist in paying for the proposed classification revisions as submitted by the State Auditor's Office for most of these targeted classifications series.

Requested Funding for Fiscal Years 2010-2011

Retention and Recruitment for Health Care Professionals
(HHSC Exceptional Item #16- $45.8 million GR)

As Table V.1 below indicates, HHS agencies struggle to fill positions for critical health care professions across several agencies. With turnover rates in excess of 25 percent for nurses and 21 percent for doctors and similarly high vacancy rates, the health professionals that are essential to make the state's system of care for vulnerable Texans work effectively are often choosing to leave state agencies as the private sector salaries outpace salaries for comparable HHS agency positions.

These rates are significantly higher than the statewide turnover rate of 13 percent. Likewise, vacancy rates of 31 percent for registered nurses and 22 percent for psychiatrists are indicative of the challenges HHS agencies face in recruiting and retaining quality health care staff. The inability to recruit and retain core health care professionals often leaves agencies with only the more costly option of contracting to hire temporary employees. This also increases the risk of errors and adversely impacts agencies' ability to comply with federal standards and conditions for participation in federally funded programs.

Table V.1

Turnover, Vacancy Rates, and Average Salaries for Select Health Care Professions (2008)

Occupational Category/Agency	Annual Turnover Rate	Vacancy Rate	Average HHS Employee salary	Comparable Market Salary
Registered Nurses (DADS, DSHS, HHSC, DFPS)	25%	31%	$ 52,600	$ 61,750
Licensed Vocational Nurses (DSHS, DADS)	27%	10%	$ 33,898	$ 36,948
Physicians (DSHS, DADS, HHSC)	21%	14%	$ 146,637	$ 158,414
Psychiatrists (DSHS, DADS)	11%	22%	$ 167,301	$ 203,623

One key factor contributing to the high turnover rate and difficulty filling positions is the disparity between state salaries and private sector salaries. The table above illustrates how much lower HHS agency salaries are compared to the private sector, based on recent estimates from State Auditor's Office. For example, with registered nurses at 15 percent below the market the HHS programs, such as state hospitals and state schools serving thousands of Texans, struggle to maintain a consistent workforce.

The appropriations request would increase salaries of nurses, physicians and psychiatrists to amounts closer to the market rate for these professions (Refer to Table V.2). This item, which totals $45.8 million in GR, is included in the HHSC LAR as Exceptional Item #16. These recommendations were developed by a workgroup of key staff involved in the recruitment and retention of health professionals from the affected agencies.

Table V.2

Requested FY 2010-2011 Funding for Health Professional Retention and Recruitment

Occupational Category	Agency	Number of Positions	Requested Salary Increase	Biennial General Revenue	Biennial All Funds
Registered Nurses	DSHS, DADS, HHSC, DFPS	2,519	15% direct care; 10% non-direct	$ 28,989,396	$ 44,047,973
Licensed Vocational Nurses	DSHS, DADS	1,225	15% direct care; 10% non-direct	$ 7,934,317	$ 12,419,445
Physicians	DSHS, DADS, HHSC	124	10%	$ 2,399,258	$ 3,361,690
Psychiatrists	DSHS, DADS	146	15%	$ 6,554,258	$ 7,005,078
	Total	**4,014**		**$ 45,877,230**	**$ 66,834,186**

Note: Recommended salary increases are not intended to be implemented across the board but would be targeted based on an assessment of needs.

HHS Direct Care Staff Retention and Recruitment for Major Service Delivery Systems $88.2 million GR

Direct service delivery staff in HHS agencies provide the daily contact and care for HHS clients, whether in state schools, state mental health hospitals, protective services, or eligibility determination. These staff are often among the lowest paid in the HHS system and account for the greatest employee turnover. For example, turnover among mental retardation assistants in state schools exceeds 50 percent annually. The turnover rate for psychiatric nurse assistants in state mental hospitals is 39 percent annually. Table V.3 indicates turnover and vacancy rates for these critical front line employees.

As is the case for health care professionals described previously, a significant salary disparity exists between the direct care workers in HHS agencies and the private market for comparable positions. For example, private sector market rates for nurse assistants exceed state salaries by 30 percent and protective services workers lag behind the market by 14 percent for similar jobs. This disparity drives high turnover rates which contribute directly to widespread burnout among employees who interact directly with HHS clients. Direct care staff in state mental hospitals and state schools, along with protective services and eligibility determination staff who care for Texas' most vulnerable citizens are experiencing high workloads and non-competitive compensation packages. High turnover and vacancy rates increase the risk of deficiencies in the quality of care provided as workload increases and burnout becomes more prevalent.

Table V.3

Turnover, Vacancy Rates, and Average Salaries for Front Line Staff

Occupational Category/ Agency	Annual Turnover Rate	Vacancy Rate	Average HHS Employee salary	Comparable Market Salary
State Hospitals and State Schools				
Psychiatric Nursing Assistants (DSHS)	39%	9%	$ 22,452	$ 31,534
Mental Retardation Assistants (DADS)	52%	8%	$ 22,174	$ 31,534
Protective Services				
Protective Services Workers (DFPS,DADS)	30%	9%	$ 34,216	$ 39,669
Eligibility Determination				
Human Services Specialists (HHSC)	22%	7%	$ 33,044	$ 38,226
Office of Eligibility Services Clerical Workers (HHSC)	21%	7%	$ 24,924	$ 26,816
Additional Human Services Specialists				
Human Services Specialists (DADS, DSHS, DFPS)	21%	7%	$ 33,044	$ 38,226

The funding request to improve salary levels for front line staff is detailed below in Table V.4. This request does not appear in an individual agency LAR because of the broad nature of the request. The large systems of care included in this request encompass approximately 25,000 FTEs, more than half of the total HHS FTEs. This request totals $88.2 million in general revenue and $141.3 million in all funds for the biennium. The cost of this request could increase if FTEs are increased in these areas in FY 2010-2011 through funding of other exceptional item requests in HHS agencies.

Table V.4

Requested FY 2010-2011 Funding for Service Delivery Staff

Occupational Category	Agency	Number of Positions	Requested Salary Increase	Biennial General Revenue	Biennial All Funds
State Hospitals and State Schools					
Psychiatric Nursing Assistants	DSHS	3,045	10%	$ 12,673,169	$ 12,673,169
Mental Retardation Assistants	DADS	6,708	10%	$ 12,264,596	$ 29,482,202
subtotal		**9,753**		**$ 24,937,765**	**$ 42,155,371**
Protective Services					
Protective Services Workers	DFPS	6,207	10%	$ 36,792,283	$ 43,082,299
Protective Services Workers	DADS	56	10%	$ 458,860	$ 458,860
subtotal		**6,263**		**$ 37,251,144**	**$ 43,541,159**
Eligibility Determination					
Human Services Specialists	HHSC	5,583	10%	$ 17,976,521	$ 38,247,916
OES Clerical Workers	HHSC	1,635	10%	$ 3,856,160	$ 8,204,596
subtotal		**7,218**		**$ 21,832,681**	**$ 46,452,512**
Additional Human Services Specialists					
Human Services Specialists	DADS, DSHS, DFPS	1,353	10%	$ 4,151,278	$9,149,510
	Total	**24,587**		**$ 88,172,867**	**$ 141,298,553**

Note: Recommended salary increases are not intended to be implemented across the board but, would be targeted based on an assessment of needs.

Additional Agency Requests

The Department of State Health Services and the Department of Family and Protective Services each include an exceptional item related to staff recruitment and retention for specific areas of those agencies that experience high turnover and difficulty hiring qualified staff.

DSHS includes a $4.7 million GR request for increasing salaries in several areas such sanitarians epidemiologists and microbiologists. These positions are specialized staff that are essential for the agency to carry out its public health mission. In addition DSHS is requesting funding for medical resident stipends.

The Department of Family and Protective Services is requesting $46.9 million All Funds to provide funding in four areas related to improving recruitment and retention of protective services staff including recruitment and retention bonuses, educational stipends, increase pay groups for Adult Protective Services and Statewide Intake staff, and enhanced training.

Updated February 3, 2009

Cross Agency IT Systems and Telecommunications

The Health and Human Services Commission Enterprise Information Technology provides leadership and direction related to automated systems and telecommunications to achieve an efficient and effective health and human services system for Texans. In order to fulfill this purpose, two exceptional items are included in the HHSC FY 2010-2011 Legislative Appropriations Request. These items cut across multiple agencies and represent the most critical information technology needs to enable HHS programs to provide client services in the most efficient manner possible. Without these upgrades in technology and maintenance of automated systems, HHS agencies' fundamental data management capabilities will not meet the daily needs of the programs they support, creating gaps in timeliness, security, and data management, which threatens to diminish the quality of client services.

The first item requested encompasses projects in several key areas, such as security, telecommunications, and document management that provide HHS staff with the tools they need to work effectively. The second item is requested to ensure the success of the statewide data center consolidation effort led by the Department of Information Resources. While expenditures are required at this time to move these initiatives forward, over the long term, these investments will benefit the state through:

- reduced maintenance of existing hardware and software;
- reduced need to maintain multiple systems with similar functionality;
- protection of vital health and human services information assets against unauthorized access or disclosure, while assuring the availability, integrity, authenticity, and confidentiality of this information;
- increased productivity through enhanced sharing of data and systems capabilities; and
- better decision making through more timely, complete, secure, and accurate data availability.

In addition to the two exceptional items described below, each individual HHS agency has included in its LAR the agency-specific information technology requests to support essential projects that do not impact multiple agencies.

Maintain and Improve Critical HHS Technological Systems

This initiative includes several priority projects supporting direct services staff throughout the HHS System as described below.

Table V.5

Maintain and Improve Critical HHS Technological Systems
Requested Funding by Project

	BIENNIAL TOTAL GR	BIENNIAL TOTAL All Funds	FY 2010 FTEs	FY 2011 FTEs
Applications for State Schools and Hospitals	$ 4,644,863	$ 6,745,938	5.2	5.2
Security	$ 2,693,947	$ 3,616,206	-	-
HRMS PeopleSoft Upgrade	$ 7,059,289	$ 9,476,000	-	-
HHSAS Financials Accounts Receivable	$ 1,243,538	$ 1,669,471	1.0	1.0
HHSAS Financial Inventory	$ 1,770,089	$ 2,376,285	1.0	1.0
Telecom	$ 11,108,002	$ 15,394,305	13.5	13.5
Identity Management	$ 3,040,176	$ 4,080,965	-	-
Enterprise Data Warehouse	$ 1,318,614	$ 1,772,000	-	-
Total Exceptional Item	**$ 32,878,518**	**$ 45,131,170**	**20.8**	**20.8**

State Schools & Hospitals Application Enhancements

State Schools and State Hospitals are charged with treating and protecting their very vulnerable population. New software and hardware is needed to provide improved patient care and safety.

- **Document imaging/archiving and electronic interfaces** with trading partners (i.e. laboratory and radiology vendors) are needed to improve service delivery providing hospitals, therapists, and staff with access to all records of persons served from a single access point.
- **Incident reporting system** replacement is needed to document situations/occurrences that adversely affect the safety or well-being of persons served, visitors or the operation of a facility to enable timely documentation, reporting, and investigation. The replacement would provide the capability to collect all data elements needed to effectively document, track, address, and report on the incidents.
- **Pharmacy Software** enhancements to improve medication administration and ensure client safety. Current software does not have capability in many areas to effectively manage drug orders, labeling, and distribution. Examples of the software enhancements needed include the ability to customize pharmaceutical order codes for specific facilities; to have controls on certain data fields to ensure appropriate dosage information is entered; to track incorrect, expired, or discontinued orders; and to accurately populate emergency order data.
- **Online staff training and certification system** to facilitate ongoing training and re-certification for staff caring for clients and patients will significantly reduce the need for formal training classes and associated expenses, allow staff flexibility in scheduling training, and keep training curriculum current.
- **Personal funds of clients and patients** management system replacement to ensure proper management of personal funds and avoid risk of not functioning properly.
- **Consumables inventory** application replacement or upgrade, used to manage consumable supplies, including supplies used to prepare meals and supplies used in daily living by persons served, will reduce the need for manual intervention and avoid risk of loss.
- **Hardware and automated testing infrastructure** to perform load and stress testing on new releases of automated systems for hospitals and schools will ensure that upgrades to the applications function correctly providing 24-hour availability of administrative and clinical support systems.

Security Improvements

Improvements are needed to bring HHS agencies into compliance with state and federal electronic data security requirements and protect client data from unauthorized access or release. Limited automated tools are currently available to prevent network security attacks and to appropriately classify data. The implementation of a managed service will ensure that electronic data is classified according to Texas Administrative Code (TAC) standards, file and data transfers are converted to security transfers, and applications are tested for security weaknesses prior to deployment.

PeopleSoft System Upgrades

- The current version of Oracle/PeopleSoft on which the HHS Enterprise runs its human resources management system (HRMS) is nearing end of support. Extended Payroll Tax Update support from Oracle/PeopleSoft will no longer be available by the end of calendar year 2009. Without this support, HHSC will have to engineer custom-built payroll tax updates or contract with a vendor, if one exists, at a potentially significant cost, to obtain the needed payroll tax updates to produce a correct payroll. Extended support for the current version of the Oracle database will expire July 2011. Without extended support, the application is at risk for potential system performance issues and/or security breaches.
- Additional modules to the existing Health and Human Services Administrative System (HHSAS) Financials will allow the HHS agencies to eliminate stand-alone systems, standardize all agencies on one enterprise solution, and provide integration with the current HHSAS Financials.
    - An accounts receivable solution provides integrated accounts receivable and cash receipt functionality and eliminates several offline systems and interfaces. Generating, managing, and reporting on revenue journals and related processes can be integrated with the existing general ledger and accounts payable modules.
    - The inventory solution allows HHS to replace/upgrade software applications used by agencies to manage various inventories with the HHS agencies and will provide a single enterprise solution for all agencies, eliminating dependency on stand alone/multi-vendor support. The solution will support DADS and DSHS facilities inventory management, DARS processes used to track inventory stock for materials distribution warehousing and would incorporate HHS regional/facility warehouse services consolidation.

Enterprise Telecommunications Enhancements

Current telephone systems are at or near the end of life. Many are classified as obsolete systems, which mean they are no longer supported by manufacturers. Repairs are costly and are dependant on refurbished parts being available. Failure to replace these systems will jeopardize the effective delivery of services in many of our local offices and make it difficult for clients to access our services. Additional capacity and functionality are needed to ensure that employees have reliable access to voice communications services, that our clients and public have uninterrupted access to our services, and that we are using the kinds of technical innovations designed to enhance performance. Federal mandates for Homeland Security Essential Functions and emergency

response and preparedness are dependant on communications systems being reliable and cross-functional with other technical capacities.

Enterprise Identity Management

The Enterprise Identity Management solution will improve access to, and protect the security of, HHS electronic information and confidential client data. This solution provides streamlined and automated processes for providing users with access to applications and information and for terminating the access when users leave employment or job functions change so that the user no longer needs the access. It also provides users with single sign-on to all systems they are authorized to access, a standardized method for identifying and managing user access, and the capability to tailor system access to enforce security policies such as password requirements.

Enterprise Data Warehouse

Integrates information from various programs into a single source of reliable information across the enterprise; will provide HHS staff with comprehensive decision making functionality to support and enhance business planning, monitoring and governance of programs and activities.

Maintain IT Services for HHS Provided by DIR's Data Center Services

On March 31, 2007, the Department of Information Resources (DIR) commenced a contract with International Business Machines Corporation (IBM) to provide data center services for 27 Texas state agencies. The state's goals for the data center services (DCS) contract include management of in-place services, migration of services to the consolidated data centers, and improvements to services, security, and disaster recovery capability.

Issues surrounding the change from in-house operations to DCS outsourcing include:

- **Variance from Business Case** – The business case for the consolidated data center was developed in FY 2006. Since then, business needs have continued to change (moves/adds/changes for staff and offices, growth). Interpretations of the DCS contract have also evolved, moving certain things out-of-scope that were planned by the agencies to be in-scope (regional server uninterruptible power supplies, change in classification of certain regional servers). Therefore, HHS agencies will bear a cost that was thought to be part of the contract rate with DIR.
- **Application remediation** – Staff time to write and test upgrades to applications and equipment purchases to upgrade desktop configurations to work on the newer technology required in the consolidated data center.
- **Transformation** – As we move to new technologies, different architectural and configuration standards will apply. This will be more expensive (albeit more robust) than our former environment.
- **Network costs** – Traffic will shift as servers and mainframes are moved to the consolidated data center. Public Internet traffic and agency remote site traffic will change in volume and end points for transmissions.

- **Network Security** – Disaster recovery, encryption, and change in telephony technology required by the move to the consolidated data center (and subsequent use of commercial networks instead of state networks) will require larger circuits.
- **Management/oversight of DCS contract** – Managing such a large and complex contract requires additional oversight to ensure the State obtains the best value for its funds.

Table V.6

Maintain IT Services for HHS Provided by DIR's Data Center Services
Requested Funding by Type of Expense

	BIENNIAL TOTAL		FY 2010	FY 2011
	GR	All Funds	FTEs	FTEs
Team for Texas (TFT) Payments (Variances from Business Case)	$ 25,461,281	$ 31,160,387		
Internal Expenses	$ 13,294,114	$ 15,752,917		
Transformation	*$ 3,573,901*	*$ 4,035,600*		
Application Remediation	*$ 3,965,140*	*$ 4,823,700*		
Network Configuration/Security	*$ 3,895,449*	*$ 4,436,914*		
Operations & Contract Management	*$ 1,750,325*	*$ 2,110,169*	14	14
Overhead	*$ 109,298*	*$ 346,535*		
Total Exceptional Item	**38,755,395**	**46,913,304**	**14**	**14**

Table V.7

Allocation of Exceptional Item by Agency

Agency	BIENNIAL TOTAL	
	GR	All Funds
DADS	$ 3,513,891	$ 6,315,058
DARS	$ 2,455,707	$ 2,455,707
DFPS	$ 18,185,942	$ 21,210,263
DSHS	$ 12,118,611	$ 12,173,590
HHSC	$ 2,481,245	$ 4,758,687
Total Exceptional Item	**$ 38,755,395**	**$ 46,913,305**

Note: Agency totals include applicable HHSC costs billed to each agency.

VI. AGENCY BUDGET REQUEST SUMMARIES

Department of Aging and Disability Services (DADS)

General Functions

The Department of Aging and Disability Services (DADS) is the agency responsible for long term services and supports to individuals who are aging or have a disability. The department administers programs for community care through various programs such as Medicaid 1915 (c) home and community based waivers, community attendant services (CAS), primary home care (PHC), and day activity and health services (DAHS); for institutional care such as Nursing Facilities and ICF-MRs; and other community services to individuals who are aging or have a disability (cognitive and physical). Additionally, DADS provides regulatory services related to these programs. DADS' mission is "to provide a comprehensive array of aging and disability services, supports, and opportunities that are easily accessed in local communities." To that end, DADS is a functional organization, which requires each division to work internally across agency divisions as well as externally within the HHS Enterprise and with stakeholders.

Figure VI.1

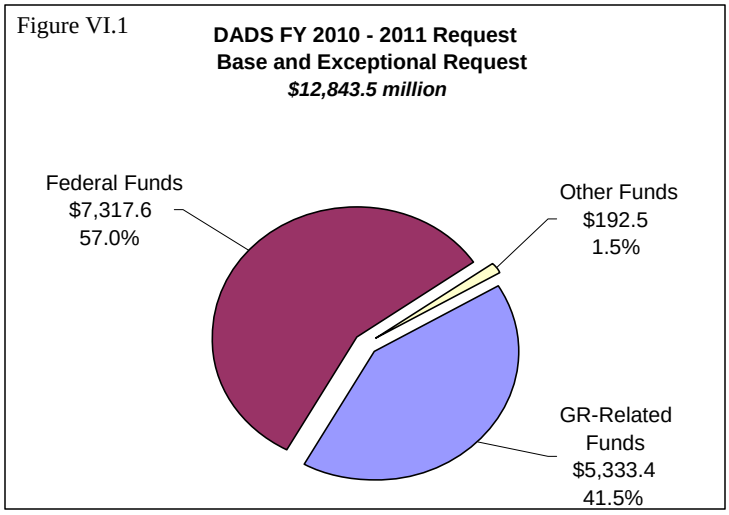
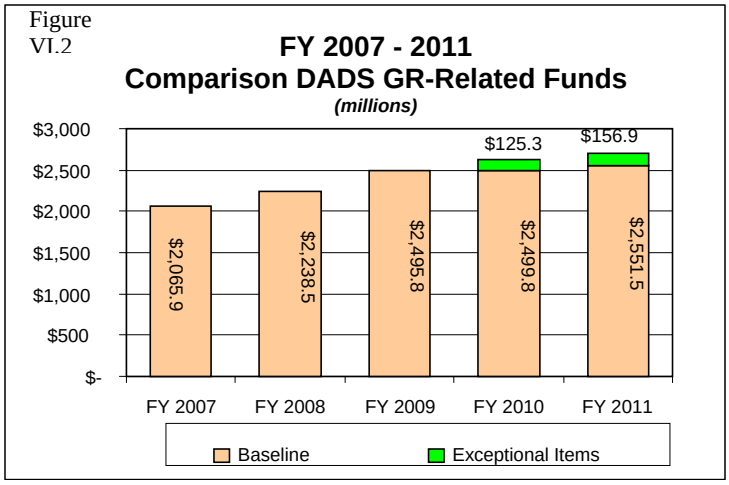


Figure VI.2



This functionality provides numerous opportunities to simplify and improve how services are provided, received, and regulated with a goal of enhancing the quality of life for individuals and improving the system of care that will serve all of us as we age, and those of us who may experience a disability.

Summary of Budget Request

The baseline request totals $12.2 billion in all funds (AF) over the biennium, with $5.1 billion being General Revenue (GR)-related. This is an increase of over $351.9 million in all funds from FY 2008-2009 amount

of $11.8 billion (3 percent). The GR-related base and exceptional item request for FY 2010-2011 is $5.3 billion.

Base Request

DADS baseline request includes a state fund increase of approximately $316.9 million (6.7 percent) over the projected expenditures for 2008-2009 biennium.

The DADS LAR was prepared in accordance with the instructions received from the Legislative Budget Board and Governor's Office. The FY 2010-2011 DADS base appropriations request will provide long-term supports and services to an estimated 296,000 individuals in Texas. Even with the increase in DADS FY 2010-2011 budget, the baseline request does not fully serve the number of individuals who will be receiving services at the end of FY 2009 or those who are eligible to receive DADS services. In accordance with baseline request instructions, DADS baseline request does not include funds to serve 5,772 individuals who are expected to be receiving non-entitlement services in FY 2009. Services for these individuals are addressed in the exceptional items.

Exceptional Items

There are of two types of exceptional items in the DADS request: first, to maintain the department to its FY 2009 service levels and second, to address significant needs for the future.
All figures noted below are on a biennial basis.

Maintain services to the FY 2009 service levels ($190.7 million GR; $ 440.5 million AF)

- In FY 2008-2009 there is an estimated reduction of the federal match rate (FMAP) for Medicaid programs, from 60.56 percent in FY 2008 to an estimated 58.14 percent in FY 2011. With each 1 percent drop in FMAP, the annual cost to DADS waiver programs is about $13 million in GR. ($42.5 million GR; $106.2 million AF).

- DADS received a $71.5 million GR increase in FY 2008-2009 to reduce interest/waiting lists by 10 percent this biennium, serving 8,902 new consumers. DADS also received $12.5 million in GR to provide HCS services to an additional 550 individuals moving from institutions to the community and for individuals aging out of child protective services. Since the additional number of individuals served were ramped-up over the course of the biennium, the amount funded for these items in FY 2008-2009 is only about half of the amount needed to maintain services for FY 2010-2011. In addition, for some waiver programs the FY 2009 rates were increased above FY 2008 levels as a result of the August 2008 minimum wage increase. Finally, there was an increase in FTEs from FY 2008 to FY 2009 for some strategies. ($93.9 million GR; $204.1 million AF).

- The LAR instructions require agencies to assume that costs will not increase above the FY 2009 baseline request. However, cost drivers experienced in certain programs will cause costs to exceed the FY 2009 level. Projected cost increases in the average units of service received by PHC, CAS, and DAHS clients as well as the weighted average daily rate for NF and Hospice as a result of increasing patient acuity, are based upon historical trend

data. For waivers, a one percent per year increase in average cost per client is assumed. Inflation-related cost increases in State Schools for food, utilities, and drug costs, as well as inflation for Skilled Title XVIII (the daily co-insurance rate is adjusted annually for inflation for Medicare), are also expected for FY 2011-2011. ($54.3 million GR; $130.2 million AF)

Address Future Needs ($91.4 million GR; $218.2 million AF)

- Promoting Independence requests funds to move 500 persons from large and medium sized ICF-MRs and funds to assist 250 individuals to relocate from nursing facilities to community settings. ($16.3 million GR; $35.6 million AF)

- MR Safety Net exceptional item requests the restoration of $31.3 million reduction made in FY 2003 for GR services provided by Mental Retardation Authorities (MRAs). These GR services provide much needed, albeit limited, services while individuals wait on various Interest Lists, or for those individuals who do not qualify for Medicaid but are in need. Based on current costs, 3,533 individuals would receive services. ($31.3 million GR; $31.3 million AF)

- Prevention of Institutionalization requests GR funding to provide waiver services to 196 children and adults. There are two initiatives associated with this exceptional item; (1) to reduce the number of children admitted to institutions and (2) to continue to serve individuals in the community who would be at imminent risk of institutionalization in the event of emergencies or crisis situations. ($4.6 million GR; $11.1 million AF)

- Area Agency on Aging (AAA) Benefit Counseling requests funds to expand the scope of the AAAs to provide benefit counseling (assistance with long-term care insurance, financial planning, and the need for advance planning documents such as wills and powers of attorney) to individuals under the age of 60. This item allows the state to better prepare for the needs of the baby boomer population. ($3.0 million GR; $3.0 million AF)

- PACE site expansion requests funds to serve an additional 150 individuals in the Program of All-Inclusive Care for the Elderly (PACE). Each site would serve and additional 50 individuals by the end of FY 2011. ($3.2 million GR; $7.7 million AF)

- Hospital Level of Care Waiver requests funding to create a new Medicaid Waiver to provide the required level of nursing services for individuals over 21 years of age with complex medical needs while maintaining cost neutrality in Texas' other waivers. The request assumes that 39 individuals will begin service immediately in FY 2010 and then grow at a rate of 2.5 percent per month for a total of 99 individuals for the biennium. ($15.1 million GR; $36.5 million AF)

- State Schools request funding to address infrastructure needs such as staff training, replacement of old and damaged equipment and furniture, and life safety requirements such as roofs, heating, ventilation, A/C (HVAC), plumbing, and electrical. ($8.5 GR; $70.1 General Obligation Bonds; $80.1 AF)

- Survey and Certification FTEs would enable DADS to visit 100 percent of HCS group homes and foster homes annually. Currently there are 34 FTEs that visit a sample of residences of all provider contracts as part of each initial and annual HSC certification review. This exceptional item would add 35 FTEs. ($2.3 million GR; $4.6 million AF)

- Information Technologies requests several infrastructure needs at DADS that are currently based on old and unsupported software from the legacy agencies at DADS. These applications run software that is slow, unstable and difficult to maintain. DADS programs that are affected include caseload assignments, Nursing Facility Administrator Licensure database, and the Licensing and Certification program. ($7.1 GR, $8.3 million AF)

DADS has five Enterprise Exceptional Item Requests included in HHSC's LAR and the HHS Consolidated Budget. The first of these is the continuation of the DADS interest/waiting list reductions from 2008-2009. The second item pertains to rate increases for providers and the third item is employee retention and recruitment. The fourth and fifth requests are for vehicles at DADS' State Schools with a goal for continued replacement of old vehicles and information technology infrastructure for all HHS agencies, respectively.

The DADS Legislative Appropriations Request can be found online at:
http://cfoweb.dads.state.tx.us/lar/default.asp

Department of Assistive and Rehabilitative Services (DARS)

General Functions

The Department of Assistive and Rehabilitative Services (DARS) is charged with administering programs that assist Texans with disabilities to find or retain employment, prepare children with disabilities and developmental delays age 0-3 to meet educational and developmental goals, and help Texans with disabilities to live independently in their communities. The agency also helps survivors of traumatic brain and spinal cord injuries to regain functionality and independence and make disability determinations for Texans who apply for Social Security Disability Insurance and/or Supplemental Security Income.

Figure VI.3

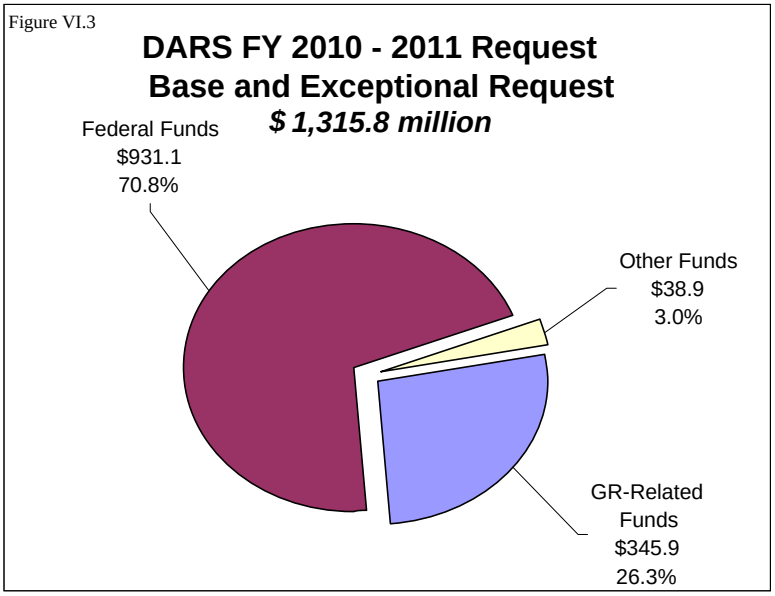
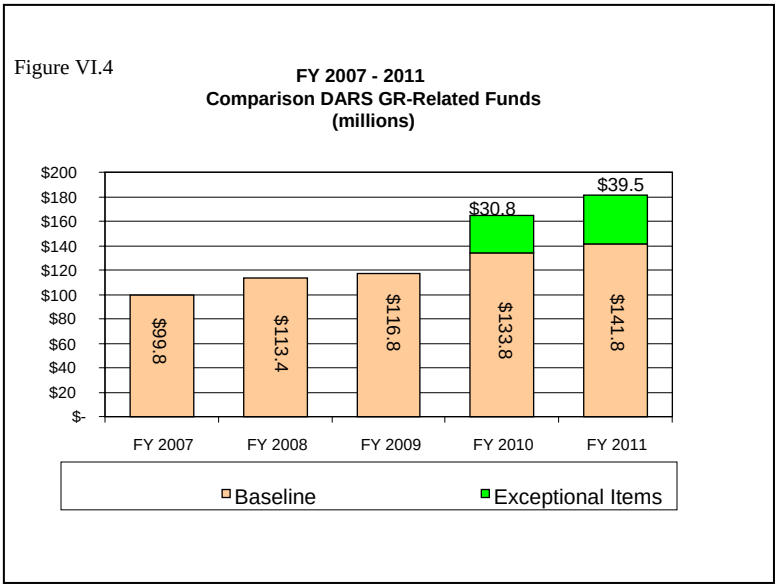


Figure VI.4



Summary of Budget Request

The FY 2010-2011 LAR base and exceptional items total more than $1.3 billion, with a base request of more than $1.2 billion and exceptional items totaling about $95 million (AF). The GR-related base and exceptional item request for FY 2010-2011 of $345.9 million represents a 50.3 percent increase over FY 2008-2009. Federal and other funds requested have decreased by less than one percent over FY 2008-2009 levels for a total of $970 million in FY 2010-2011.

Exceptional Items

Vocational Rehabilitation (VR) Growth to Maintain Services and Serve General Population Growth

- Request GR match for VR federal grant growth estimated to be roughly four percent per year (last four years average growth percent). This will allow the Division for Rehab Services (DRS) and the

Division for Blind Services (DBS) to make some infrastructure improvements and to cover projected population growth of 18 percent over the past nine years. Indirect FTEs needed from DARS and HHSC to cover these direct FTE increases are included.

Request to Maintain Services

- To maintain services in these programs: 1) Blind Children: biannualize the emergency funding received in 2009 to avert a waiting list and maintain ideal caseload size of 69; 2) Autism ages 3-8: biannualize the 2009 funding; 3)Independent Living-Blind: achieve ideal caseload size of 60 and avoid a waiting list by adding 7.5 FTEs to this program; and 4) STAP (Specialized Telecommunications Assistance Program): applications have increased 100 percent over past years and there has been no increase in funding to match the growth. Indirect FTEs needed from DARS and HHSC to cover these direct FTE increases are included in the exceptional item.

Growth to Serve More Clients

- Growth to serve more clients in these programs: 1) Early Childhood Intervention (ECI) - request adding five FTEs (three for program monitoring and two for third party reimbursements); 2) Blind Children: request increase in funding to add three new FTEs and increase the Texas Education Agency roster penetration from 33 percent to 37 percent; 3) IL-Blind: request funding for 10.5 FTEs to increase penetration of population in need (FY 2010 Strategic Plan projection is 21,800) from three percent to four percent; 4) Business Enterprise of Texas: request increase in funding for two new facilities and renovate 10 existing facilities; and 5) IL Centers: the State Independent Living Council and the Promoting Independence Advisory Council is requesting adding three new centers during the biennium. Indirect FTEs needed from DARS and HHSC to cover these direct FTE increases are included in the exceptional item.

Increase Number of Service Hours and Offset Inflation

- Increased numbers of children with high service needs, increased costs, and an average cost per child that has remained essentially flat for the last 10 years has resulted in providers adjusting by trimming the number of services children receive. Of the children with developmental delays, the percentage of children with delays in multiple areas increased from 37 percent in FY 2004 to 47 percent in FY 2007. The number of children diagnosed with conditions on the Autism Spectrum more than doubled between FY 2004 and FY 2007. Additionally, eight to nine percent of children served are involved in Child Protective Services, which often means more complex service needs for the child and the family. Increased complexity translates into increased costs. Since ECI services are delivered in the home, travel represents an important cost of doing business and travel costs are straining budgets. To attract high quality therapists and other professionals, providers must pay higher salaries. This request would address both the quality and quantity of services delivered.

Accessibility

- Under HHS enterprise policy, all HHS agencies must comply with all provisions of §2054.456, Texas Government Code, and Section 508 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794d). HHSC has proposed a consolidated model for enterprise accessibility that would expand these services to the enterprise, delivering accessibility testing services upon request to all HHS agencies beginning in FY 2010. Under this model, DARS would hire three new FTEs to act as Accessibility consultants to the other HHS agencies and these FTEs would provide accessibility testing, training, and consultation. To accomplish this proposal, additional resources are needed. Included in this request are FTEs and funds that will be used by the other HHS agencies.

The full Legislative Appropriations Request for DARS can be found at:
http://www.dars.state.tx.us/reports/lar2010_2011.pdf

Department of Family and Protective Services (DFPS)

General Functions

The Department of Family and Protective Services (DFPS) is charged with protecting children, the elderly, and people with disabilities from abuse, neglect, and exploitation, and regulating all child-care operations and child-placing agencies. The agency is also charged with managing community-based programs that prevent child abuse and neglect and juvenile delinquency. The agency's services are provided through its Adult Protective Services (APS), Child Protective Services (CPS), Child Care Licensing (CCL), and Prevention and Early Intervention (PEI) programs. By the end of fiscal year 2008, over 10,800 DFPS employees across the state will be working to protect the physical safety and emotional well-being of the most vulnerable citizens of Texas.

Figure VI.5

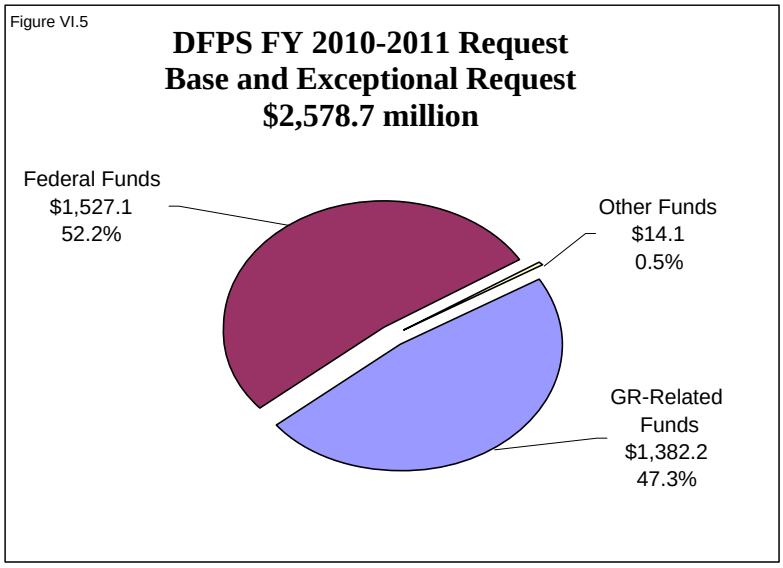
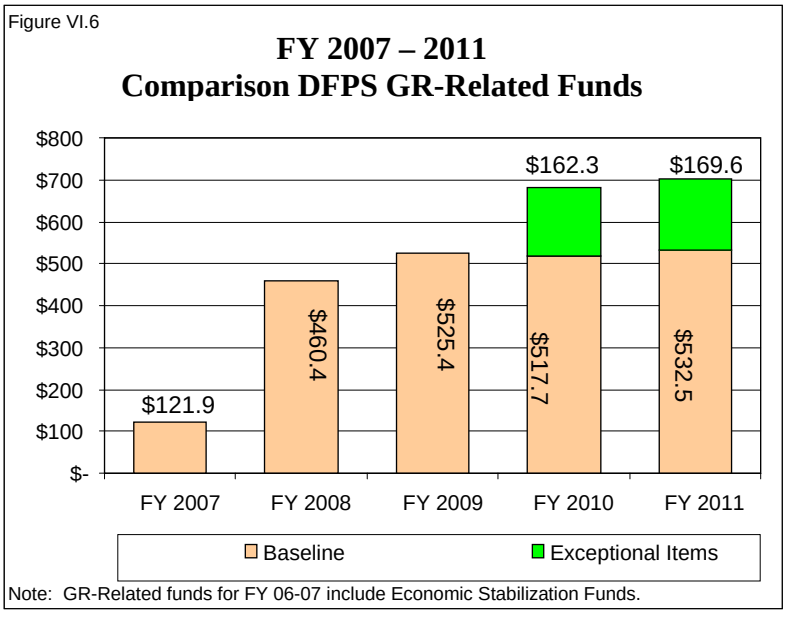


Figure VI.6



Note: GR-Related funds for FY 06-07 include Economic Stabilization Funds.

Summary of Budget Request

The FY 2010-2011 LAR base and exceptional items total $2.9 billion, a 17.8 percent increase in All Funds over the 2008-2009 biennium. The base request totals $2.5 billion and exceptional items total $384.1 million. The GR-related base and exceptional item request for FY 2010-2011 of $1.4 billion represents a 40.2 percent increase over FY 2008-2009. Federal and other funds requested have increased by 3.0 percent from FY 2008-2009 levels for a total of $1.5 billion in FY 2010-2011.

Exceptional Items

DFPS is requesting funding for the following 18 exceptional items totaling $332.0 million in GR.

- Increase funding for base FTEs to avoid a reduction of 891 currently authorized FTEs, which are critical to sustain current levels of staff-delivered services.

- Maintain phased-in staff and initiatives needed to continue improvements in FY 2010-2011 that were provided by the 80th Legislature and were phased in over the current biennium.

- Replace non-recurring federal revenue to prevent a reduction of 443.5 currently authorized direct delivery CPS staff. The loss of these federal funds was a result of DFPS discontinuing the claiming of targeted case management.

- Direct delivery staff to maintain caseloads including CPS investigative staff, statewide intake staff, and APS MH and MR investigations staff.

- Increase the number of direct delivery staff to meet the federal standards of achieving face-to-face monthly contacts with 95 percent of children and parents.

- Increase funding to address recruitment and retention as a result of high turnover rates.

- Address caseload growth for Kinship Program, which provides monetary assistance as well as day care services to relatives and other designated caregivers for children in DFPS conservatorship who are placed in their care.

- Additional purchased client services and program support for caseload growth are needed. These types of resources were recognized through agency reform appropriations as being critical to address the improvements needed in protective services

- CPS capped caseload pilot seeks funds to evaluate the effectiveness of a capped caseload for CPS substitute care workers, targeting youth who have been in care for two or more years, who have major behavioral health needs, and have had multiple placements.

- Mobile caseworker enhancements to maximize the existing mobile technology investment and enhance the agency's mobile caseworker business model.

- Increase funding for prevention services by 10 percent for the Services to At-Risk Youth program and two new sites for the Community Youth Development program.

- IT and data management initiatives are needed for additional automation tools and resources that strengthen the agency's ability to support the programs and to manage automation and utilization of data

- Strengthen CPS services to families to enhance efforts to divert children from foster care. through more family team meetings and family group conferences, Kinship and the Foster and Adoptive Home Development programs, enhancements to the automated system for the Foster and Adoptive Home Development program, and tablet PCs for family group decision making staff.

- Strengthen services to youth transitioning from foster care to adulthood through increased funding for programs and through seed money to communities to help develop a transition

center designed to provide comprehensive services such as apartment locator services, employment services, and college prep or GED assistance, to these older youth.

- Create higher adoption subsidy ceilings for children who have been in care for three or more years since becoming legally free for adoption, have a plan for adoption, and are not in a placement intended to be permanent.

- Address pending and projected appeals hearings to handle the growing backlog of appeals of abuse and neglect findings from individuals who were found to have abused or neglected their own children and have applied to work in day care or residential care, and child care employees who were found to have abused or neglected a child in the child care setting.

- Enhance CPS risk management to strengthen risk management activities, thus ensuring that proper risk assessments are made and appropriate services are provided that will help prevent some children from entering out-of-home care and allow others to be reunited more quickly. This also addresses the need for a public awareness campaign that targets the dangers of unregulated care.

- Strengthen APS and Day Care Licensing program oversight to enhance supervisors' ability to review and approve all cases, while freeing up time for other critical management duties, particularly staff development. Increased number of administrative assistants would free up caseworkers, while Day Care Licensing program administrators would provide a mid-level management.

The DFPS Legislative Appropriations Request can be found online at:
http://www.dfps.state.tx.us/About/Financial_and_Budget_Information/2010_11_LAR.asp

Department of State Health Services (DSHS)

General Functions

The Texas Department of State Health Services (DSHS) was officially launched on September 1, 2004, combining the legacy functions of the Department of Health, the Commission on Alcohol and Drug Abuse, the mental health component of the Department of Mental Health and Mental Retardation and the Texas Health Care Information Council. The agency's mission is to improve health and well-being in Texas. DSHS fulfills its mission through a complex array of programs and services that fall into four general areas.

- **Preparedness and Prevention Services.** The range of activities related to this function includes improving the state's capacity to respond to natural disasters and man-made public health threats, maintaining vital records and health care data critical to policymakers and the public, immunizing Texas children, addressing the health needs of specific groups such as children with special health care needs and kidney health patients, and operating a laboratory for health-related testing statewide.

- **Community Health Services.** Services provided in this area cover primary care and indigent health services, WIC nutrition services, women and children's health services, family planning services, community-based mental health and substance abuse services as well as tobacco prevention and enforcement activities. This goal also provides funding for the development and coordination of the State's emergency medical services and trauma care systems to strategically position clinics to apply for and receive support as Federally Qualified Health Centers.

- **Hospital Facilities Management and Services.** DSHS is responsible for operating the state's 11 facility mental health hospital system, the Texas Center for Infectious Diseases and the South Texas Health Care System.

- **Consumer Protection.** DSHS is the state authority for enforcing consumer health protection in areas such as food and drug safety, environmental health and radiation control. The department is also responsible for licensing health care professionals and facilities.

Summary of Budget Request

The FY 2010-2011 LAR base and exceptional items total $5.9 billion, an eight percent increase in all funds over the 2008-2009 biennium. The base request totals $5.5 billion, and exceptional items total $445.4 million. The GR-related base and exceptional item request for FY 2010-2011 of $3.2 billion represents a 12.8 percent increase over FY 2008-2009. Federal and other funds requested have remained constant from FY 2008-2009 levels for a total of $2.8 billion in FY 2010-2011.

However, federal grants for public health preparedness have decreased while federal funds for Women's, Infants, Children program have increased.

Exceptional Items

DSHS is requesting funding for the following 12 exceptional items totaling $359.1 million GR.

- Maintain operating capacity in existing programs, such as crisis mental health services, state hospitals, laboratory services, women's health services and trauma care.
- Maintain regulatory capacity to ensure compliance with state and federal requirements, including licensure and inspection of health facilities and professionals.

Figure VI.7

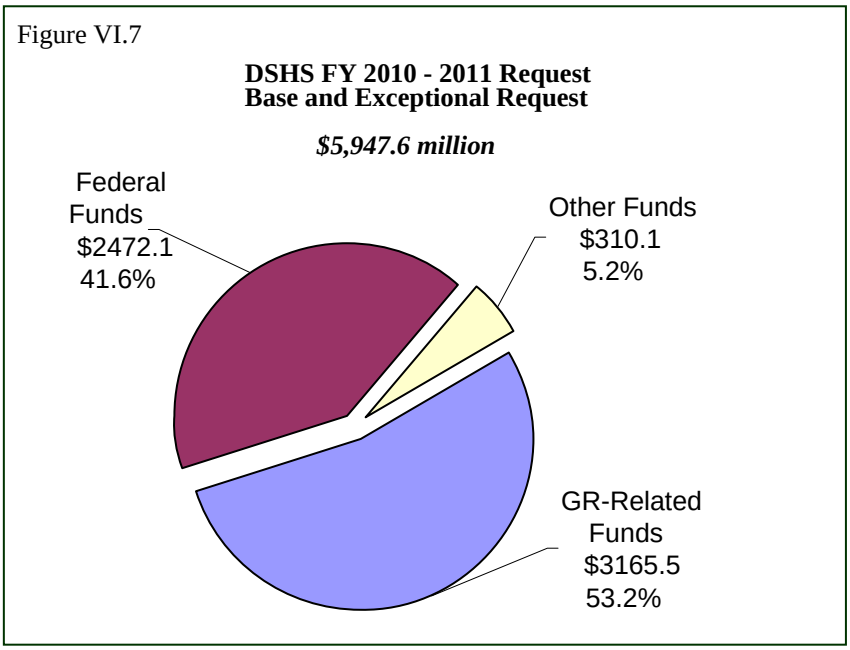
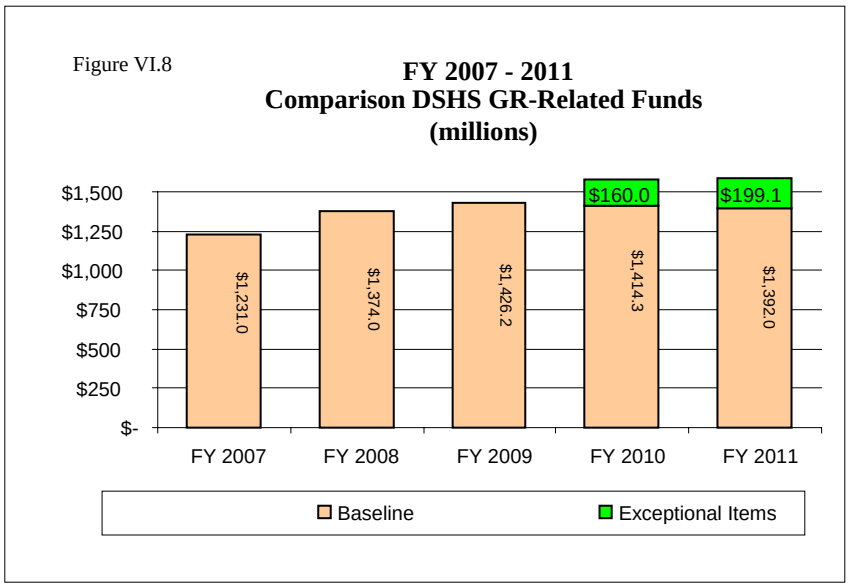


Figure VI.8



- Enhance collection of health data to improve prevention and treatment of illnesses.
- Ensure compliance with federal law related to Vital Statistics, such as birth and death records.
- Improve information technology to assure the viability of patient records, client case files, regulatory rules, and pharmacy records and to provide reliability to the internet connectivity among the DSHS offices and hospitals across the state.
- Respond quickly and effectively to disasters and disease outbreaks through reducing timeframes for laboratory testing, supporting local health services, increasing staff dedicated to disaster response, and integrating mental health components of disaster response with DSHS regional activities.

- Provide stipends for psychiatric residency placements in the state hospital system and physician placements in public health programs.
- Repairing and replacing buildings and equipment in state hospitals in order to ensure safety and compliance with accreditation standards.
- Increase substance abuse prevention and treatment services throughout the state, including adding an outpatient Medicaid benefit. Untreated or under-treated substance abuse frequently leads to increases in criminal behavior, domestic violence and child abuse, increased unemployment, and high school dropout rates.
- Expand the community mental health services initiative in the current biennium to relieve the pressure on hospital emergency rooms, local jails, and the state mental hospital system. Transitional services and funds for higher intensity treatment are critical to assure individuals do not continue to cycle in and out of crisis services.
- Prevent chronic diseases through encouragement of physical exercise, evidence-based policies and programs in healthcare sites and worksites, improved nutrition, and reduced incidence of smoking.
- Prevent infection diseases, such as HIV and tuberculosis, with improved laboratory testing to detect disease earlier and routine testing of HIV.

The DSHS Legislative Appropriations Request can be found online at:
http://www.dshs.state.tx.us/budget/lar/default.shtm

Health and Human Services Commission (HHSC)

General Functions

The Health and Human Services Commission (HHSC) was created in 1992 to coordinate and improve the delivery of health and human services across Texas. During its 16-year history, HHSC has increased its oversight role of health and human services programs and consolidated functions culminating in a major transformation of the HHS system which consolidated 11 agencies into a five agency structure.

In addition to overseeing the health and human services system in Texas, HHSC is responsible for program administration of Medicaid, Children's Health Insurance Program (CHIP), Disaster Assistance, Temporary Assistance for Needy Families, Food Stamps, and Family Violence programs. Thus, HHSC has responsibilities as a leadership, operational, and oversight agency. The agency is accountable to Texans for ensuring that the consolidated Health and Human Services (HHS) agencies provide quality services as efficiently and effectively as possible.

Figure VI.9

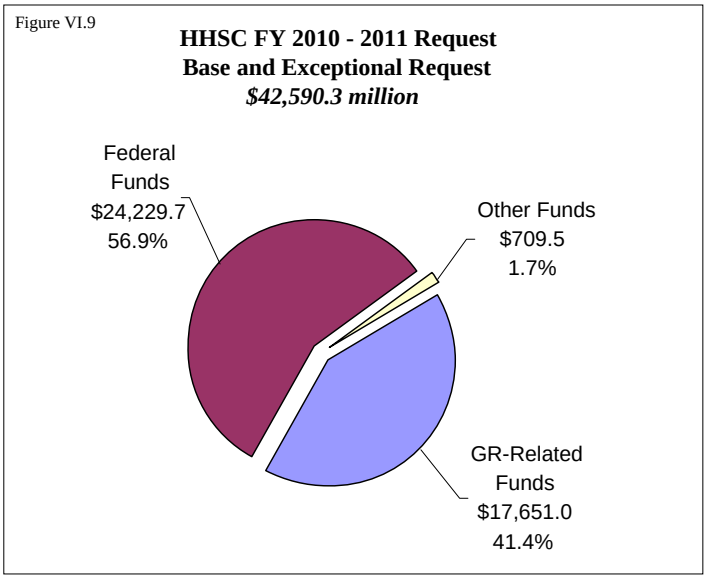
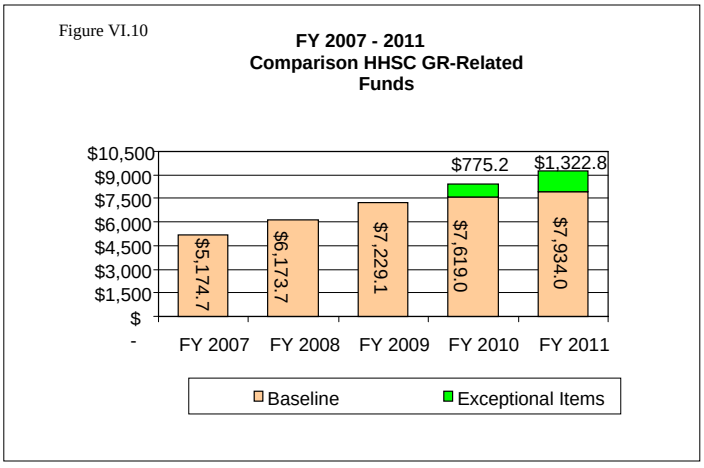


Figure VI.10



Summary of Budget Request

The FY 2010-2011 LAR base and exceptional items total $42.6 billion, a 23 percent increase in all funds over the 2008-2009 biennium. The base request totals $37.8 billion, and exceptional items total $4.8 billion. The GR-related base and exceptional item request for fiscal year 2010-2011 of $17.7 billion represents a 32 percent increase over 2008-2009. Federal and other funds requested would increase by 18 percent from 2009-2010 levels for a total of $25.0 billion in FY 2010-2011.

Exceptional Items

In addition to the base request, HHSC is seeking funding for 18 exceptional items totaling $2.1 billion GR, of which approximately one-third of the request, or $1.4 billion GR, is needed to maintain current services in Medicaid, CHIP and other agency programs and administration.

Exceptional items can be categorized in four categories:

- **Maintain Medicaid Acute Care and CHIP** ($1.3 billion GR)
  Provides for cost increases in the Medicaid and CHIP programs and maintains funding for the Frew lawsuit Corrective Action Orders and Strategic Initiatives.

- **Current Operations** ($151.2 million GR)
  Maintains operations of regional administration and eligibility services, including increased costs for leases, utilities, and security. This request also annualizes the Nurse Family Partnership and the Healthy Marriages programs, which were funded for only a portion of the current biennium due to implementation timelines.

- **Other Critical Services and System Improvements** ($98.5 million GR)
  Provides additional staff and resources associated with caseload growth for Food Stamps, Medicaid, and CHIP. Also includes funding for a new Medicaid buy-in program for children, enhanced Family Violence Services, Office of Inspector General staff, and 211 expansion.

- **Implement Enterprise Initiatives** ($351.5 million GR)
  Includes five items that support the following efforts across HHS agencies:

  - Maintain Data Center Services
  - Maintain HHS Transportation
  - Increase the Capacity in HHS Community Services
  - Maintain and Improve HHS Technology
  - Improve Retention and Recruitment of Targeted Health Care Professions

The HHSC Legislative Appropriations Request can be found online at:
http://www.hhsc.state.tx.us/LAR/2010-2011/index.html

VII. PROVIDER RATE CONSIDERATIONS AND METHODOLOGY

Overview of Provider Rate Considerations and Methodology

Direct services received by health and human services clients are predominantly provided through the private sector. While state employees determine client eligibility and provide protective and regulatory services, medical, residential and social services are generally received by clients in community settings from private sector individuals or entities[1]. These providers may also serve individuals 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 health and human services system should provide adequate reimbursement to permit client access to necessary and efficiently delivered services for clients enrolled in state funded programs.

The rate table in Chapter VIII, Appendix A1 illustrates the cost of providing increases in the rates paid to providers and, for any rate increase greater than 1 percent, the cost of providing a 1 percent rate increase. The rate increases in this chart represent increases in costs incurred by providers as verified through audited cost reports, in some cases routine inflation over current rates, for select programs the cost to implement federally mandated rates, or the cost to increase rates to Medicare rates for programs that have their rates based on the Medicare methodology. Rate increases are needed in order to appropriately reimburse providers for changes in their costs in delivering care to HHS clients. Without additional funding for rate increases, continued rising costs incurred by providers will erode the quality of services delivered and could result in access to care problems for clients due to fewer providers willing to deliver services for the level of Medicaid reimbursement. In general most Medicaid services had rate increases effective September 1, 2007, however those rate increases in some cases still lag behind routine inflation, or the costs incurred by providers (as determined through the rate methodologies and provider reported/audited costs) or Medicare rates. Prior to the September 1, 2007 rate increases, most services had their rates reduced effective September 1, 2003, and then had them held flat until the rate increases restored the reduced rates for most services effective September 1,2007.

HHSC develops approximately 157,787 different rates, primarily for the Medicaid program. Of this amount 360 rates are for health maintenance organizations, 955 are for nursing facilities, 28,000 for school health and related services, 473 for inpatient hospital standard dollar amounts and 745 for inpatient hospitals diagnostic related groups, 112,592 are for physicians and other professionals, 1,991 are for durable medical equipment, and 2,773 are for Texas Health Steps (THSteps) medical providers.

HHSC is currently assessing the impact of the rate increases on Medicaid provider enrollment and participation, and on client utilization. Preliminary findings show that new providers are enrolling in the Medicaid program at an accelerated pace since implementation of the new reimbursement

[1] State employees also provide mental health and residential services at state hospitals, state schools and state centers.

rates. This growth shows up in two ways: 1) the number of new *unique providers*, and 2) the number of new *provider locations* (i.e., counting every practice location when a provider has more than one in the program). Also, new provider participation grew across all provider types, including primary care physicians and dentists, and participation grew in rural and urban areas. These preliminary findings also show that utilization of dental services by Medicaid clients increased after the increase in provider rates. An increase in utilization of THSteps medical services was not observed. These finding are based on the first 2-3 quarters of fiscal year 2008 and are preliminary. However, the results are encouraging. It is expected that the full impact of these rate increases may not be known for a couple of years.

Cost of One Percent Rate Increase

In both Table VII.1 below and in Chapter VIII, Appendix A1 the cost of providing a 1 percent rate increase for each program is identified.

Table VII.1
Cost of 1 Percent Rate Increase

Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Incremental Cost of 1 Percent Rate Increase			
			2010		2011	
			AF	GR	AF	GR
DADS						
Access and Intake - Mental Retardation Service Coordination	1/1/2002	2.00%	167,731	69,340	167,731	70,212
Community Attendant Services without Minimum Wage	9/1/2007	5.49%				
Community Attendant Services Minimum Wage Only	8/1/2008	8.80%				
Community Attendant Services Total			3,676,360	1,519,807	3,798,505	1,590,054
Community Based Alternatives without Minimum Wage	9/1/2007	6.06%				
Community Based Alternatives Minimum Wage Only	8/1/2008	3.82%				
Community Based Alternatives Total			4,561,892	1,885,886	4,628,719	1,937,582
Community Living Assistance and Support Services without Minimum Wage	9/1/2007	4.05%				
Community Living Assistance and Support Services Minimum Wage Only	8/1/2008	0.23%				
Community Living Assistance and Support			1,518,267	627,651	1,533,529	641,935
Consolidated Waiver Program without Minimum Wage	9/1/2007	3.73%				
Consolidated Waiver Program Minimum Wage Only	8/1/2008	0.23% Habilitation; 3.82% Personal Attendant Svcs.				
Consolidated Waiver Program Total			46,911	19,393	47,379	19,833
Day Activity and Health Services - Title XIX without Minimum Wage	9/1/2007	1.79%				
Day Activity and Health Services - Title XIX Minimum Wage Only	8/1/2008	0.66%				
Day Activity and Health Services - Title XIX Total			1,069,942	442,314	1,093,417	457,704

Cost of 1 Percent Rate Increase, continued

Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Incremental Cost of 1 Percent Rate Increase			
			2010		2011	
			AF	GR	AF	GR
DADS, continued						
Deaf-Blind Multiple Disabilities without Minimum Wage	9/1/2007	3.76%				
Deaf-Blind Multiple Disabilities Minimum Wage Only	8/1/2007	8.96% Chore; 0.23% Habilitation				
Deaf-Blind Multiple Disabilities Total			80,941	33,461	81,751	34,221
Home and Community-based Services without Minimum Wage	9/1/2007	5.00%				
Home and Community-based Services Minimum Wage Only	NA	NA				
Home and Community-based Services Total			6,502,184	2,688,003	6,601,752	2,763,494
Hospice Payments (NF Related Only) without Minimum Wage	9/1/2008	4.00%				
Hospice Payments (NF Related Only) Minimum Wage Only	NA	NA				
Hospice Payments (NF Related Only) Total			2,019,576	834,893	2,132,442	892,640
Intermediate Care Facilities - Mental Retardation without Minimum Wage	9/1/2007	7.50%				
Intermediate Care Facilities - Mental Retardation Minimum Wage Only	NA	NA				
Intermediate Care Facilities - Mental Retardation Total			3,574,929	1,477,876	3,574,579	1,496,319
Medically Dependent Children Program without Minimum Wage	9/1/2007	unknown				
Medically Dependent Children Program Minimum Wage Only	8/1/2008	3.82% PAS No Delegation; 3.49% PAS Delegation				
Medically Dependent Children Program Total			477,920	197,572	482,690	202,054
Non-Medicaid Services - Title XX without Minimum Wage	9/1/2007	various				
Non-Medicaid Services - Title XX Minimum Wage Only	8/1/2008	various				
Non-Medicaid Services - Title XX Total			905,314	905,314	905,314	905,314
Nursing Facility without Minimum Wage	9/1/2008	5.00%				
Nursing Facility Additional Funds for Fixed Capital	NA	NA				
Nursing Facility Subtotal without Minimum Wage						
Nursing Facility Minimum Wage Only	NA	NA				
Nursing Facility Total			24,129,445	9,975,113	24,207,319	10,133,184
Primary Home Care without Minimum Wage	9/1/2007	5.49%				
Primary Home Care Minimum Wage Only	8/1/2007	0.66%				
Primary Home Care Total			5,230,598	2,162,329	5,604,108	2,345,879
Program of All-inclusive Care for the Elderly without Minimum Wage	9/1/2007	various				
Program of All-inclusive Care for the Elderly Minimum Wage Only	9/1/2007	various				
Program of All-inclusive Care for the Elderly Total			416,606	172,225	416,606	174,391
Promoting Independence Services without Minimum Wage	9/1/2007	various				
Promoting Independence Services Minimum Wage Only	8/1/2008	various				
Promoting Independence Services Total			976,592	403,723	1,057,501	442,670
Texas Home Living Waiver without Minimum Wage	9/1/2007	5.00%				
Texas Home Living Waiver Minimum Wage Only	NA	NA				
Texas Home Living Waiver Total			100,948	41,732	101,894	42,653
Total DADS (with totals only included)			**55,456,156**	**23,456,632**	**56,435,236**	**24,150,139**

Cost of 1 Percent Rate Increase, continued

Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Incremental Cost of 1 Percent Rate Increase			
			2010		2011	
			AF	GR	AF	GR
DARS						
ECI - Case Management	2/1/2000	New Service	143,304	59,242	154,195	64,546
ECI - Development Rehabilitative Services	4/4/2003	62.69%	461,745	190,885	496,837	207,976
Total DARS			**605,049**	**250,127**	**651,032**	**272,522**
DFPS						
24-Hr. Residential Child Care (Foster Care) - Foster Family	9/1/2007	4.30%	212,172	122,288	218,883	127,256
24-Hr. Residential Child Care (Foster Care) - Child Placing Agency	9/1/2007	4.30%	2,462,963	1,551,284	2,537,017	1,605,300
24-Hr. Residential Child Care (Foster Care) - Residental Treatment Facility	9/1/2007	7.00%	908,099	637,524	916,779	651,361
24-Hr. Residential Child Care (Foster Care) - Emergency Shelter	9/1/2007	9.90%	254,122	174,627	265,216	182,944
24-Hr. Residential Child Care (Foster Care) - Total All Provider Types	9/1/2007		3,837,356	2,485,723 See note 1	3,937,895	2,566,861 See note 2
Psychiatric Transition (Intensive Psychiatric Step Down)	New Service	NA	58,317	44,752 See note 3	70,661	54,362 See note 4
Adoption Subsidies	NA	NA	1,557,887	851,000	1,670,531	915,808
Total DFPS			**5,453,560**	**3,381,475**	**5,679,087**	**3,537,031**

Note 1 - If TANF funding is available, up to $967,451 of this amount is eligible for TANF funding the remaining $1,518,272 must be GR

Note 2 - If TANF funding is available, up to $999,525 of this amount is eligible for TANF funding the remaining $1,568,336 must be GR

Note 3 - If TANF funding is available, up to $17,079 of this amount is eligible for TANF funding the remaining $27,673 must be GR

Note 4 - If TANF funding is available, up to $20,694 of this amount is eligible for TANF funding the remaining $33,668 must be GR

DSHS						
Children with Special Health Care Needs (CSHCN) - Outpatient Hospital	NA	NA	20,952	20,952	22,544	22,544
CSHCN - Ambulance Services	9/1/2007	55.50%	5,069	5,069	5,454	5,454
CSHCN - ASCs/HASCs	9/1/1995	Changed to Fee Schedule	1,012	1,012	1,089	1,089
CSHCN - Dental Services	9/1/2007	52.50%	3,768	3,768	4,054	4,054
CSHCN - Durable Medical Equipment, Prosthetics, Orthotics,Supplies	Various 2008	10.00%	85,843	85,843	92,367	92,367
CSHCN - Drugs/Biologicals	10/1/2008	3.59%	48,250	48,250	51,917	51,917
CSHCN - Inpatient Hospital Rebasing	9/1/2008	14.00%	92,261	92,261	99,034	99,034
CSHCN - Clinical Laboratory	4/1/2008	2.60%	3,403	3,403	3,662	3,662
CSHCN - Nursing	11/1/2002	various	202	202	218	218
CSHCN - Physician & Professional Services - Other	9/1/2007	27.50%	1,417	1,417	1,525	1,525
CSHCN - Physician & Professional Services - Medicare	9/1/2007	27.50%	10,981	10,981	11,816	11,816
CSHCN - Physician & Professional Services - Total			12,398	12,398	13,341	13,341
CSHCN - Therapies	9/1/2007	8.41%	0	0	0	0

Cost of 1 Percent Rate Increase, continued

Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Incremental Cost of 1 Percent Rate Increase			
			2010		2011	
			AF	GR	AF	GR
DSHS, continued						
Family Planning - Durable Medical Equipment, Prosthetics, Orthotics,Supplies	Various 2008	10.00%	6,050	6,050	6,494	6,494
Family Planning - Drugs/Biologicals	10/1/2008	3.59%	76,720	76,720	82,352	82,352
Family Planning - FQHCs	1/1/2008	Medicare Economic Index (MEI) or MEI+1.5%	35,644	35,644	37,613	37,613
Family Planning - Clinical Laboratory	4/1/2008	2.60%	95,882	95,882	102,919	102,919
Family Planning - Physician & Professional Services - Children - Other	9/1/2007	27.50%	5,220	5,220	5,617	5,617
Family Planning - Physician & Professional Services - Children - Medicare	9/1/2007	27.50%	40,452	40,452	43,526	43,526
Family Planning - Physician & Professional Services - Children - Total			45,672	45,672	49,143	49,143
Family Planning - Physician & Professional Services - Adults - Children/Adults Parity	9/1/2007	12.50%	14,828	14,828	15,876	15,876
Family Planning - Physician & Professional Services - Adults - Medicare	9/1/2007	12.50%	114,902	114,902	123,026	123,026
Family Planning - Physician & Professional Services - Adults - Total			129,730	129,730	138,902	138,902
Institutions for Mental Disease	9/1/2007	32.65%	117,732	48,670	121,606	50,904
Maternal and Child Health - Clinical Lab	4/1/2008	2.60%	63	63	68	68
Maternal and Child Health - Durable Medical Equipment, Prosthetics, Orthotics,Supplies	Various 2008	10.00%	699	699	750	750
Maternal and Child Health Drugs/Biologicals	10/1/2008	3.59%	289	289	310	310
Maternal and Child Health - Dental	9/1/2007	52.50%	15,470	15,470	17,560	17,560
Maternal and Child Health - Physician & Professional Services - Children - Other	9/1/2007	27.50%	11,119	11,119	11,964	11,964
Maternal and Child Health - Physician & Professional Services - Children - Medicare	9/1/2007	27.50%	11,116	11,116	11,961	11,961
Maternal and Child Health - Physician & Professional Services - Children - Total			11,116	11,116	11,961	11,961
Maternal and Child Health - Physician & Professional Services - Adults - Children/Adults Parity	9/1/2007	12.50%	136,538	136,538	146,191	146,191
Maternal and Child Health - Physician & Professional Services - Adults - Medicare	9/1/2007	12.50%	136,510	136,510	146,161	146,161
Maternal and Child Health - Physician & Professional Services - Adults - Total			136,515	136,515	146,167	146,167
Mental Health (MH) Targeted Case Management	9/1/2004	New Service	85,431	35,317	91,701	38,386
MH Rehabilitative Services	9/1/2004	New Service	563,599	232,992	604,143	252,894
NorthSTAR -- Medicaid Inpatient Hospital - Standard Dollar Amount (SDA) Rebasing	9/1/2008	14.00%	19,572	8,091	21,009	8,794
NorthSTAR -- MH Rehabilitative Services - Children	9/1/2004	New Service	31,748	13,125	34,160	14,299
NorthSTAR -- MH Rehabilitative Services - Adults	9/1/2004	New Service	13,863	5,731	14,843	6,213
NorthSTAR -- MH Targeted Case Management - Children	9/1/2004	New Service	9,130	3,774	9,823	4,112
NorthSTAR -- MH Targeted Case Management - Adults	9/1/2004	New Service	468	193	501	210
NorthSTAR - Physician & Professional Services - Other	9/1/2007	27.50%	964	399	1,035	433
NorthSTAR - Physician & Professional Services - Medicare	9/1/2007	27.50%	7,469	3,088	8,017	3,356
NorthSTAR - Physician & Professional Services - Total			8,433	3,487	9,052	3,789
NorthSTAR -- Medicaid Institutions for Mental Disease	9/1/2007	32.65%	25,427	10,512	27,294	11,425
Total DSHS (with totals only included)			**1,702,411**	**1,188,900**	**1,822,051**	**1,278,945**

Cost of 1 Percent Rate Increase, continued

Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Incremental Cost of 1 Percent Rate Increase			
			2010		2011	
			AF	GR	AF	GR
HHSC, continued						
Ambulance Services	9/1/2007	55.50%	4,982,584	2,059,800	5,348,306	2,238,801
Ambulatory Surgical Center/Hospital Ambulatory Surgical Center	9/1/2007	2.50%	1,410,202	582,977	1,513,733	633,649
Birthing Centers	9/1/2007	2.50%	3,097	1,280	3,268	1,368
Children & Pregnant Women - Case Management	9/1/2007	55.50%	12,272	5,073	12,949	5,420
Childrens Health Insurance Program (CHIP) (including perinate)			1,688,891	478,294	1,817,246	532,453
CHIP Dental	9/1/2007	41.10%	56,959	16,131	64,654	18,944
CHIP Vendor Drug Dispensing Fee ($9.40 Dispensing Expense + 2%)	9/1/2007	44.80%	201,434	57,046	203,822	59,720
Clinical Laboratory Fees	4/1/2008	2.60%	3,815,266	1,577,231	4,095,307	1,714,295
Dental Services - THSteps - CCP	9/1/2007	52.50%	16,593,268	6,859,657	18,835,019	7,884,339
Drugs/Biological Fees	10/1/2008	3.59%	1,334,121	551,526	1,432,046	599,454
Durable Medical Equipment, Prosthetics, Orthotics, Supplies	Various 2008	10.00%	3,333,896	1,378,233	3,578,604	1,498,004
Family Planning Services - Other	9/1/2007	22.50%	87,182	8,718	93,581	9,358
Family Planning Services - Medicare	9/1/2007	22.50%	348,729	34,873	374,326	37,433
Family Planning Services - Total	9/1/2007	22.50%	435,911	43,591	467,907	46,791
Federally Qualified Health Centers	1/1/2008	Medicare Economic Index (MEI) or MEI+1.5%	925,304	382,521	993,236	415,769
Freestanding Psychiatric Hospitals	1/1/2008	18.18%	1,285,040	531,236	1,382,658	578,781
Home Health Services	11/1/2002	Various	932,622	385,546	1,002,886	419,808
Inpatient Hospital - SDA Rebasing	9/1/2008	14.00%	31,597,095	13,062,239	33,916,829	14,197,585
Medical Transportation Program	6/1/2008	16.77%	934,108	386,160	987,560	413,393
Outpatient Hospital	9/1/2007	2.50%	15,240,792	6,300,543	16,359,710	6,848,175
Physician & Professional Services - Children - Other	9/1/2007	27.50%	1,540,696	636,924	1,603,284	671,135
Physician & Professional Services - Children - Medicare	9/1/2007	27.50%	11,938,708	4,935,462	12,423,694	5,200,558
Physician & Professional Services - Children - Total	9/1/2007	27.50%	13,479,404	5,572,386	14,026,978	5,871,693
Physician & Professional Services - Adults - Children/Adult Parity	9/1/2007	12.50%	1,328,712	549,290	1,437,402	601,696
Physician & Professional Serivces - Adults - Medicare	9/1/2007	12.50%	5,541,567	2,290,884	5,994,873	2,509,454
Physician & Professional Services - Adults - Total	9/1/2007	12.50%	6,870,279	2,840,174	7,432,275	3,111,150
Renal Dialysis Facilities	9/1/2007	2.50%	2,442,054	1,009,545	2,666,740	1,116,297
Rural Health Clinics	1/1/2008	Medicare Economic Index (MEI)	829,302	342,833	890,186	372,632
STAR+PLUS -- Community Based Alternatives without Minimum Wage	9/1/2000	2.20%				
STAR+PLUS -- Community Based Alternatives Minimum Wage Only	8/1/2008	3.82%				
STAR+PLUS -- Community Based Alternatives Total			1,386,144	573,032	1,518,295	635,558

Cost of 1 Percent Rate Increase, continued

Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Incremental Cost of 1 Percent Rate Increase			
			2010		2011	
			AF	GR	AF	GR
HHSC, continued						
STAR+PLUS -- Day Activity and Health Services without Minimum Wage	9/1/2002	1.30%				
STAR+PLUS -- Day Activity and Health Services Minimum Wage Only	8/1/2008	0.66%				
STAR+PLUS -- Day Activity and Health Services Total			364,134	150,533	398,850	166,959
STAR+PLUS -- Primary Home Care without Minimum Wage	9/1/2000	1.20%				
STAR+PLUS -- Primary Home Care Minimum Wage Only	8/1/2007	52.50%				
STAR+PLUS -- Primary Home Care Total			252,807	104,510	276,909	115,914
THSteps Medical Checkups	9/1/2007	27.50%	1,292,883	534,478	1,391,142	582,332
THSteps Personal Care Services - Minimum Wage	8/1/2008	3.78%				
THSteps Personal Care Services - Other	8/1/2008	3.78%				
THSteps Personal Care Services - Total			603,044	249,298	648,876	271,619
THSteps Private Duty Nursing	7/1/2008	15.00%	0	0	0	0
THSteps Therapies	9/1/2007	0.50%	0	0	0	0
TB Clinics	9/1/1996	NA	859	355	922	386
Vendor Drug Dispensing Fee ($9.40 Dispensing Expense + 2%)	9/1/2007	44.80%	2,758,414	1,140,328	2,887,652	1,208,771
Total HHSC (with totals only included)			**115,062,186**	**47,176,556**	**124,154,564**	**51,560,060**
Total HHS			**178,279,362**	**75,453,690**	**188,741,970**	**80,798,697**

Long Term Care

Nursing Facility Fixed Capital Reimbursement

The nursing facility (NF) fixed capital asset use fee rate component (use fee) is intended to cover NF costs for building and building equipment depreciation and lease expenses, leasehold improvements amortization and mortgage interest.

Under the current use fee determination methodology, the value of the Fixed Capital Asset Use Fee is calculated as follows.

1. The eightieth percentile value of all the facilities' allowable appraised property values per licensed bed (including land, buildings and other improvements) is determined.
2. The eightieth percentile value from step 1 is inflated forward to the rate period. The eightieth percentile value is inflated by one-half of the forecasted increase in the Personal Consumption Expenditure (PCE) chain-type price index.
3. The annual use fee is determined from the composite future capital value from step two by multiplying it by an annual use rate of 14 percent.
4. The annual use fee is converted into a per resident per day (per diem) value and adjusted to account for utilization (occupancy). To adjust for occupancy, the annual use fee per bed is divided by number of calendar days in the rate year multiplied by the higher of either 85 percent occupancy or the statewide average percent occupancy during the cost-reporting period.

Updated February 3, 2009

The use fee is limited to the lesser of the fee as calculated above or the fee as calculated by inflating the fee from the previous rate year by the forecasted rate of change in the PCE chain-type price index (the PCE chain type price index when used to determine the rate is referred to as the "capped" fee).

This methodology has been in place since 1990 and the fee has been limited to the prior year's fee plus general inflation (i.e., "capped") since 1996. For the 2010-2011 biennium, the uncapped fee is projected at $9.57 per day of service while the "capped" fee is projected at $6.75 per day of service. The difference between the uncapped and capped fees is projected at $2.82 per day of service.

HHSC and NF providers believe that there is a need to redesign the rate methodology for the fixed capital asset costs to adequately fund the physical plant requirements of the NF provider base and to ensure an adequate supply of NF beds for Medicaid recipients in the future. The current fee covers the fixed capital asset costs of 45.4 percent of NFs and conversely 54.6 percent of NFs currently have fixed capital asset costs greater than the current fee. Because of this situation, NFs generally cannot afford to make major improvements to their facilities.

In August, 2008, HHSC convened a workgroup of NF providers and agency staff to develop proposals for modifying the use fee to be effective September 1, 2009. The workgroup's parameters for any revised fixed capital methodology include that it must be administratively feasible, based upon data that is verifiable, provide incentives for maintenance, upgrades and modernizations of physical plants, and have a reasonable price tag. The workgroup is still exploring options for redesign of the use fee within the parameters described above. The 2010-2011 Consolidated Budget request includes $50.3 million general revenue for the 2010-2011 biennium to fund a modified use fee.

Comparison of Nursing Facility Medicaid Rates to Private Pay Rates

Data from nursing facility provider's Fiscal Year (FY) 2006 cost reports show the average daily payment for a Medicaid recipient was $104.89, whereas the average daily payment for a private pay resident was $112.92 and the average daily payment for a Medicare resident was $312.48. A comparison of Nursing Facility Medicaid rates to estimated private pay amounts is detailed below in Table VII.2.

Table VII.2

Comparison of Nursing Facility Rates
FY 2006

Procedure Description	Average Medicaid Fee	Average Private Pay	% Medicaid to Average Private Pay
Nursing Facility	$104.89	$112.92	92.9%

Nursing Facility Conversion from the Texas Index for Level of Effort to the Resource Utilization Group Classification System

Effective September 1, 2008, HHSC replaced the Texas nursing facility Texas Index for Level of Effort (TILE) case mix system with the federal Resource Utilization Group (RUG) case mix system for purposes of nursing facility reimbursement.

The TILE system is based on data from 1987 and does not reflect changes in practice patterns and resident characteristics over the past 20 years. The RUG system is a case mix classification system that uses data from the federal minimum data set (MDS) form which all nursing facilities are required to complete. The RUG system is periodically updated by the federal government. At present, the RUG system is based on data from 1995 and 1997, and the federal Centers for Medicare and Medicaid Services (CMS) is in the midst of a data collection that will further update the RUG model in the next few years.

In order to ease the transition from the TILE to the RUG system, HHSC adopted an 8.5 percent rate increase for the resident care cost areas and a 2.5 percent rate increase for the non-resident care cost areas for FY 2009. HHSC instituted a one year TILE to RUG transition hold harmless feature to ensure that no nursing facility receives a lower average Medicaid per diem payment under the RUG system in FY 2009 than it received under the TILE system in FY 2008. This hold harmless feature will be in effect during FY 2009 only.

The hold harmless feature incorporates two hold harmless payments and a final settle-up. HHSC estimates that the hold harmless feature will cost approximately $5.1 million general revenue / $13.0 million all funds for FY 2009.

Minimum Wage and Attendant Wages

The federal minimum wage increased by $0.70 in late July 2007, by another $0.70 in July 2008 and will increase by an additional $0.70 in July 2009. Prior to July 2007, the federal minimum wage was equal to $5.15 per hour; after July 2009, it will be equal to $7.25 per hour, an increase of 40.7 percent.

This 2010-2011 Consolidated Budget includes requests for funding rate increases required to address increased provider expenses due to compliance with the July 2009 minimum wage increase as follows: rates for all legacy Texas Department of Human Services (DHS) programs are increased to allow for an $0.80 per hour increase in attendant compensation costs and rates for Nursing Facilities (NFs), Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR), and the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) waiver programs are increased to allow for a $0.40 per hour increase in attendant compensation costs.

The $0.80 per hour increase is based on the increase required to maintain the attendant cost area base rate at the new minimum wage plus 10.25 percent for payroll taxes and benefits and a 4.4 percent incentive factor for Primary Home Care Non-Priority (PHC NP), which is the DADS program with the lowest paid attendants. The current PHC NP attendant cost area rate is $7.54. The minimum wage effective July 24, 2009 will be $7.25. The July 2009 minimum wage plus

payroll taxes, benefits and the incentive factor equals $8.34 ($7.25 * 1.1025 * 1.044). The required increase is equal to $8.34 - $7.54 or $0.80 per unit of service.

The PHC NP rate increase is applied to all other legacy DHS attendant programs in order to maintain the current rate differentials for attendant care among these various programs. These rate differentials exist because of the programs' varying service delivery requirements and the varying educational, training and experience requirements for attendants in these programs. For programs where the unit of service is one hour, the rate increase is equal to $0.80; for programs where the unit of service is a half day or full day, the rate increase is equal to $0.80 times the average number of attendant hours included in a unit of service.

For the NF, ICF/MR, HCS, and TxHmL programs, requested minimum wage rate increases are based on the cost of increasing the wages of the lowest paid direct care workers by $0.40 to maintain half of the existing wage differential between these programs and the community care programs addressed above. These programs' current attendant-type employees are already paid significantly more than attendants in the community care programs which allows for a decrease in the differential.

Table VII.3 below shows projected hourly wages for attendants in the two largest attendant programs (PHC NP and CBA) starting with the average hourly wage reported on 2006 Texas Medicaid Cost Reports and ending with the average hourly wages supported by the rates incorporated in the 2010 - 2011 Consolidated Budget request. As can be seen in the table below, the average hourly wage for PHC NP is projected to be $7.80 per hour if the 2010 - 2011 Consolidated Budget request is fully funded while the average hourly wage for CBA attendants is projected to be $7.72 per hour. Refer to Chapter VIII, Appendix A2 for detailed schedule of Attendant Wages per Hour and Cost of Increasing Attendant Wages by $1.00 per Hour.

Table VII.3

Projected Hourly Wages for Attendant Services
PHC-NP and CBA

	2006 Hourly Wage	Minimum Wage (MW) Related Rate Increases Per Hour				9/1/07 Not Related to Minimum Wage	Total Increase	Total Increase Less Payroll Taxes and Benefits and Mark-Up*	2006 Hourly Wage + Rate Inc.
		8/1/07	9/1/07	8/1/08	8/1/09				
Primary Home Care Non-Priority	$6.00	$0.15	$0.12	$0.79	$0.80	$0.21	$2.07	$1.80	$7.80
Community Based Alternatives	$6.56	$0.15	$0.12	$0.40	$0.80	$0.26	$1.73	$1.56	$8.12

Funding for August 2009 Minimum Wage Rate Increases.

The final increase in the federal minimum wage will occur July 24, 2009 and rates for those DADS long term care programs with the lowest paid attendants will have to be increased August 1, 2009 to enable providers in these programs to pay wages in compliance with the required federal minimum wage. Funding for these rate increases was not included in the 2008-09 appropriations for these programs and may need to be provided through supplemental appropriations for the 2008-2009 biennium. Cost estimates will be available in the spring of 2009. The impacted programs are Primary Home Care, Community Based Alternatives, Day Activity & Health Services, Community Living Assistance Support Services, Deaf-Blind with Multiple Disabilities, Medically Dependent Children Program, Residential Care, CBA Assisted Living / Residential Care, Community Attendant Services, Consolidated Waiver, and Non-Medicaid Services Title XX. The minimum wage impact is expressed separately in rate increase request included in the 2010-2011 Consolidated Budget for these programs.

Direct Care Staffing and Compensation Rate Enhancements

HHSC currently operates three reimbursement related programs designed to incentivize increased compensation for staff providing direct care in long term care programs operated by the Department of Aging and Disability Services (DADS).

The Attendant Compensation Rate Enhancement is designed to incentivize increased compensation (salaries/wages, payroll taxes and benefits) for attendants working in the Primary Home Care, Community Based Alternatives (CBA), Community Living Assistance and Support Services, Day Activity & Health Services, Deaf-Blind Multiple Disabilities Waiver, Residential Care, and CBA Assisted Living / Residential Care programs. This rate enhancement provides up

to $1.00 per hour additional funding for attendant compensation for providers who commit to spend the additional funding on attendant compensation. Participating providers failing to meet their spending requirements are subject to recoupment of unspent funds. The Attendant Compensation Rate Enhancement has been in effect since FY 2001. The 2010-2011 Consolidated Budget includes $26 million general revenue for the biennium to increase available funding from $1.00 per hour to $1.25 per hour additional funding for attendant compensation.

The Nursing Facility (NF) Direct Care Staff Rate Enhancement is designed to incentivize increased compensation and staffing levels for direct care staff (e.g., Registered Nurses, Licensed Vocational Nurses, Medication Aides and Certified Nurses Aides) in NFs. This program provides up to $9.18 per day of additional funding for direct care staff hours and compensation for providers who commit to spend the additional funding on direct care staff. Participating providers failing to meet their staffing and spending requirements are subject to recoupment of funds associated with unmet requirements. The NF Direct Care Staff Rate Enhancement has been in effect since mid-FY 2000. Current funding for the rate enhancement is not adequate to allow all interested NF providers to participate at their optimum level. The 2010 -2011 Consolidated Budget includes $47.9 million general revenue for the biennium to fully fund the NF Direct Care Staff Rate Enhancement for all interested NF providers.

The Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) program and the Home and Community-based Services (HCS) waiver program are currently subject to fiscal accountability through their rate determination methodology. Providers are required to spend a minimum percentage of the direct care portion of their rates on direct care compensation. If a provider does not meet its spending requirements, funds associated with unmet requirements are recouped. All providers in these programs receive the same direct care portion of the rates and cannot receive additional funds for direct care staff compensation as is the case for the Attendant Compensation Rate Enhancement and the NF Direct Care Staff Rate Enhancement; rather, spending requirements are applied to the base rate paid to all providers. In another difference from the two rate enhancement programs, participation in fiscal accountability is mandatory for all ICF/MR and HCS providers.

The ICF/MR and HCS fiscal accountability system is overly complex, contentious, and more expansive than the rate enhancement systems. The 2010-2011 Consolidated Budget includes $2.8 million general revenue for the biennium to convert these two programs from their current fiscal accountability systems and to include TxHmL in a system similar to the Attendant Compensation Rate Enhancement. Refer to Chapter VIII, Appendix A3 for Impact of Increasing Direct Care/Attendant Rate Enhancement.

Home and Community-Based Services Monthly Fee

HHSC establishes rates for community-based waiver services to persons with mental retardation through the Home and Community-based Services (HCS) waiver program. Under this waiver, providers are currently reimbursed approximately $938 per client per month under an "Administration and Operations" fee (Fee). This Fee is meant to help cover the administrative and overhead costs incurred by the provider.

During the renewal of the HCS waiver program, the federal Centers for Medicare and Medicaid Services (CMS) informed HHSC that the monthly Fee could not be claimed as a separate item of reimbursement because the services covered by the fee are not considered a waiver service. CMS further stated that the costs for administrative overhead for waiver services should be included within the rates for the specific waiver services. CMS reported that it could not approve the HCS waiver renewal without a plan in place with a firm timeline to redistribute the monthly Fee by allocating administration and operations costs to the associated specific waiver services. This means that administrative and/or operations reimbursement amounts must be included in the rates for covered waiver services, such as residential care, foster care, respite, supported home living, supported employment, nursing, day habilitation and therapies, and that they can no longer be reimbursed to providers through a separate monthly fee.

To explore ways to address CMS' concerns, HHSC solicited nominations from provider associations and advocates for individuals to participate on a workgroup to explore options for redistributing the Fee. The workgroup included residential and foster care providers and advocates. The workgroup met and developed an option for HHSC's consideration based on data provided by workgroup members related to their input regarding the amount of administrative and operations effort related to the delivery of each of the waiver services. HHSC met separately with additional foster care providers to solicit their input into options for redistributing this fee because of concerns raised by these providers.

Data provided by workgroup members and the additional foster care providers was combined for use in developing options for redistribution of the Fee to the waiver service rates. The data collected represent approximately equal percentages of residential units of service and foster care units of services (i.e., 25 percent of total residential units and 23 percent of total foster care units) delivered in Texas.

To date, no decision has been made on how this Fee will be redistributed. HHSC is still reviewing the data and considering possible options and the effects of this change in payment structure on participating providers. Once a decision is made on which option to pursue, HHSC will work with the workgroup and other interested parties to develop an implementation plan to come into compliance with CMS requirements.

Equalization of Texas Home Living and Home and Community-Based Services Rates

The Texas Home Living (TxHmL) waiver for persons with mental retardation provides services that are the same as many of the services provided in the Home and Community-based Services (HCS) waiver, but the current payment rates differ. This Consolidated Budget includes a request for funds to increase TxHmL rates to parity with HCS rates for similar services. Increasing TxHmL payment rates to parity with HCS rates will increase payment equity between the two programs, enable simplification of the HCS / TxHmL cost report, and allow the inclusion of TxHmL into an accountability system along with HCS. Initial analyses show that the cost to make the TxHmL rates equal to the HCS rates would be $4.2 million all funds/$1.7 million general revenue for fiscal year 2010. In addition to this rate increase, the current client specific cost ceiling will need to be increased to ensure that clients will continue to receive current services without a reduction in services as the rates are increased.

Foster Care and Intensive Psychiatric Transition Program Access to Care Issues

At any given time, there are approximately 18,000 to 20,000 children in foster care. Many of those children are appropriate for placement in one of the 9,500 foster family homes, but some of them require services provided by residential treatment centers or other facilities. In addition, children have other placement needs, such as being placed with siblings and in close proximity to relatives and schools.

Statewide, the percentage of children placed in an out-of-home region increases as the child's service level increases. Placement data as of March 31, 2008 shows that 16 percent of children in the basic service level are placed outside their home region, 28 percent in the moderate service level, 46 percent in the specialized service level, and 65 percent in the intense service level. Some out-of-home region placements are due to the child being placed with relatives, but the majority is due to inadequate capacity in the home region.

One of the more dramatic capacity challenges for foster youth includes a small, but highly publicized number who have had to stay overnight in Department of Family and Protective Services (DFPS) offices (or other locations supervised by DFPS staff) because no immediate and appropriate placement was available. This group is comprised mostly of older youth with challenging behaviors that many foster care providers are reluctant to accept. A sub-set of these children who temporarily stay in offices are children who upon discharge from psychiatric hospitals have no immediate and appropriate placement options available. This is particularly significant since the 80th Legislature approved a new psychiatric step-down program, also known as Intensive Psychiatric Transition program, intended to serve these youth transitioning from inpatient psychiatric care into less restrictive settings that are appropriate to meet their needs.

The step-down program was originally funded to serve an average of 56.5 full-time equivalent children per month in FY 2008. Since the inception of this new program, the average served per month has been 8.1 full-time equivalent children. DFPS has only three contractors participating in the step-down program, with only one contract actively participating in serving children. To date, 86 children have been referred. Of the 86 referred, 44 were not accepted for placement and 42 have been served. The current rate for this service is $374.33 per day.

In 2007, Residential Child Care Licensing Standards were rewritten for the first time in 18 years, which increased the licensing requirements for providers of foster care, and brought about cost increases for many providers.

Apportioning Rate Increases Pro Rata

In the event that appropriations are not adequate to fully fund payment rate increases included in this 2010-2011 Consolidated Budget estimate for a specific program and no direction is given by the Legislature as to Legislative intent on the distribution of appropriated funds across services and cost areas (e.g., direct care versus indirect care) within that program, HHSC will distribute appropriated funds for the program proportionally based on each of the program's service type's and cost area's ratio of rates as determined in accordance with published reimbursement methodology to existing payment rates.

For example, if the 2010-2011 Consolidated Budget included estimated rate increase of 10 percent for Program A and Program A's rates were comprised of two cost centers: one a direct care cost center and one an indirect cost center. The 10 percent estimated rate increase is a total rate increase for the program, comprised of a 20 percent increase for direct care costs and a 5 percent increase for indirect costs (based on a calculation of the rates at the time the request was determined). If funds were appropriated to cover 50 percent of the estimated rate increase (i.e., a 5 percent rate increase overall), the direct care cost center would increase 10 percent (50 percent of the 20 percent increase) and the indirect cost center would increase 2.5 percent (50 percent of the 5 percent increase).

Status of Work Related to House Bill 2540

House Bill (H.B.) 2540, 80th Legislature, Regular Session, 2007, requires HHSC to develop and implement a pilot project to simplify, streamline, and reduce costs associated with Medicaid cost reporting and auditing for private intermediate care facilities for persons with mental retardation (ICFs/MR) and home and community-based services (HCS) providers. The bill also required HHSC to submit a report to the Legislature not later than September 1, 2012 that evaluates the operation of the pilot project and makes recommendations regarding the continuation or expansion of the pilot project.

H.B. 2540 required that the HHSC Executive Commissioner appoint a workgroup to be responsible for developing and proposing cost report forms and processes, audit processes, and rules necessary to implement the pilot. This workgroup was formed in January, 2008 and includes representatives of public and private providers of ICF/MR and HCS services, experienced cost report preparers, accounting firms, commission staff, and other interested stakeholders.

The workgroup met 5 times beginning in January, 2008 (three times in person and twice through internet-based conferencing). It developed pilot cost report forms and instructions, and it recruited provider volunteers to complete the pilot cost reports.

The pilot began June 23, 2008 when 90 ICF/MR and HCS pilot volunteers were notified by e-mail how to download the pilot reports and instructions from the HHSC website. Completed reports were due back to HHSC by August 11, 2008. The completed reports were then either desk reviewed for field audited by the HHSC Office of Inspector General auditors during the months of August through October 2008. The workgroup will analyze pilot results with a goal of submitting a report evaluating the pilot to the HHSC Executive Commissioner and the Legislature by December 31, 2008.

Hospitals

Change in the Diagnosis-Related Group Classification System

The Centers for Medicare and Medicaid Services (CMS) adopted a Medicare Severity – Diagnosis-Related Group (MS-DRG) classification system for the Medicare inpatient prospective payment program effective October 1, 2007. The Health and Human Services Commission (HHSC) adopted the new MS-DRG listings on October 1, 2007, to use in the Medicaid inpatient hospital prospective payment system. The previous version of the Medicare DRG listing had 540

valid DRG codes for billing purposes. The new Medicare DRG listing has 745 valid DRGs. CMS developed and HHSC adopted the expanded DRG listing in an effort to better recognize severity of illness among patients reimbursed in the prospective payment system.

Outpatient Hospital Rates – Increasing to 100 Percent of Cost

Currently HHSC pays outpatient hospital providers a defined percent of their allowable costs. Non high volume providers are reimbursed 80.30 percent and high volume providers are reimbursed 84.48 percent of their allowable costs. A high volume provider is defined as a provided who was paid at least $200,000 for outpatient services in calendar year 2004. The amounts reported in this 2010-2011 Consolidated Budget reflect the computation of paying outpatient services to 100 percent of the provider's allowable costs rather than the current methodology of paying either 80.30 percent or 84.48 percent of allowable costs.

Acute Care Services

Physician/Professional Services

The 80th Legislature appropriated funding to increase Medicaid payments by 27.5 percent to physicians and certain other professionals for delivering services to children. The increases were prioritized by the Physician Payment Advisory Committee (PPAC) as follows: elimination of 2.5 percent Medicaid payment reduction in effective since September 1, 2003; Texas Health Steps (THSteps) medical checkups; immunization administration services; and other medical services. Appropriations were also made to increase Medicaid payments by 12.5 percent for delivering services to adults. The increases for adults were for office visits, immunization administration services, anesthesia, and other medical services.

The amounts reported in this 2010-2011 Consolidated Budget for physicians and professional services are subdivided into services to children and services to adults.

Medicare pays all physicians and professionals according to the same fee schedule. Medicaid pays Advanced Practice Nurses (APNs) and Physician Assistants (PAs) at 92 percent of the fee paid to physicians for the same service. Medicaid pays Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs) at 70 percent of the fee paid to psychiatrists and psychologists for the same service.

Medicaid currently pays approximately 72 percent of Medicare for physician and professional services to adults and 75 percent of Medicare for physician and professional services to children. For those Medicaid services that are based on the Medicare reimbursement methodology, the rate increase amounts reflected in this 2010–2011 Consolidated Budget are a result of increasing rates to Medicare rate levels, and they result in an overall 33.33 percent increase for children and a 36.22 percent increase for adults.

The cost to fund the methodology for children is reported separately as "Medicare" and "Other" and as the total for both. "Medicare" refers to updating Medicaid payments to Medicare levels by increasing the primary Medicaid conversion factor for children services ($28.640) to the Medicare conversion factor (2008 = $38.087). "Other" refers to updating Medicaid payments resulting from

fee reviews requested by the Texas Medical Association (TMA) to increase radiology and pathology fees for all providers and not just to physicians with specialties in radiology or pathology as was done effective September 1, 2007, as well as to increase fees for services to children that were not implemented September 1, 2007, because these services were not billed in 2006 (the year used as a basis for fee increases for September 1, 2007).

The cost to fund the methodology for adults is reported separately as "Children/Adults Parity" and "Medicare" and as the total for both. "Children/Adults Parity" refers to updating the primary Medicaid conversion factor for adults ($27.276) to the primary Medicaid conversion factor for children ($28.640) and implementing increases resulting from fee reviews requested by TMA referenced above. "Medicare" refers to updating Medicaid payments to Medicare levels by increasing the Medicaid conversion factor of $28.640 to the Medicare conversion factor (2008 = $38.087).

A comparison of 2008 select physician and professional Medicaid rates to 2008 Medicare rates is detailed in Chapter VIII, Appendix A4, along with the ranking of the procedure code within the top 125 most utilized payments.

Telemedicine services are physician services. Senate Bills 24 and 760, 80th Legislature, Regular Session, 2007, directed HHSC to make policy changes to the Medicaid telemedicine program. Senate Bill 24 instructed HHSC to add office visits as additional telemedicine services for which distant site providers may receive Medicaid reimbursement. Senate Bill 760 directed HHSC to encourage all health-care providers and health-care facilities to provide telemedicine services. HHSC is proposing new policy rules to remove the limitations on the location of the distant site, expand the options for distant site locations and the distant site provider base, as well as expand the distant site professional services to include office visits, pharmacologic management, psychiatric diagnostic interview examinations, and individual psychotherapy. The proposed program policy rules allow any licensed or certified health professional to serve as the patient site provider/presenter and add local health departments as patient site locations. Finally, the rules specify that HHSC will directly reimburse the patient site provider a facility fee only, rather than a professional fee as has been the reimbursement methodology. The proposed changes are to be implemented effective April 1, 2009.

Dental Fees

The 80th Legislature appropriated funding to increase payments by 52.5 percent for dental services. A comparison of the top 20 dental procedures with respect to Medicaid payment utilization for FY 2007 and the 50th percentile fees from the 2007 American Dental Association (ADA) Fee Survey is detailed in Chapter VIII, Appendix A5.

Ambulance Fees

The 80th Legislature appropriated funding to increase Medicaid payments by 55.5 percent to providers. Texas Medicaid reimburses for ground advanced life support (ALS) services at the

same rate as it reimburses for ground basic life support (BLS) services, which is significantly lower than the Medicare reimbursement for ALS services.

Texas air ambulance providers requested that the Medicaid methodology not be the average Medicare Urban/Rural fee, but instead be 130 percent of the Medicare Rural fee since 80 percent or more of Texas meets the Medicare definition of rural. A comparison of the current Medicaid fees and the average 2008 Medicare Urban/Rural Average Fees is detailed in Chapter VIII, Appendix A6. The amounts reported in this 2010–2011 Consolidated Budget for ambulance fees reflect proposed increases to the 2008 Medicaid Urban/Rural Average Fees.

Clinical Laboratory Fees

Federal regulations require that the Medicaid fee for a clinical laboratory procedure code cannot exceed the Medicare fee for that code. Therefore, Medicaid clinical laboratory fees are reviewed each year.

The Department of State Health Services (DSHS) Laboratory is the sole provider of clinical laboratory services for THSteps medical and newborn screenings under a Freedom-of-Choice Exception granted in 1994 by the Health Care Financing Administration [now known as the Centers for Medicare & Medicaid Services (CMS)] in accordance with Section 1915(a) of the Social Security Act and 42 CFR §431.51. That Exception required that the DSHS Laboratory be reimbursed its Medicaid-allowable costs in accordance with OMB A-87, as long as those costs do not exceed the associated Medicare fee for the specific clinical laboratory service. Effective November 1, 2008, the DSHS Laboratory, retaining its Freedom-of-Choice Exception, will seek to be reimbursed the same clinical laboratory fees as all other Texas Medicaid providers of these services and will no longer be cost reimbursed. This change in reimbursement methodology will be sent to CMS for approval in December 2008.

A comparison of the 2008 DSHS Laboratory interim cost per procedure and the 2008 Medicare fee is detailed in Chapter VIII, Appendix A7.

Medical Transportation Program

The Medical Transportation Program (MTP) was transferred from the Texas Department of Transportation (TxDOT) to HHSC on September 1, 2007. The current three-year MTP contracts were executed in the summer of 2006 and were transferred to HHSC as executed. The contract allows for an annual contract unit price adjustment based on the producer price index (PPI), also known as "gasoline unit price," from the Bureau of Labor Statistics. Under the methodology developed by TxDOT in the contract, the contract unit price adjustment for June 2008 represented an increase of 16.77 percent for the contract year. The PPI is not forecast for future anticipated changes, but is a historical index only. Therefore this historical inflation index is used to determine future contract unit price adjustments. If this same methodology is used for the contract unit price adjustment for June 2009 and June 2010 the estimated increases would be an approximate average increase of 18.37 percent for each year of the 2010–2011 biennium. These are estimates as the actual PPIs are not yet available for these time periods. This PPI increase is applied to the total expenses of the contractor, including gasoline, wages, equipment and overhead costs. In comparison, routine inflation as calculated from the Personal Consumption Expenditure

(PCE) chain-type price index from the Bureau of Economic Analysis from FY 2009 to the FY 2010–2011 biennium is forecast at 2.58 percent. The PCE is used for most non-acute care programs to adjust historical costs to the rate period to account for inflation. The PCE also calculates a consumer gasoline and oil forecast, which currently forecasts gasoline costs to remain relatively flat during the biennium.

Additional Audit Resources for Verification of Cost Reports

Recent changes from CMS now mandate that cost reports be collected, reconciled and cost settled for the School- Based Services program, known is Texas as School Health and Related Services (SHARS). Texas also anticipates additional changes from CMS that will modify the cost reporting requirements for Targeted Case Management, Rehabilitation Services, and Early Childhood Intervention services. These federally mandated changes require that the cost reports be audited and/or reviewed annually by audit staff from the HHSC Office of Inspector General (OIG). Current auditing responsibilities for cost reports submitted by other programs already place a strain on the HHSC OIG audit resources to where OIG can not absorb this additional audit work. Additional audit resources were requested in the HHSC Legislative Appropriations Request for the 2010-2011 biennium and are needed to be in compliance with these new auditing requirements so that the work is completed within the specified time frames. Noncompliance with this requirement will place the state at risk of losing eligible federal funds.

VIII. APPENDICES

A1. Rate Schedule – Rate Increase Based on Current Review of Costs

Impact of Rate Increase Based on Current Review of Costs

and

Cost of 1 Percent Rate Increase

KEY - A - Access based
B - Based on rates from other Medicaid programs
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				AF	GR	2010	2011	AF	GR	AF	GR
DADS											
Access and Intake - Mental Retardation Service Coordination	1/1/2002	2.00%	T	34,947,091	12,063,196	3.84%	3.84%	1,288,172	535,879	335,461	139,552
Community Attendant Services without Minimum Wage	9/1/2007	5.49%	CR			0.48%	0.48%	3,594,697	1,495,545		
Community Attendant Services Minimum Wage Only	8/1/2008	8.80%	PA			7.61%	7.61%	56,876,968	23,663,237		
Community Attendant Services Total				691,208,740	283,462,256	8.09%	8.09%	60,471,665	25,158,782	7,474,866	3,109,862
Community Based Alternatives without Minimum Wage	9/1/2007	6.06%	CR			4.80%	4.80%	44,115,240	18,352,775		
Community Based Alternatives Minimum Wage Only	8/1/2008	3.82%	PA			5.16%	5.16%	47,423,238	19,728,964		
Community Based Alternatives Total				862,136,402	343,657,011	9.96%	9.96%	91,538,478	38,081,737	9,190,610	3,823,468
Community Living Assistance and Support Services without Minimum Wage	9/1/2007	4.05%	CR			5.61%	5.61%	17,120,636	7,122,408		
Community Living Assistance and Support Services Minimum Wage Only	8/1/2008	0.23%	PA			4.46%	4.46%	13,610,945	5,662,330		
Community Living Assistance and Support Services Total				286,207,787	114,366,569	10.07%	10.07%	30,731,581	12,784,737	3,051,796	1,269,587
Consolidated Waiver Program without Minimum Wage	9/1/2007	3.73%	B			1.85%	1.85%	174,420	72,561		
Consolidated Waiver Program Minimum Wage Only	8/1/2008	0.23% Habilitation; 3.82% Personal Attendant Svcs. (PAS)	B			4.79%	4.79%	451,667	187,900		
Consolidated Waiver Program Total				8,619,864	3,445,006	6.64%	6.64%	626,087	260,460	94,290	39,226

Impact of Rate Increase Based on Current Review of Costs

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				AF	GR	2010	2011	AF	GR	AF	GR
DADS, continued											
Day Activity and Health Services - Title XIX without Minimum Wage	9/1/2007	1.79%	CR			1.33%	1.33%	2,877,040	1,196,932		
Day Activity and Health Services - Title XIX Minimum Wage Only	8/1/2008	0.66%	PA			2.09%	2.09%	4,521,648	1,881,131		
Day Activity and Health Services - Title XIX Total				203,867,136	74,625,355	3.42%	3.42%	7,398,688	3,078,063	2,163,359	900,018
Deaf-Blind Multiple Disabilities without Minimum Wage	9/1/2007	3.76%	B			4.08%	4.08%	663,783	276,142		
Deaf-Blind Multiple Disabilities Minimum Wage Only	8/1/2007	8.96% Chore; 0.23% Habilitation	B			2.27%	2.27%	369,311	153,638		
Deaf-Blind Multiple Disabilities Total				13,946,036	5,575,706	6.35%	6.35%	1,033,094	429,780	162,692	67,682
Home and Community-based Services without Minimum Wage	9/1/2007	5.00%	CR			3.84%	3.84%	50,346,317	20,945,133		
Home and Community-based Services Minimum Wage Only	NA	NA	PA			0.27%	0.27%	3,563,008	1,482,212		
Home and Community-based Services Total				1,164,054,611	459,708,271	4.11%	4.11%	53,909,325	22,427,344	13,103,936	5,451,496
Hospice Payments (NF Related Only) without Minimum Wage	9/1/2008	4.00%	B			14.90%	14.90%	61,872,304	25,743,267		
Hospice Payments (NF Related Only) Minimum Wage Only	NA	NA	B			1.01%	1.01%	4,171,573	1,735,654		
Hospice Payments (NF Related Only) Total				388,006,894	155,094,664	15.91%	15.91%	66,043,877	27,478,920	4,152,018	1,727,533

Impact of Rate Increase Based on Current Review of Costs

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				AF	GR	2010	2011	AF	GR	AF	GR
DADS, continued											
Intermediate Care Facilities - Mental Retardation without Minimum Wage	9/1/2007	7.50%	CR			3.11%	3.11%	22,841,974	9,502,261		
Intermediate Care Facilities - Mental Retardation Minimum Wage Only	NA	NA	PA			1.53%	1.53%	10,322,985	4,294,358		
Intermediate Care Facilities - Mental Retardation Total				685,176,998	265,842,183	4.64%	4.64%	33,164,959	13,796,619	7,149,508	2,974,194
Medically Dependent Children Program without Minimum Wage	9/1/2007	unknown	B			0.98%	0.98%	941,426	391,645		
Medically Dependent Children Program Minimum Wage Only	8/1/2008	3.82% PAS No Delegation; 3.49% PAS Delegation	B			4.13%	4.13%	3,967,294	1,650,445		
Medically Dependent Children Program Total				83,453,532	33,376,837	5.11%	5.11%	4,908,720	2,042,091	960,611	399,626
Non-Medicaid Services - Title XX without Minimum Wage	9/1/2007	various	CR			1.87%	1.87%	3,385,020	3,385,020		
Non-Medicaid Services - Title XX Minimum Wage Only	8/1/2008	various	PA			4.42%	4.42%	8,003,826	8,003,826		
Non-Medicaid Services - Title XX Total				171,200,419	19,939,806	6.29%	6.29%	11,388,846	11,388,846	1,810,627	1,810,627
Nursing Facility without Minimum Wage	9/1/2008	5.00%	CR			12.40%	12.40%	599,438,725	249,369,191		
Nursing Facility Additional Funds for Fixed Capital	NA	NA	PA			2.50%	2.50%	120,854,582	50,276,047		
Nursing Facility Subtotal without Minimum Wage						14.90%	14.90%	720,293,307	299,645,237		
Nursing Facility Minimum Wage Only	NA	NA	PA			1.01%	1.01%	48,573,095	20,206,406		
Nursing Facility Total				3,807,077,063	1,522,826,000	15.91%	15.91%	768,866,402	319,851,644	48,336,764	20,108,296

Impact of Rate Increase Based on Current Review of Costs

and

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DADS, continued											
Primary Home Care without Minimum Wage	9/1/2007	5.49%	CR			0.47%	0.47%	5,093,042	2,119,149		
Primary Home Care Minimum Wage Only	8/1/2007	0.66%	PA			7.61%	7.61%	82,451,382	34,307,178		
Primary Home Care Total				915,018,533	365,819,834	8.08%	8.08%	87,544,424	36,426,327	10,834,706	4,508,209
Program of All-inclusive Care for the Elderly without Minimum Wage	9/1/2007	various	CD			16.57%	16.57%	13,807,328	5,743,849		
Program of All-inclusive Care for the Elderly Minimum Wage Only	9/1/2007	various	CD			1.75%	1.75%	1,459,960	607,343		
Program of All-inclusive Care for the Elderly Total				61,155,469	24,435,340	18.32%	18.32%	15,267,288	6,351,192	833,211	346,616
Promoting Independence Services without Minimum Wage	9/1/2007	various	B			4.18%	4.18%	8,502,355	3,537,860		
Promoting Independence Services Minimum Wage Only	8/1/2008	various	B			4.98%	4.98%	10,129,939	4,215,102		
Promoting Independence Services Total				168,844,912	67,505,830	9.16%	9.16%	18,632,294	7,752,962	2,034,093	846,393
Texas Home Living Waiver without Minimum Wage	9/1/2007	5.00%	B			39.48%	39.48%	8,010,640	3,332,529		
Texas Home Living Waiver Minimum Wage Only	NA	NA	B			2.58%	2.58%	521,610	216,990		
Texas Home Living Waiver Total				18,490,700	7,389,698	42.06%	42.06%	8,532,250	3,549,519	202,842	84,385
Total DADS (with totals only included)								**1,261,346,150**	**531,394,902**	**111,891,391**	**47,606,770**

Impact of Rate Increase Based on Current Review of Costs

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				AF	GR	2010	2011	AF	GR	AF	GR
DARS											
ECI - Case Management	2/1/2000	New Service	T	29,872,238	12,116,180	6.17%	6.17%	1,835,566	763,771	297,499	123,788
ECI - Development Rehabilitative Services	4/4/2003	62.69%	T	68,860,114	27,929,662	6.17%	6.17%	5,914,453	2,460,976	958,582	398,861
Total DARS								**7,750,019**	**3,224,747**	**1,256,081**	**522,649**
DFPS											
24-Hr. Residential Child Care (Foster Care) - Foster Family	9/1/2007	4.30%	CR	38,613,384	20,830,273	23.27%	23.27%	9,989,725	5,524,367	429,297	237,405
24-Hr. Residential Child Care (Foster Care) - Child Placing Agency	9/1/2007	4.30%	CR	450,071,326	282,083,885	16.83% see note 1	16.83% see note 1	75,447,795	45,591,334	4,488,851	2,713,855
24-Hr. Residential Child Care (Foster Care) - Residental Treatment Facility	9/1/2007	7.00%	CR	161,798,043	112,147,612	39.04%	39.04%	63,314,488	43,489,777	1,707,649	1,168,568
24-Hr. Residential Child Care (Foster Care) - Emergency Shelter	9/1/2007	9.90%	CR	44,017,674	29,847,193	34.73%	34.73%	16,174,103	10,661,987	465,708	306,995
24-Hr. Residential Child Care (Foster Care) - Total All Provider Types	9/1/2007		CR	694,500,427	444,908,963	22.81%	22.81%	164,926,111	105,267,465 see note 2	7,091,505	4,426,823 see note 4
Psychiatric Transition (Intensive Psychiatric Step Down)	New Service	NA	PA	2,457,852	1,861,492	47.70%	47.70%	1,978,571	1,520,337 see note 3	41,477	31,871 see note 5
Subtotal Foster Care								**166,904,682**	**106,787,802**	**7,132,982**	**4,458,694**
Adoption Subsidies	NA	NA	PA	277,666,114	149,753,071	3.84%	3.84%	12,397,125	6,784,542	3,228,418	1,766,808
Total DFPS								**179,301,807**	**113,572,344**	**10,361,400**	**6,225,502**

Note 1 The percentage rate change for 24-Hr. Residential Child Care (Foster Care) - Child Placing Agency is the weighted average of a 23.27 percent increase for the foster family pass-through component of the rate, and a 9.27 percent increase for the Child Placing Agency component.

Note 2 If TANF funding is available, up to $37,841,262 of this amount is eligible for TANF funding; the remaining $67,426,203 must be GR.

Note 3 If TANF funding is available, up to $579,409 of this amount is eligible for TANF funding; the remaining $940,928 must be GR.

Note 4 If TANF funding is available, up to $1,513,039 of this amount is eligible for TANF funding; the remaining $2,913,784 must be GR.

Note 5 If TANF funding is available, up to $12,145 of this amount is eligible for TANF funding; the remaining $19,726 must be GR.

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				AF	GR	2010	2011	AF	GR	AF	GR
DSHS											
Children with Special Health Care Needs (CSHCN) - Outpatient Hospital	NA	NA	B	10,137,569	6,570,093	21.00%	21.00%	913,414	913,414	43,496	43,496
CSHCN - Ambulance Services	9/1/2007	55.50%	B	35,843	23,229	43.49%	43.49%	457,620	457,620	10,523	10,523
CSHCN - ASCs/HASCs	9/1/1995	Changed to Fee Schedule	B	221,031	143,249	36.37%	36.37%	76,391	76,391	2,101	2,100
CSHCN - Dental Services	9/1/2007	52.50%	B	364,403	236,167	25.00%	25.00%	195,559	195,559	7,822	7,822
CSHCN - Durable Medical Equipment, Prosthetics, Orthotics,Supplies	Various 2008	10.00%	B	2,939,119	1,904,823	25.00%	25.00%	4,455,269	4,455,269	178,210	178,210
CSHCN - Drugs/Biologicals	10/1/2008	3.59%	B	31,165,411	20,198,098	5.00%	10.00%	760,414	760,414	100,167	100,167
CSHCN - Inpatient Hospital Rebasing	9/1/2008	14.00%	B	9,169,812	5,942,894	24.46%	24.46%	4,679,067	4,679,067	191,295	191,295
CSHCN - Clinical Laboratory	4/1/2008	2.60%	B	985,680	638,813	3.00%	6.00%	32,181	32,181	7,065	7,065
CSHCN - Nursing	11/1/2002	various	B	5,974	3,872	2.50%	2.50%	1,050	1,050	420	420
CSHCN - Physician & Professional Services - Other	9/1/2007	27.50%	B			4.30%	4.30%	115,093	115,093	2,942	2,942
CSHCN - Physician & Professional Services - Medicare	9/1/2007	27.50%	B			33.33%	33.33%	891,848	891,848	22,797	22,797
CSHCN - Physician & Professional Services - Total				4,713,343	3,054,686	37.63%	37.63%	1,006,941	1,006,941	25,739	25,739
CSHCN - Therapies	9/1/2007	8.41%	B	NA	NA	0.00%	0.00%	0	0	0	0

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				AF	GR	2010	2011	AF	GR	AF	GR
DSHS, continued											
Family Planning - Durable Medical Equipment, Prosthetics, Orthotics,Supplies	Various 2008	10.00%	B	1,127,800	180,448	25.00%	25.00%	313,595	313,595	12,544	12,544
Family Planning - Drugs/Biologicals	10/1/2008	3.59%	B	14,302,008	2,288,321	5.00%	10.00%	1,207,116	1,207,116	159,072	159,072
Family Planning - FQHCs	1/1/2008	Medicare Economic Index (MEI) or MEI+1.5%	B	6,767,930	1,082,869	3.20%	3.20%	234,425	234,425	73,257	73,258
Family Planning - Clinical Laboratory	4/1/2008	2.60%	B	17,874,012	2,859,842	3.00%	6.00%	905,161	905,161	198,801	198,801
Family Planning - Physician & Professional Services - Children - Other	9/1/2007	27.50%	B			4.30%	4.30%	395,554	395,554	10,837	10,837
Family Planning - Physician & Professional Services - Children - Medicare	9/1/2007	27.50%	B			33.33%	33.33%	3,065,118	3,065,118	83,978	83,978
Family Planning - Physician & Professional Services - Children - Total				7,754,436	1,240,710	37.63%	37.63%	3,460,672	3,460,672	94,815	94,815
Family Planning - Physician & Professional Services - Adults - Children/Adults Parity	9/1/2007	12.50%	B			7.99%	7.99%	2,317,636	2,317,636	30,704	30,704

Impact of Rate Increase Based on Current Review of Costs

and

Cost of 1 Percent Rate Increase, continued

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Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Method of Determining Rate Change	Estimated Current Biennial Cost		Percentage Rate Change		Estimated Biennial Cost of Rate Change FY 2010-2011		Estimated Biennial Cost of 1 Percent Rate Increase FY 2010-2011	
				AF	GR	2010	2011	AF	GR	AF	GR
DSHS, continued											
Family Planning - Physician & Professional Services - Adults - Medicare	9/1/2007	12.50%	B			33.33%	33.33%	9,663,584	9,663,584	237,928	237,928
Family Planning - Physician & Professional Services - Adults - Total				24,243,632	3,878,981	41.32%	41.32%	11,981,220	11,981,220	268,632	268,632
Institutions for Mental Disease	9/1/2007	32.65%	T	17,004,028	6,704,028	6.92%	6.92%	1,655,433	688,730	239,338	99,574
Maternal and Child Health - Clinical Lab	4/1/2008	2.60%	B	8,071,954	4,602,580	3.00%	6.00%	593	593	131	131
Maternal and Child Health - Durable Medical Equipment, Prosthetics, Orthotics,Supplies	Various 2008	10.00%	B	119,059	57,732	25.00%	25.00%	36,223	36,223	1,449	1,449
Maternal and Child Health Drugs/Biologicals	10/1/2008	3.59%	B	49,252	23,882	5.00%	10.00%	4,548	4,548	599	599
Maternal and Child Health - Dental	9/1/2007	52.50%	B	3,710,209	1,799,073	25.00%	25.00%	825,733	825,733	33,030	33,030
Maternal and Child Health - Physician & Professional Services - Children - Other	9/1/2007	27.50%	B			4.30%	4.30%	99,258	99,258	23,083	23,083
Maternal and Child Health - Physician & Professional Services - Children - Medicare	9/1/2007	27.50%	B			33.33%	33.33%	769,139	769,139	23,077	23,077
Maternal and Child Health - Physician & Professional Services - Children - Total				6,013,570	2,916,032	37.63%	37.63%	868,397	868,397	23,077	23,077

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				AF	GR	2010	2011	AF	GR	AF	GR
DSHS, continued											
Maternal and Child Health - Physician & Professional Services - Adults - Children/Adults Parity	9/1/2007	12.50%	B			7.99%	7.99%	2,258,998	2,258,998	282,729	282,729
Maternal and Child Health - Physician & Professional Services - Adults - Medicare	9/1/2007	12.50%	B			33.33%	33.33%	9,421,447	9,421,447	282,671	282,671
Maternal and Child Health - Physician & Professional Services - Adults - Total				23,102,891	7,105,756	41.32%	41.32%	11,680,445	11,680,445	282,682	282,682
Mental Health (MH) Targeted Case Management	9/1/2004	New Service	T	24,941,447	9,962,861	3.84%	3.84%	680,187	283,021	177,132	73,703
MH Rehabilitative Services	9/1/2004	New Service	T	141,226,564	56,412,951	3.84%	3.84%	4,484,130	1,865,802	1,167,742	485,886
NorthSTAR -- Medicaid Inpatient Hospital - Standard Dollar Amount (SDA) Rebasing	9/1/2008	14.00%	B	105,748	42,783	24.46%	24.46%	992,622	413,022	40,581	16,885
NorthSTAR -- MH Rehabilitative Services - Children	9/1/2004	New Service	T	9,614,818	3,889,935	3.84%	3.84%	253,087	105,308	65,908	27,424
NorthSTAR -- MH Rehabilitative Services - Adults	9/1/2004	New Service	T	17,596,746	7,119,240	3.84%	3.84%	110,230	45,866	28,706	11,944
NorthSTAR -- MH Targeted Case Management - Children	9/1/2004	New Service	T	3,726,838	1,507,793	3.84%	3.84%	72,780	30,283	18,953	7,886

Impact of Rate Increase Based on Current Review of Costs

and

Cost of 1 Percent Rate Increase, continued

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Program by Budget Agency	Date of Last Rate Increase	Percent of Last Rate Increase	Method of Determining Rate Change	Estimated Current Biennial Cost		Percentage Rate Change		Estimated Biennial Cost of Rate Change FY 2010-2011		Estimated Biennial Cost of 1 Percent Rate Increase FY 2010-2011	
				AF	GR	2010	2011	AF	GR	AF	GR
DSHS, continued											
NorthSTAR -- MH Targeted Case Management - Adults	9/1/2004	New Service	T	2,768,555	1,120,094	3.84%	3.84%	3,723	1,549	969	403
NorthSTAR - Physician & Professional Services - Other	9/1/2007	27.50%	M,CD			4.30%	4.30%	67,305	28,006	1,999	832
NorthSTAR - Physician & Professional Services - Medicare	9/1/2007	27.50%	M,CD			33.33%	33.33%	521,542	217,009	15,486	6,444
NorthSTAR - Physician & Professional Services - Total				60,615,858	24,523,789	37.63%	37.63%	588,847	245,015	17,485	7,276
NorthSTAR -- Medicaid Institutions for Mental Disease	9/1/2007	32.65%	B	49,365	19,972	6.92%	6.92%	364,657	151,731	52,721	21,937
Total DSHS (with totals only included)								**53,301,730**	**47,926,360**	**3,524,462**	**2,467,845**

The amounts shown for DSHS for Children with Special Health Care Needs (CSHCN), Family Planning and Maternal and Child Health programs in the "Estimated 2008-2009 Biennial Cost" all funds (AF) column include expenditures used in the computation of maintenance of effort requirements of the federal government. The amounts computed for the "estimated Cost of Rate Change" and "Estimated Biennial Cost of 1 Percent Rate Increase" are computed showing the general revenue cost of the rate increases and not the amounts needed for maintenance of effort requirements.

HHSC											
Ambulance Services	9/1/2007	55.50%	M	130,648,854	52,873,592	43.49%	43.49%	449,290,416	186,946,167	10,330,890	4,298,601
Ambulatory Surgical Center/Hospital Ambulatory Surgical Center	9/1/2007	2.50%	M	262,894,534	106,630,023	43.94%	43.94%	128,480,748	53,459,820	2,923,935	1,216,626
Birthing Centers	9/1/2007	2.50%	M	588,016	238,499	37.00%	37.00%	235,470	97,971	6,365	2,648

Impact of Rate Increase Based on Current Review of Costs

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				AF	GR	2010	2011	AF	GR	AF	GR
HHSC, continued											
Children & Pregnant Women - Case Management	9/1/2007	55.50%	B	1,730,470	700,322	3.84%	3.84%	96,851	40,296	25,221	10,493
Childrens Health Insurance Program (CHIP) (including perinate)			T	286,725,478	116,037,800	Trend	Trend	102,238,950	29,778,719	3,506,137	1,010,747
CHIP Dental	9/1/2007	41.10%	T	4,476,202	1,267,660	25.00%	25.00%	3,040,333	885,691	121,613	35,075
CHIP Vendor Drug Dispensing Fee ($9.40 Dispensing Expense + 2%)	9/1/2007	44.80%	PA	285,933,964	80,976,499	21.68%	21.53%	8,755,378	2,549,604	405,256	116,766
Clinical Laboratory Fees	4/1/2008	2.60%	M	711,232,840	287,835,930	3.00%	6.00%	36,017,637	15,017,465	7,910,573	3,291,526
Dental Services - THSteps - CCP	9/1/2007	52.50%	A,CD	1,026,124,682	415,272,658	25.00%	25.00%	885,707,178	368,599,900	35,428,287	14,743,996
Drugs/Biological Fees	10/1/2008	3.59%	A,M	203,552,270	82,377,604	5.00%	10.00%	20,991,063	8,752,172	2,766,167	1,150,980
Durable Medical Equipment, Prosthetics, Orthotics, Supplies	Various 2008	10.00%	CD,M	621,497,018	251,519,844	25.00%	25.00%	172,812,503	71,905,907	6,912,500	2,876,237
Family Planning Services - Other	9/1/2007	22.50%	A,CD,M			6.72%	6.72%	6,075,470	607,547	180,763	18,076
Family Planning Services - Medicare	9/1/2007	22.50%	A,CD,M			26.89%	26.89%	24,301,882	2,430,188	723,055	72,306
Family Planning Services - Total	9/1/2007	22.50%	A,CD,M	81,261,586	32,886,564	33.61%	33.61%	30,377,352	3,037,735	903,818	90,382
Federally Qualified Health Centers	1/1/2008	Medicare Economic Index (MEI) or MEI+1.5%	T	172,498,186	69,965,264	3.20%	3.20%	6,139,326	2,554,525	1,918,540	798,290
Freestanding Psychiatric Hospitals	1/1/2008	18.18%	T,M	239,038,249	96,953,914	7.36%	7.36%	19,638,217	8,171,367	2,667,698	1,110,017
Home Health Services	11/1/2002	Various	A,CD,M	162,370,664	65,711,408	2.50%	2.50%	4,838,771	2,013,385	1,935,508	805,354

Impact of Rate Increase Based on Current Review of Costs

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Cost of 1 Percent Rate Increase, continued

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HHSC, continued											
Inpatient Hospital - SDA Rebasing	9/1/2008	14.00%	BR	7,562,476,366	3,027,310,551	24.46%	24.46%	1,602,470,581	666,775,288	65,513,924	27,259,824
Medical Transportation Program	6/1/2008	16.77%	T	242,923,926	98,311,313	18.37%	36.74%	53,442,516	22,281,807	1,921,668	799,553
Outpatient Hospital	9/1/2007	2.50%	CD	2,841,198,615	1,152,390,158	21.00%	21.00%	663,610,534	276,123,075	31,600,502	13,148,718
Physician & Professional Services - Children - Other	9/1/2007	27.50%	M,CD			4.30%	4.30%	120,358,978	50,080,791	3,143,980	1,308,059
Physician & Professional Services - Children - Medicare	9/1/2007	27.50%	M,CD			33.33%	33.33%	932,650,452	388,071,360	24,362,402	10,136,020
Physician & Professional Services - Children - Total	9/1/2007	27.50%	M,CD	2,507,315,870	1,014,710,732	37.63%	37.63%	1,053,009,430	438,152,151	27,506,382	11,444,079
Physician & Professional Services - Adults - Children/Adult Parity	9/1/2007	12.50%	M,CD			7.99%	7.99%	121,632,325	50,609,845	2,766,114	1,150,986
Physician & Professional Serivces - Adults - Medicare	9/1/2007	12.50%	M,CD			33.33%	33.33%	507,283,524	211,074,978	11,536,440	4,800,338
Physician & Professional Services - Adults - Total	9/1/2007	12.50%	M,CD	1,373,532,582	555,868,636	41.32%	41.32%	628,915,849	261,684,823	14,302,554	5,951,324
Renal Dialysis Facilities	9/1/2007	2.50%	CD	111,514,139	45,230,135	25.00%	25.00%	127,719,842	53,146,059	5,108,794	2,125,842
Rural Health Clinics	1/1/2008	Medicare Economic Index (MEI)	T	154,601,176	62,706,237	1.70%	1.70%	2,923,129	1,216,291	1,719,488	715,465
STAR+PLUS -- Community Based Alternatives without Minimum Wage	9/1/2000	2.20%	B			4.80%	4.80%	14,623,261	6,085,006		
STAR+PLUS -- Community Based Alternatives Minimum Wage Only	8/1/2008	3.82%	PA			5.16%	5.16%	14,304,950	5,952,552		

Impact of Rate Increase Based on Current Review of Costs

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				AF	GR	2010	2011	AF	GR	AF	GR
HHSC, continued											
STAR+PLUS -- Community Based Alternatives Total				270,904,022	108,281,507	9.96%	9.96%	28,928,211	12,037,558	2,904,439	1,208,590
STAR+PLUS -- Day Activity and Health Services without Minimum Wage	9/1/2002	1.30%	B			1.33%	1.33%	1,248,496	519,522		
STAR+PLUS -- Day Activity and Health Services Minimum Wage Only	8/1/2008	0.66%	PA			2.09%	2.09%	1,360,908	566,299		
STAR+PLUS -- Day Activity and Health Services Total				88,992,654	35,571,072	3.42%	3.42%	2,609,404	1,085,821	762,984	317,492
STAR+PLUS -- Primary Home Care without Minimum Wage	9/1/2000	1.20%	B			0.47%	0.47%	2,253,626	937,775		
STAR+PLUS -- Primary Home Care Minimum Wage Only	8/1/2007	52.50%	PA			7.61%	7.61%	2,026,473	843,253		
STAR+PLUS -- Primary Home Care Total				468,381,070	187,275,043	8.08%	8.08%	4,280,099	1,781,027	529,716	220,424
THSteps Medical Checkups	9/1/2007	27.50%	A,M	30,153,532	12,203,134	3.00%	3.00%	8,052,077	3,350,431	2,684,025	1,116,810
THSteps Personal Care Services - Minimum Wage	8/1/2008	3.78%	B			4.86%	4.86%	8,567,841	3,565,037		
THSteps Personal Care Services - Other	8/1/2008	3.78%	B			5.70%	5.70%	4,652,436	1,935,856		
THSteps Personal Care Services - Total				54,990,840	22,029,959	10.56%	10.56%	13,220,277	5,500,893	1,251,920	520,917
THSteps Private Duty Nursing	7/1/2008	15.00%	B	599,986,250	242,814,435	0.00%	0.00%	0	0	0	0
THSteps Therapies	9/1/2007	0.50%	A,M	536,953,868	217,305,230	0.00%	0.00%	0	0	0	0
TB Clinics	9/1/1996	NA	M	160,192	64,974	264.09%	264.09%	470,519	195,780	1,781	741
Vendor Drug Dispensing Fee ($9.40 Dispensing Expense + 2%)	9/1/2007	44.80%	PA	4,792,763,440	1,939,631,364	20.82%	20.44%	116,453,781	48,448,916	5,646,066	2,349,099
Total HHSC (with totals only included)								**6,174,766,441**	**2,545,590,644**	**239,216,751**	**98,736,616**
Total HHS								**7,695,366,393**	**3,258,830,152**	**367,021,332**	**156,252,386**

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				AF	GR	2010	2011	AF	GR	AF	GR
DADS - Direct Care Staff Rate Enhancement											
Nursing Facility Direct Care Wage Enhancements	NA	NA	PA	NA	NA	2.39%	2.38%	115,242,989	47,941,084	48,341,833	20,110,419
Community Care Attendant Wage Enhancements	NA	NA	PA	NA	NA	Varies because enhancement encompasses multiple programs		62,578,840	26,032,797	NA	NA
Intermediate Care Facility/Mental Retardation Direct Care Staff Wage Enhancements	NA	NA	PA	NA	NA	0.00%	0.73%	2,695,196	1,128,209	NA	NA
Home and Community-based Services Direct Care Staff WageEnhancements	NA	NA	PA	NA	NA	0.00%	0.76%	5,032,103	2,106,438	NA	NA
Texas Home Living Direct Care Staff Wage Enhancements	NA	NA	PA	NA	NA	0.00%	5.13%	523,000	218,928	NA	NA
Total Direct Care Wage Enhancements								186,072,128	77,427,456	NA	NA
Note: Direct Care Wage Enhancements are proposed to be implemented in FY 2011 for the Intermediate Care Facility/Mental Retardation, Home and Community-based Services and Texas Home Living Programs.											

A2. Rate Schedule – Attendant Wages per Hour and Cost of Increasing Attendant Wages by $1.00 per Hour

Attendant Wages per Hour and Cost of Increasing Attendant Wages by $1.00 per Hour

Program	Attendant Wages per Hour Assumed in FY2009 Rates	Attendant Wages per Hour if Based on FY2010-2011 Consolidated Budget Minimum Wage Estimate *	Attendant Wages per Hour After Estimated Minimum Wage Increase and Increase of $1.00 per Hour	Cost of Increasing Attendant Wages by $1.00 per Hour Plus Associated Payroll Taxes and Benefits **			
				FY 2010		FY 2011	
				All Funds	State	All Funds	State
Nursing Facility	$9.67	$10.03	$11.03	$42,795,136	$17,691,509	$42,794,384	$17,913,729
Hospice (NF-related only)	$9.67	$10.03	$11.03	$3,575,342	$1,478,046	$3,764,442	$1,575,795
Community Based Alternatives (CBA) ***	$7.04	$7.77	$8.77	$49,484,865	$20,457,043	$51,599,728	$21,599,646
Medically Dependent Children Program	$7.04	$7.77	$8.77	$2,721,838	$1,125,208	$2,749,056	$1,150,755
CBA Assisted Living/Residential Care	$7.41	$8.14	$9.14	$1,443,809	$596,871	$1,482,189	$620,444
Residential Care	$6.55	$7.28	$8.28	$347,117	$347,117	$347,117	$347,117
Primary Home Care - NonPriority/Priority ***	$6.55/$7.32	$7.28/$8.08	$8.28/$9.05	$78,547,415	$32,471,501	$84,731,241	$35,468,497
Community Attendant Services	$6.57	$7.30	$8.30	$38,468,479	$15,902,869	$39,750,728	$16,639,655
Family Care	$6.57	$7.30	$8.30	$4,051,390	$4,051,390	$4,051,390	$4,051,390
Client Managed Personal Attendant Services	$6.55	$7.28	$8.28	$706,060	$706,060	$706,060	$706,060
Day Activity and Health Services (DAHS) - Title XIX Medicaid ***	$6.55	$7.28	$8.28	$4,439,443	$1,835,266	$4,633,641	$1,939,642
DAHS - Title XX	$6.55	$7.28	$8.28	$387,967	$387,967	$387,967	$387,967
Community Living Assistance and Support Services	$8.55	$9.28	$10.28	$9,337,820	$3,860,255	$9,431,198	$3,947,899
Deaf Blind Multiple Disabilities Waiver	$8.55	$9.28	$10.28	$483,759	$199,986	$488,593	$204,525

Attendant Wages per Hour and Cost of Increasing Attendant Wages by $1.00 per Hour, continued

Program	Attendant Wages per Hour Assumed in FY2009 Rates	Attendant Wages per Hour if Based on FY2010-2011 Consolidated Budget Minimum Wage Estimate *	Attendant Wages per Hour After Estimated Minimum Wage Increase and Increase of $1.00 per Hour	Cost of Increasing Attendant Wages by $1.00 per Hour Plus Associated Payroll Taxes and Benefits **			
				FY 2010		FY 2011	
				All Funds	State	All Funds	State
Consolidated Waiver Program (CWP) - Habilitation	$8.55	$9.28	$10.28	$34,874	$14,417	$35,224	$14,745
CWP - Personal Attendant Services	$7.04	$7.77	$8.77	$269,953	$111,599	$272,653	$114,133
CWP- Residential Care	$7.41	$8.14	$9.14	$601	$248	$607	$254
CWP - Home & Community-based Residential	$8.11	$8.47	$9.47	$4,326	$1,788	$4,374	$1,831
Home and Community-Based Services	$8.11	$8.47	$9.47	$22,673,027	$9,373,029	$22,673,027	$9,490,929
Intermediate Care Facilities for Persons With Mental Retardation	$8.30	$8.66	$9.66	$13,787,426	$5,699,722	$13,874,225	$5,807,751
Texas Home Living	$8.11	$8.47	$9.47	$721,978	$298,466	$721,978.00	$302,220
Texas Health Steps (TxHSteps) - Personal Care Services	$7.04	$7.77	$8.77	$3,134,139	$1,295,653	$3,372,334	$1,411,659
TxHSteps - Behavioral Personal Care Services	$8.55	$9.25	$10.28	$9,402,418	$3,886,960	$10,117,002	$4,234,977
Total Cost				$286,819,182	$121,792,970	$297,989,158	$127,931,621
FMAP					0.5866		0.5814
State School Attendant - Entry/Average	$9.87/$10.50						

* The third minimum wage increase will be reflected in rate increases effective August 1, 2009, for one month of FY 2009 as well as for FY 2010 - 2011.
** This impact does not include any increases in the numbers of clients in waiver programs for FY 2010-2011.
*** Includes the impact to STAR PLUS.
Note 1 - The wages and impact above do not include the Attendant/Direct Care Wage Enhancements for programs that have enhancement add-on amounts.
Note 2 - The wages above do not include payroll taxes and benefits.

A3. Rate Schedule – Impact of Increasing Direct Care/Attendant Rate Enhancement

Impact of Increasing Direct Care/Attendant Rate Enhancement

Program by Budget Agency	Percentage Rate Change		Estimated Cost of Rate Change				Estimated Biennial Cost of Rate Change	
			2010		2011			
	2010	2011	AF	GR	AF	GR	AF	GR
DADS - Direct Care Staff Rate Enhancement								
Nursing Facility Direct Care Wage Enhancements	2.39%	2.38%	$ 57,621,494	$ 23,820,726	$ 57,621,494	$ 24,120,358	$ 115,242,989	$ 47,941,084
Community Care Attendant Wage Enhancements	Varies because enhancement encompasses multiple programs		31,289,420	12,935,046	31,289,420	13,097,751	62,578,840	26,032,797
Intermediate Care Facility/Mental Retardation Direct Care Staff Wage Enhancements	0.00%	0.73%	0	0	2,695,196	1,128,209	2,695,196	1,128,209
Home and Community-based Services Direct Care Staff Wage Enhancements	0.00%	0.76%	0	0	5,032,103	2,106,438	5,032,103	2,106,438
Texas Home Living Direct Care Staff Wage Enhancements	0.00%	5.13%	0	0	523,000	218,928	523,000	218,928
Total Direct Care Wage Enhancements			$ 88,910,915	$ 36,755,772	$ 97,161,214	$ 40,671,684	$ 186,072,128	$ 77,427,456

Note: Direct Care Wage Enhancements are proposed to be implemented in FY 2011 for the Intermediate Care Facility/Mental Retardation, Home and Community-based Services and Texas Home Living programs.

A4. Rate Schedule – Comparison of Select Physician/Professional Fees

Comparison of Select Physician/Professional Fees					
FY07 Payments Utilization Ranking in Top 125	**Procedure Description**	**Procedure Code**	**Current Medicaid Rate**	**2008 Medicare Rate**	**Medicaid as % of Medicare**
1	Established Patient Office Visit - 15 minutes (Children)	99213	$37.64	$63.99	58.8%
1	Established Patient Office Visit - 15 miinutes (Adults)	99213	$33.95	$63.99	53.1%
2	Personal Care Services in School, Group (SHARS)	T1019-U5-UD	District-specific interim rates; cost settlement	N/A	N/A
3	Vaginal Delivery with postpartum care	59410	$746.03	$903.80	82.5%
4	Established Patient Office Visit - 25 minutes (Children)	99214	$52.86	$96.36	54.9%
4	Established Patient Office Visit - 25 minutes (Adults)	99214	$47.68	$96.36	49.5%
5	Psychosocial Rehabilitation Services, per 15 minutes (MH Rehabilitative Services)	H2017	Various	N/A	N/A
6	Individual Counseling Services by LCSWs and LPCs, per hour	90806	$56.55	$95.60	59.2%
7	FQHC Encounter	T1021	Facility-Specific Rate	N/A	N/A
8	Established patient 1-4 years	99392	$85.07	$85.31	99.7%
9	Established patient under 1 year	99391	$77.75	$76.17	102.1%
10	Cesarean Deliver with postpartum care	59515	$819.10	$1,118.62	73.2%
11	Emergency Department Visit - Moderate Severity (Children)	99283	$61.56	$65.13	94.5%
11	Emergency Department Visit - Moderate Severity (Adults)	99283	$55.52	$65.13	85.2%
12	Neonate Critical Care, Subsequent	99296	$377.68	$404.10	93.5%
13	Subsequent Hospital Care - 25 minutes (Children)	99232	$50.43	$69.70	72.4%
13	Subsequent Hospital Care - 25 minutes (Adults)	99232	$45.48	$69.70	65.3%
14	Pediatric Critical Care, Subsequent	99294	$375.59	$398.77	94.2%

Comparison of Select Physician/Professional Fees, continued					
FY07 Payments Utilization Ranking in Top 125	**Procedure Description**	**Procedure Code**	**Current Medicaid Rate**	**2008 Medicare Rate**	**Medicaid as % of Medicare**
15	Emergency Department Visit - High Severity (Children)	99284	$90.07	$120.74	74.6%
15	Emergency Department Visit - High Severity (Adults)	99284	$81.24	$120.74	67.3%
16	Established patient 5-11 years	99393	$84.72	$84.55	100.2%
17	Subsequent Hospital Care - 35 minutes (Children)	99233	$67.82	$99.79	68.0%
17	Subsequent Hospital Care - 35 minutes (Adults)	99233	$61.17	$99.79	61.3%
18	Personal Care Services in School, Individual (SHARS)	T1019-U5	District-specific interim rates; cost settlement	N/A	N/A
19	Medication Management	90862	$45.54	$56.37	80.8%
20	Established Patient Office Visit - 10 minutes (Children)	99212	$25.04	$39.23	63.8%
20	Established Patient Office Visit - 10 miinutes (Adults)	99212	$22.59	$39.23	57.6%
21	Skills Training and Development, per 15 minutes (MH Rehabilitative Services	H2014	Various	N/A	N/A
27	Established patient 12-17 years	99394	$92.40	$92.93	99.4%
29	New Patient Office Visit - 30 minutes (Children)	99203	$61.56	$97.12	63.4%
29	New Patient Office Visit - 30 minutes (Adults)	99203	$55.52	$97.12	57.2%
30	Subsequent Intensive Care, per day (body weight of 1500-2500 g)	99299	$127.50	$128.73	99.0%
37	Neonate Critical Care, Initial	99295	$869.77	$936.56	92.9%
48	Subsequent Intensive Care, per day (body weight of 2501-5000 g)	99300	$124.50	$126.45	98.5%
49	New patient under 1 year	99381	$84.51	$94.84	89.1%
52	First Vaccine*	90471	$8.00	$21.33	37.5%
58	New patient 1-4 years	99382	$92.47	$102.83	89.9%
62	New patient 5-11 years	99383	$92.09	$101.31	90.9%
69	Subsequent Intensive Care, per day (body weight less than 1500 g)	99298	$159.38	$141.68	112.5%
80	New patient 12-17 years	99384	$100.43	$110.45	90.9%

Comparison of Select Physician/Professional Fees, continued					
FY07 Payments Utilization Ranking in Top 125	**Procedure Description**	**Procedure Code**	**Current Medicaid Rate**	**2008 Medicare Rate**	**Medicaid as % of Medicare**
93	Pediatric Critical Care, Initial	99293	$759.19	$813.92	93.3%
100	Circumcision	54150	$80.48	$197.67	40.7%
110	Eye Exam	92012	$46.40	$74.27	62.5%
	Femoral (leg, above knee) Fracture (Children)	27514	$984.94	$1,069.86	92.1%
	Femoral (leg, above knee) Fracture (Adults)	27514	$1,034.19	$965.89	107.1%
	Coronary Artery Bypass (Children)	33533	$1,647.74	$2,007.95	82.1%
	Coronary Artery Bypass (Adults)	33533	$1,730.13	$2,007.95	86.2%
	Upper GI Endoscopy	43239	$218.23	$342.02	63.8%
	Colonoscopy	45392	$257.49	$373.63	68.9%

* Administration of first vaccine with one toxoid/component = $8.00; with two toxoids/components = $12.00; with three toxoids/components = $16.00 unless under Texas Vaccines for Children Program, which is capped at $14.85.

A5. Rate Schedule – Comparison of Select Dental Fees

Comparison of Select Dental Fees					
FY07 Payments Utilization Ranking in Top 20	Procedure Description	Procedure Code	Current Medicaid Rate	50th Percentile 2007 American Dental Association Fee Survey	Medicaid as a % of 50th Percentile ADA Fee Survey
1	RESIN-BASED COMPOSITE - 1 SURFACE, POSTERIOR - PRIMARY	D2391	$76.98	$129.00	59.7%
1	RESIN-BASED COMPOSITE - 1 SURFACE, POSTERIOR - PERMANENT	D2381	$84.08	$129.00	65.2%
2	PREFAB STNLSS STEEL CRWN PRIMARY	D2930	$76.98	$291.00	26.5%
2	PREFAB STNLSS STEEL CRWN PERMANENT	D2930	$150.00	$291.00	51.5%
3	DENTAL SEALANT PER TOOTH	D1351	$28.82	$40.00	72.1%
4	PERIODIC ORTHODONTC TX VISIT	D8670	$68.10	$150.00	45.4%
5	RESIN-BASED COMPOSITE - 2 SURFACE, POSTERIOR - PRIMARY	D2392	$98.98	$168.00	58.9%
5	RESIN-BASED COMPOSITE - 2 SURFACE, POSTERIOR - PERMANENT	D2392	$110.20	$168.00	65.6%
6	DENTAL PROPHYLAXIS CHILD	D1120	$48.00	$52.00	92.3%
7	PERIODIC ORAL EVALUATION	D0120	$28.44	$36.00	79.0%
8	COMPREHENSVE ORAL EVALUATION	D0150	$36.04	$59.00	61.1%
9	THERAPEUTIC PULPOTOMY	D3220	$87.96	$137.00	64.2%
10	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	D7140	$67.04	$120.00	55.9%
11	IMPACT TOOTH REMOV COMP BONY	D7240	$300.00	$365.00	82.2%
12	TOPICAL FLUOR W/O PROPHY CHI	D1203	$15.00	$28.00	53.6%
13	DENTAL BITEWINGS TWO FILMS	D0272	$23.86	$33.00	72.3%
14	SEDATION (NON-IV)	D9248	$187.50	$125.00	150.0%
15	DENTAL PROPHYLAXIS ADULT	D1110	$56.00	$70.00	80.0%
16	COMPRE DENTAL TX ADOLESCENT	D8080	$2,325.00	$4,500.00	51.7%
17	AMALGAM ONE SURFACE - PRIMARY	D2140	$61.98	$95.00	65.2%
17	AMALGAM ONE SURFACE - PERMANENT	D2140	$65.72	$95.00	69.2%
18	ROOT CANAL THERAPY 3 CANALS	D3330	$624.26	$795.00	78.5%
19	DENTAL PANORAMIC FILM	D0330	$65.08	$85.00	76.6%
20	DENTAL BITEWINGS FOUR FILMS	D0274	$35.32	$48.00	73.6%

A6. Rate Schedule – Comparison of Select Ambulance Fees

Comparison of Ambulance Fees								
Procedure Code	Description	Current Medicaid Fee	2008 Medicare Rural Fee	2008 Medicare Urban Fee	2008 Average Medicare Rural/ Urban Fee	Medicaid as % of 2008 Average Medicare Rural/ Urban Fee	130% of 2008 Medicare Rural Fee	Medicaid as % of 130% 2008 Medicare Rural Fee
A0425	Ground mileage, per mile	$4.50	$6.55	$6.61	$6.58	68.4%	$8.52	52.8%
A0426	Advanced Life Support (ALS), nonemergency transport, Level 1	$200.00	$258.95	$256.44	$257.70	77.6%	$336.64	59.4%
A0427	ALS, emergency transport, Level 1	$250.00	$406.03	$410.01	$408.02	61.3%	$527.84	47.4%
A0428	Basic Life Support (BLS), nonemergency transport	$200.00	$215.80	$213.70	$214.75	93.1%	$280.54	71.3%
A0429	BLS, emergency transport	$250.00	$345.27	$341.92	$343.60	72.8%	$448.85	55.7%
A0430	Conventional air services, transport, one-way, fixed wing	$2,250.00	$4,131.55	$2,754.37	$3,442.96	65.4%	$5,371.02	41.9%
A0431	Conventional air services, transport, one-way, rotary wing	$3,000.00	$4,803.53	$3,202.35	$4,003.00	74.9%	$6,244.59	48.0%
A0435	Fixed wing air mileage, per statute mile	$16.24	$11.54	$7.69	$10.00	162.4%	$15.00	108.3%
A0436	Rotary wing air mileage, per statute mile	$16.24	$30.75	$20.50	$25.63	63.4%	$39.98	40.6%

A7. Rate Schedule – Comparison of Department of State Health Services Laboratory Fees

Comparison of Department of State Health Services Laboratory Fees					
Procedure Code	**Description**	**2008 Medicare Rate per Procedure Code**	**2008 Medicare Rate per DSHS Lab Test**	**DSHS Laboratory Current Interim Cost Rate per Lab Test**	**DSHS Lab as a % of Medicare**
82261	Biotinidase	$13.93	$13.93	$3.11	22.3%
82776	Galactose Transferase Test	$11.44	$11.44	$0.98	8.6%
83021	Hemoglobin Chromotography	$25.23	$25.23	$1.50	5.9%
83498	Assay of Progestrone	$37.95	$37.95	$3.34	8.8%
83788	MS/MS	$25.23	$25.23	$11.83	46.9%
84443	Assay Thyroid Stim Hormone	$23.47	$23.47	$7.34	31.3%
80061	Lipid Panel	$18.72	$44.28	$35.94	81.2%
82465	Cholesterol Serum or Whole Blood-Total	$6.08			
83718	Lipoprotein, direct (HDL Cholesterol)	$11.44			
84478	Triglycerides	$8.04			
82465	Assay, Blood/Serum Cholestrol	$6.08	$17.52	$8.52	48.6%
83718	Lipoprotein, direct (HDL Cholesterol)	$11.44			
83655	Assay of Lead	$16.91	$16.91	$6.45	38.1%
85018	Hemoglobin	$3.31	$21.30	$4.15	19.5%
83020	Hemoglobin Electrophoresis	$17.99			
86592	Blood Serology, Qualitative	$5.96	$5.96	$5.30	88.9%
82947	Glucose Fasting, Random	$5.48	$5.48	$6.80	124.1%
82947	Glucose Post Prandial	$5.48	$5.48	$14.00	255.5%
86689	HIV antibody Blot w/ or w/o oral fluid	$27.05	$27.05	$25.00	92.4%
86701	HIV-1	$12.41	$12.41	$8.50	68.5%
87490	CT additional probe	$28.02	$28.02	$12.00	42.8%
87590	GC additional probe	$28.02	$28.02	$12.00	42.8%
82465	Total Cholesterol	$6.08	$6.08	$6.00	98.7%
83718	HDL	$11.44	$11.44	$3.52	30.8%
84478	Triglycerides	$8.04	$8.04	$5.00	62.2%
88142	Liquid Pap	$28.31	$28.31	$22.00	77.7%
88164	Conventional Pap	$14.76	$14.76	$12.00	81.3%
80061	Lipid Panel	$18.72	$18.72	$28.00	149.6%

B. Increase Capacity of HHS – Community Services

TEXAS Department of Aging and Disability Services

FY 2010-2011 LAR

Increase Capacity for Community Services

(dollars in millions)

Increase Capacity	Est August 2009 clients	% Increase in Capacity	Percent Phase-in		FY 2010			FY 2011			Biennium		
			FY 10	FY 11	Avg. Monthly Caseload	GR	AF	Avg. Monthly Caseload	GR	AF	Caseload as of Aug. 09	GR	AF
Community Based Alternatives (CBA)	26,719	10%	50%	50%	688	$5.4	$12.7	2,004	$15.7	$36.9	2,672	$21.1	$49.6
Comm. Living Asst. & Supp. Svcs. (CLASS)	4,199	45%	50%	50%	472	$8.7	$20.9	1,417	$26.7	$63.6	1,890	$35.3	$84.5
Medically Dep. Children's Program (MDCP)	2,745	30%	50%	50%	206	$4.6	$10.9	618	$13.9	$33.1	824	$18.5	$44.0
Consolidated Waiver Program (CWP)[2]	199	10%	50%	50%	5	$0.1	$0.2	15	$0.2	$0.5	20	$0.3	$0.7
Deaf-Blind w/ Mult. Disab. Waiver (DBMD)	172	5%	50%	50%	2	$0.0	$0.1	6	$0.1	$0.3	9	$0.2	$0.4
Non-Medicaid Services[1]	39,577	5%	50%	50%	495	$1.3	$1.3	1,484	$3.8	$3.8	1,979	$5.1	$5.1
In-Home & Family Support	5,560	15%	50%	50%	209	$0.4	$0.4	626	$1.1	$1.1	834	$1.5	$1.5
Home and Community-Based Svcs. (HCS)	15,516	33%	50%	50%	1,280	$25.4	$61.0	3,840	$76.5	$182.3	5,120	$101.8	$243.3
STARPLUS CBA (MAO only)	3,729	10%	50%	50%	93	$0.9	$2.2	279	$2.8	$6.7	373	$3.8	$8.9
Total	**98,416**	**13.9%**			**3,430**	**$46.9**	**$109.8**	**10,289**	**$140.8**	**$328.2**	**13,719**	**$187.7**	**$438.0**
FTEs							**75.4**			**149.6**			**149.6**

[1] Non-Medicaid Services include the following services: Family Care, Home Delivered Meals, Emergency Response, Adult Foster Care, Special Svcs. for Persons with Disabilities, Residential Care, Client Managed Attendant Care, and Title XX Day Activity & Health Services (DAHS). Waiting/Interest List count is a duplicated count of these services.

[2] CWP draws from waiting/interest lists of five waiver programs: CBA, MDCP, HCS, DBMD, and CLASS.

Incremental acute care as well as prescription drug costs are assumed for all programs except non-Medicaid services and In Home and Family Support.

TEXAS Department of Assistive and Rehabilitative Services

FY 2010-2011 LAR

Increase Capacity for Community Services

(dollars in millions)

Increase Capacity	Current Waiting/ Interest	FY 07 Avg. Annual	Phase in % FY 10	Phase in % FY 11	FY 2010 Annual Caseload	FY 2010 GR	FY 2010 AF	FY 2011 Annual Caseload	FY 2011 GR	FY 2011 AF	Biennium Cumulative Caseload	Biennium GR	Biennium AF
Comprehensive Rehabilitative Services	130	616	50%	50%	65	$1,701,846	$1,701,846	65	$1,701,846	$1,701,846	130	$3,403,692	$3,403,692
Independent Living Services	996	1,529	50%	50%	498	$1,783,054	$1,783,054	498	$1,740,421	$1,740,421	996	$3,523,475	$3,523,475
Total					**563**	**$3,484,900**	**$3,484,900**	**563**	**$3,442,267**	**$3,442,267**	**1,126**	**$6,927,167**	**$6,927,167**
Demographic growth	Current Waiting/ Interest	FY 07 Avg. Annual	Phase in % FY 10	Phase in % FY 11	FY 2010 Annual Caseload	FY 2010 GR	FY 2010 AF	FY 2011 Annual Caseload	FY 2011 GR	FY 2011 AF	Biennium Cumulative Caseload	Biennium GR	Biennium AF
Comprehensive Rehabilitative Services					12	$314,187	$314,187	25	$654,556	$654,556	37	$968,743	$968,743
Independent Living Services					35	$125,315	$125,315	71	$248,132	$248,132	106	$373,447	$373,447
Total					**47**	**$439,502**	**$439,502**	**96**	**$902,688**	**$902,688**	**143**	**$1,342,190**	**$1,342,190**
Combined - End of Year Wait List & Demographic growth	Current Waiting/ Interest	FY 07 Avg. Annual	Phase in % FY 10	Phase in % FY 11	FY 2010 Annual Caseload	FY 2010 GR	FY 2010 AF	FY 2011 Annual Caseload	FY 2011 GR	FY 2011 AF	Biennium Cumulative Caseload	Biennium GR	Biennium AF
Comprehensive Rehabilitative Services					77	$2,016,033	$2,016,033	90	$2,356,402	$2,356,402	167	$4,372,435	$4,372,435
Independent Living Services					533	$1,908,369	$1,908,369	569	$1,988,553	$1,988,553	1,102	$3,896,922	$3,896,922
Total					**610**	**$3,924,402**	**$3,924,402**	**659**	**$4,344,955**	**$4,344,955**	**1,269**	**$8,269,357**	**$8,269,357**

TEXAS Department of State Health Services

FY 2010-2011 LAR

Options to Address Interest / Waiting Lists

(dollars in millions)

Reduce the Length of Time on Waiting/Interest Lists	Current Waiting List	% Recv. Other Svcs.	August 2009 Caseload	Phase in %		FY 2010			FY 2011			Biennium		
				FY 10	FY 11	Annual Caseload	GR	AF	Annual Caseload	GR	AF	Caseload as of Aug. 09	GR	AF
Child & Adolesc. Community Mental Health	412	95%	22,239	100%	100%	206	$1.3	$1.4	206	$1.3	$1.3	206	$2.6	$2.7
Children with Special Health Care Needs (CSHCN)	1,050	100%	3,200	100%	100%	400	$12.3	$12.1	400	$13.2	$13.1	400	$25.5	$25.2
Total for Option II:						**606**	**$13.6**	**$13.5**	**606**	**$14.5**	**$14.4**	**606**	**$28.1**	**$27.9**

Assumptions for Community Mental Health Services:

1. The current waiting list estimate was based on a point in time (December 2007 at 412 clients); the community mental health services for children (under the age of 18) program updates waiting list figures monthly and is experiencing significant growth in the waiting list.
2. The numbers above are annualized figures.
3. Reduces the length of time on the waiting list from 9 months to 5 months.
4. Reduces the December 2007 waiting list by 50.0%.

Assumptions for Children with Special Health Care Needs:

1. Caseload figures are annualized.
2. The current waiting list estimate was based on a point in time (December 2007 at 1050 clients); the CSHCN program updates waiting list figures monthly and is experiencing significant growth in the waiting list.
3. Dollars to sustain clients removed from the waiting list in FY10 would be needed in FY11.
4. Assumes no additional Federal dollars available.
5. Client benefit costs exclude transportation benefit (approximately 1.8% of the total CSHCN health care benefit costs) provided through the Texas Department of Transportation (TxDOT).
6. Assumes 50% of eligible clients (not on waiting list) receive services as CSHCN is a safety net program and payor of last resort. Current rules require removal of clients from the waiting list based on priority groups, with groups 1 & 2 being the most likely to receive services at a higher cost. As one moves through the levels of priority, the need for services and related costs to CSHCN diminishes.
7. Reduces the December 2007 waiting list by 47.6%.

C. Promoting Independence Initiative

The *Promoting Independence Initiative (Initiative)* is the direct result of four public policy actions:

- The United States Supreme Court ruling, *Olmstead v. L.C.*, June 1999, which stated in part…" that individuals living in institutions must be provided community care when the following conditions are met:
    - State's treatment professionals determine that such placement is appropriate;
    - Affected persons do not oppose such treatment; and
    - Placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services…."
- Governor Bush's Executive Order GWB 99-2, September 1999, which began the Texas Initiative by requiring the Health and Human Services Commission (HHSC) to conduct a comprehensive review of all services and support systems available to people with disabilities in Texas ensuring the involvement of consumers, advocates, providers, and relevant agency representatives in this review. Executive Order GWB 99-2 also required that a report of these findings be submitted to the Governor, the Lieutenant Governor and the Speaker of House by January 2001; this report became the first *Promoting Independence Plan (Plan)*. The Plan and Initiative includes specific requirements to provide community options for persons within the *Olmstead* population who are served in large (fourteen or more bed) community Intermediate Care Facilities for Persons with Mental Retardation (ICF/MRs), state mental retardation facilities (state schools), state mental health facilities (state hospitals) and nursing facilities (NFs) who are appropriate for and choose community alternatives.
- Texas statutes enacted in 2001 which codified many of the aspects of the original Plan and appropriations language which created the "Money Follows the Person" policy.
    - S.B. 367 codified many of the aspects of the Plan that impacted the entire health and human services systems, established the Promoting Independence Advisory Committee, and requires updated Plans every two years prior to a new legislative session.
    - S. B. 368 impacts children (0-21 years of age) by emphasizing and providing direction to HHSC and all health and human services agencies regarding the implementation of permanency planning efforts.
- Governor Perry's Executive Order RP-13, April 2002, which enhances the Initiative and directs HHSC to continue its development and implementation of the state's Promoting Independence Initiative and Plan, including revising it on a regular basis. Additionally, Executive Order RP-13 highlights the need for housing, workforce, and permanency planning efforts.

The Initiative has been very successful in shaping long term services and supports public policy since 2001 by providing increased community opportunities for individuals residing in NF, state schools, and large community ICFs/MR and decreasing the number of repeat admissions to state hospitals. Two of the most successful initiatives are:

- "Money Follows the Person" (MFP) which has helped over 16,000 NF residents to move into community Medicaid waiver programs as of August 31, 2008. MFP was recognized by the Council of State Governments with its *2006 Innovation Award*. In addition, the Texas program was the impetus for Congress to include MFP in the Deficit Reduction Act (DRA) of 2005, Section 6071, and providing $1.75 billion in Demonstration awards for states to begin similar programs.
- Promoting Independence provides individuals residing in state schools and large community ICFs/MR expedited access to the Home and Community-based Services (HCS) Medicaid waiver program. Individuals in state schools may be provided a community option within six months of referral and those in large community ICFs/MR within twelve months. Since 1999, and as of August 31, 2008, over 2,000 individuals have chosen a community program.

As stated, Texas' MFP program was codified into federal law by the DRA 2005. Texas applied for a Demonstration award and will receive $18 million in enhanced federal funding through Calendar Year 2011. This project will impact nearly 3,000 individuals with complex medical/functional needs residing in NFs, state schools, and nine or more bed community ICFs/MR by providing them a choice of service settings. The Demonstration includes:

- Two new specialized supports services (Cognitive Adaptation Training and Substance Abuse Services) for individuals with co-occurring behavioral health needs who live in the San Antonio service delivery area.
- An "overnight support service" which will allow an individual with complex medical/functional needs to hire an attendant during normal sleeping hours; this service will be limited to Cameron, Hidalgo, and Willacy counties.
- Assistance to providers of nine or more bed community intermediate care for persons with mental retardation (ICF/MR) who chose to voluntarily close their facilities and take those beds off-line.
- Post-relocation services, which are ongoing contacts with individuals once they have left a nursing facility to help ensure a successful transition to the community.
- Housing initiatives to develop linkages between the long-term services and supports system with the housing system to result in increased dedicated housing voucher for the *Olmstead* population and the development of more integrated, accessible, and affordable housing.

HHSC oversees the Initiative and delegates the daily management to the Department of Aging and Disability Services (DADS). Both HHSC and DADS have exceptional items to meet the overall goals of the Initiative. HHSC has included the following exceptional item:

- **Item Priority 8:** This item requests funding to continue the effort to reduce/eliminate waiting/interest lists in programs at: DADS; the Department of Assistive and Rehabilitative Services (DARS); and the Department of State Health Services (DSHS). Specifically the programs affected are:

- DADS - Home and community waivers, non-Medicaid services, and the In-Home and Family Support (IHFS) programs. The home and community services waivers include: Community-based Alternatives (CBA); Community Living Assistance and Support Services (CLASS); Medically Dependent Children's Program (MDCP); Consolidated Waiver Program (CWP); Deaf-Blind with Multiple Disabilities (DBMD); Home and Community-based Services (HCS); and Texas Home Living (TxHL).
- DARS - Comprehensive Rehabilitation Services and Independent Living Services.
- DSHS - Child and Adolescent Community Mental Health, and Children with Special Health Care Needs (CSHCN).

DADS has included the following four exceptional items:

- **Item Priority 2:** This item will increase Home and Community-based Services (HCS) waiver capacity for individuals choosing to relocate from nine or more bed ICF/MR, allow children who are aging out of the foster care program to access HCS, and increase the capacity of the relocation support activity. This exceptional item requests funding to move 500 persons from nine or more bed community ICF/MRs and to serve 120 children aging out of the foster care program at DFPS into the HCS waiver program by the end of FY 2011. Additionally, this item includes funds to assist 250 additional individuals to relocate from nursing facilities to community settings each year.
- **Item Priority 3:** This item will restore the funding reductions made in Fiscal Year (FY) 2003 for GR services provided by Mental Retardation Authorities (MRAs). These GR services provide much needed, albeit limited, services while individuals wait on various Interest Lists, or for those individuals who do not qualify for Medicaid but are in need for services such as respite and In Home and Family Support. These services help an individual who has an intensive need or who is in crisis to protect the individual's health and safety.
- **Item Priority 4:** This item requests additional funding to provide HCS waiver services to 196 children and adults. There are two initiatives associated with this exceptional item – (1) to reduce the number of children admitted to institutions and (2) to continue to serve individuals in the community who would be at imminent risk of institutionalization in the event of emergencies or crisis situations. This item addresses the increase of children being admitted to state mental retardation facilities (state schools). In FY 2007, 152 children (0-21 years of age) were admitted into state schools. In order to provide less restrictive environments for these individuals, this item seeks to prevent future placements of children into state schools, as well as transition those already residing in these settings to the community. This item also seeks to prevent institutionalization, specifically for those on the interest list with imminent risk associated with their disability. It seeks to provide less restrictive environments through waiver services for these individuals in response to caregivers aging out, in poor health, or passing away.
- **Item Priority 7:** This item will create a new Medicaid waiver for individuals with high cost functional and/or medical needs. There are currently individuals in the DADS 1915(c) waivers who have complex medical conditions that are difficult to treat outside of a hospital setting and in existing programs. With extensive skilled nursing care and medical intervention, these individuals could remain in a home environment. The development of this new waiver would allow the state to provide a high level of nursing services to Medicaid recipients 21 years of age and older who have complex medical needs while maintaining cost neutrality and remaining in the community.

D. Long Term Care Plan

The Texas Health and Human Services Commission (HHSC), pursuant to Section 533.062 of the Texas Health and Safety Code (see Appendix A), approves this proposed Long Term Care Plan for People with Mental Retardation and Related Conditions. Section 533.062 requires the plan to be developed prior to each legislative session and adjusted following legislative action on appropriations for long-term care services. HHSC publishes the plan to reflect the legislative appropriations request for the 1) proposed number of intermediate care facilities for individuals with mental retardation (ICF/MR) beds licensed or approved as meeting license requirements, and 2) proposed capacity of the home and community-based services waiver program for persons with mental retardation or a related condition. As required by Section 533.062 of the Texas Health and Safety Code, the numbers appearing in the tables below are consistent with the projected amounts to be requested by HHSC in the consolidated health and human services budget. Effective September 1, 2004, the Texas Department of Aging and Disability Services (DADS) operates all of the programs included in this report.

This report includes information on the following programs:

- Intermediate Care Facilities for Persons with Mental Retardation or a Related Condition Program (ICF-MR/RC);
- Home and Community-based Services for Persons with Mental Retardation Waiver Program (HCS);
- Texas Home Living Waiver Program (TxHmL);
- Community Living Assistance and Support Services Program (CLASS);
- Deaf-Blind with Multiple Disabilities Waiver Program (DB/MD); and
- Consolidated Waiver Program (CWP).

The World Health Organization (WHO) estimated that the overall prevalence of mental retardation is between 1 percent and 3 percent and that mild mental retardation is much more common than severe mental retardation, accounting for 65 to 75 percent of all persons with mental retardation. The total population of Texas is expected to grow from 24.2 million in 2008 to an estimated 26.1 million in 2012. The priority population of persons with mental retardation is projected to grow from 95,000 in 2008 to 102,000 in 2012.

Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR)
This is a Medicaid funded program that provides services to people with mental retardation and related conditions in residential settings of four or more beds with 24-hour supervision. These services are provided in two settings: state-mental retardation facilities and community facilities.

State Mental Retardation Facilities
State mental retardation facilities provide services to people with mental retardation admitted to eleven state schools and two state centers. State schools are located in Abilene, Austin, Brenham, Corpus Christi, Denton, Lubbock, Lufkin, Mexia, Richmond, San Angelo, and San Antonio. The two state centers, in El Paso and Rio Grande, also provide campus-based mental retardation services. The development of community alternatives is expected to result in decreased demand for state schools. The size and rate of this trend will be a function of the availability of community resources, the capability of the community services infrastructure to expand, and individual choice of services.

Proposed ICF/MR Capacity[2] for State Mental Retardation Facilities			
Average # of persons per month[3]		**Total # of persons per year**	
FY 2010	**FY 2011**	**FY 2010**	**FY 2011**
4,642	4,540	4,792	4,690

Community Facilities
Community facilities, as the name implies, provide services to people with mental retardation in community settings. Both public and private providers operate these facilities. The public providers are local mental retardation authorities.

Proposed ICF/MR Capacity[4] for Community Facilities			
Average # of persons per month[5]		**Total # of persons per year**	
FY 2010	**FY 2011**	**FY 2010**	**FY 2011**
6,296	6,294	6,299	6,292

Waiver Programs
Section 1915(c) of the Social Security Act provides, that upon federal approval, states may "waive" some federal Medicaid requirements to provide an array of support services in the community as an alternative to institutional care. Medicaid expenses for people in waiver programs cannot exceed, in the aggregate, Medicaid expenses for institutional services for people with similar needs.

The continuation of a major expansion of the waiver programs was funded by the 80th Legislature (2007). The Texas Promoting Independence and Money Follows the Person programs work to transition adults and children residing in nursing facilities to the most integrated community

[2] Capacity in this reference means anticipated average number of persons served per month.
[3] Number of persons per month is presented as an average to avoid duplicating head counts.
[4] Capacity in this reference means anticipated average number of persons served per month.
[5] The number of persons served per month is presented as an average to avoid duplicating head counts.

settings of their choice by providing services such as thorough assessments, intensive case management, housing assistance, and funds to set up a community-based residence.

The Home and Community-based Services for Persons with Mental Retardation Waiver Program (HCS)

The HCS program is for persons with mental retardation and provides individualized services and supports for individuals living in their family home, their own home, in a foster/companion care setting or in a residence with no more than four individuals who receive services.

Proposed HCS Capacity[6]			
Average # of persons served per month[7]		Total # of persons served per year	
FY 2010	FY 2011	FY 2010	FY 2011
13,805	13,805	13,805	13,805

The Texas Home Living Waiver Program (TxHmL)

The Texas Home Living Program (TxHmL) provides community services for people with mental retardation. Selected essential services and supports are provided for people so they can continue to live with their families or in their own homes.

Proposed TxHmL Capacity[8]			
Average # of persons served per month[9]		Total # of persons served per year	
FY 2010	FY 2011	FY 2010	FY 2011
1,278	1,278	1,278	1,278

The Community Living Assistance and Support Services (CLASS) Program

CLASS provides home and community-based services to individuals with related conditions so they can live with their families or in their own homes. People with related conditions have a qualifying disability, other than mental retardation, that originated before age 22 and affects their ability to function in daily life.

Appropriated CLASS Capacity[10]			
Average # of persons served per month[11]		Total # of persons served per year	
FY 2010	FY 2011	FY 2010	FY 2011
3,736	3,736	3,736	3,736

[6] Capacity in this reference means anticipated average number of persons served per month.
[7] The number of persons served per month is presented as an average to avoid duplicating head counts.
[8] Capacity in this reference means anticipated average number of persons served per month.
[9] The number of persons served per month is presented as an average to avoid duplicating head counts.
[10] Capacity in this reference means anticipated average number of persons served per month.
[11] The number of persons served per month is presented as an average to avoid duplicating head counts.

Medicaid Waiver Program for People who are Deaf-Blind with Multiple Disabilities (DB/MD)

The DB/MD program provides home and community-based services for people who are deaf-blind with multiple disabilities. Individuals live with their families, in their own homes, or in residences with no more than six individuals who receive services. The program focuses on increasing opportunities for individuals to communicate and interact with their environment.

Proposed DB/MD Capacity[12]			
Average # of persons served per month[13]		Total # of persons served per year	
FY 2010	FY 2011	FY 2010	FY 2011
153	153	153	153

The Consolidated Waiver Program (CWP)

The purpose of CWP is to test the feasibility of consolidating five of the state's other Section 1915(c) Medicaid waiver programs over time. The program is limited to Bexar County, and serves individuals who will qualify for nursing facility or for ICF/MR/RC level of care I or VIII.

Proposed CWP Capacity[14]			
Average # of persons served per month[15]		Total # of persons served per year	
FY 2010	FY 2011	FY 2010	FY 2011
177	177	177	177

Definitions

Mental Retardation is defined by 40 Texas Administrative Code (TAC) §5.153 as:

> Consistent with THSC, §591.003, significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Related Condition is defined by 40 TAC §5.153 as:

> As defined in the Code of Federal Regulations (CFR), Title 42, 435.1009, a severe and chronic disability that:
>
> (A) is attributable to:
>
> (i) cerebral palsy or epilepsy; or
>
> (ii) any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for persons with mental retardation;

[12] Capacity in this reference means anticipated average number of persons served per month.
[13] The number of persons served per month is presented as an average to avoid duplicating head counts.
[14] Capacity in this reference means anticipated average number of persons served per month.
[15] The number of persons served per month is presented as an average to avoid duplicating head counts.

(B) is manifested before the person reaches the age of 22;
(C) is likely to continue indefinitely; and
(D) results in substantial functional limitation in three or more of the following areas of major life activity:
(i) self-care;
(ii) understanding and use of language;
(iii) learning;
(iv) mobility;
(v) self-direction; and
(vi) capacity for independent living.

Mental Retardation Priority Population

The priority population for mental retardation services consists of individuals who meet one or more of the following descriptions:

- Persons with mental retardation as defined by Texas Health Safety Code §591.003;
- Persons with pervasive developmental disorders, as defined in the current edition of the Diagnostic and Statistical Manual, including autism;
- Persons with related conditions who are eligible for services in Medicaid programs including the ICF/MR and Medicaid waiver programs;
- Nursing facility residents who are eligible for specialized services for mental retardation or a related condition pursuant to §1919(e)(7) of the Social Security Act; or
- Children who are eligible for services through the Early Childhood Intervention Interagency Council.

E. Upper Payment Limit (UPL) Programs/ Disproportionate Share Hospital (DSH)

Active UPL Programs

Large Urban Public Hospitals (effective SFY 2001)

Supplemental payments are made for inpatient and outpatient hospital services provided by a publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, Potter, and Randall counties. This UPL program makes supplemental payments to 11 of the largest public hospitals in Texas. This UPL program became effective on July 6, 2001.

SFY 2007: $900.7 AF; $547.4 Federal
SFY 2008 (est.): $971.6 AF; $588.6 Federal

State Hospital UPL (effective SFY 2004)

Supplemental payments are made for inpatient and outpatient hospital services provided by state government-owned or operated hospitals. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas. This UPL program became effective on December 13, 2003.

SFY 2007: $144.5 AF; $87.8 Federal
SFY 2008 (est.): $144.5 AF; $87.8 Federal

Rural Hospital UPL (effective SFY 2002)

Supplemental payments are made for inpatient hospital services provided by approximately 118 rural hospitals that are either publicly owned or affiliated with a local governmental entity. For purposes of this program, "rural hospital" means a hospital affiliated with a city, county, hospital authority, or hospital district located in a county of less than 100,000 population based on the most recent federal decennial census. This UPL program became effective on January 1, 2002.

SFY 2007: $76.2 AF; $46.3 Federal
SFY 2008 (est.): $68.1 AF; $41.2 Federal

Private Hospital UPL (effective SFY 2005)

Supplemental payments are made for inpatient and outpatient hospital services provided by privately owned hospitals. These private hospitals must be affiliated with a state, county or local government who would provide the non-federal share of the Medicaid supplemental payments being made to the private hospital. This UPL program became effective June 10, 2005 for a subset of private hospitals in Bexar, Montgomery, Webb, Hidalgo, Potter, Maverick, Travis, Randall,

Midland and Potter counties and was approved for statewide implementation effective November 12, 2005.

SFY 2007: $549.9 AF; $334.2 Federal
SFY 2008 (est.): $700.0 AF; $423.9 Federal

State Physician Practice Plan UPL (effective SFY 2004)

Supplemental payments are made to physicians employed by state academic health systems, specifically hospitals that are part of the systems of the University of Texas, Texas Tech University, and the University of North Texas. This program became effective on May 11, 2004.

SFY 2007: $93.8 AF; $57.0 Federal
SFY 2008 (est.): $93.8 AF; $56.8 Federal

Tarrant County Physician UPL (effective SFY 2005)

Supplemental payments are made to physicians under contract with a public hospital located in Tarrant County. This program became effective on November 26, 2004.

SFY 2007: $3.7 AF; $2.2 Federal
SFY 2008 (est.): $3.7 AF; $2.2 Federal

Children's Hospital UPL (effective SFY 2007)

Supplemental payments are made for inpatient hospital services to certain in-state children's hospitals. The state share for this UPL program comes from state General Revenue. This program became effective on September 1, 2006.

SFY 2007: $31.8 AF; $19.4 Federal
SFY 2008: $31.6 AF; $19.2 Federal

High-Volume Payments to Private Hospitals (effective SFY 2006) – 2008

High-volume payments not exceeding $26.4 million shall be allocated in proportion to uncompensated care loss for eligible hospitals participating in the current year DSH program. Eligible hospitals are defined as non-state owned or operated, non-public, hospitals located in urban counties. The state share for this UPL program comes from General Revenue instead of Intergovernmental Transfers (IGT's). This program became effective on September 1, 2005. HHSC has discontinued high-volume payment to private hospitals effective September 1, 2008.

SFY 2007: $24.4 AF; $14.7 Federal
SFY 2008 (est.): $26.4 AF; $16.0 Federal

Disproportionate Share Hospital Programs

Non-State Hospitals (effective SFY 1987)

Texas reimburses approximately 165 non-state hospitals that provide a disproportionate amount of care to indigent patients on an annual basis. The non-federal share is obtained through an intergovernmental transfer from large urban public hospitals. This DSH program has been in effect since SFY 1987.

SFY 2007:	$1,015 AF; $616.8 Federal
SFY 2008:	$981.0 AF; $594.3 Federal

State-Owned Teaching Hospitals (effective SFY 1991)

Texas reimburses three state-owned teaching hospitals on an annual basis. The non-federal share is obtained through an intergovernmental transfer of General Revenue from the state-owned teaching hospitals. The three state-owned teaching hospitals, which are deemed DSH providers, are U.T. Medical Branch, M.D. Anderson, and U.T. Tyler. These three providers have been getting DSH funds as state teaching hospitals since SFY 1991.

SFY 2007:	$180.7 AF; $109.8 Federal
SFY 2008:	$141.3 AF; $ 85.6 Federal

Other State-Owned Hospitals (effective SFY 1994)

Texas reimburses as many as 11 state psychiatric hospitals and one state chest hospital on an annual basis. The non-federal share is obtained through an intergovernmental transfer of General Revenue from the state-owned hospitals. These providers have been getting DSH funds as state psychiatric hospitals and a state chest hospital since SFY 1994.

SFY 2007:	$246.2 AF; $149.6 Federal
SFY 2008:	$312.6 AF; $189.3 Federal

F. 10% Biennial Base Reduction Options Schedule

6.I. 10 Percent Biennial Base Reduction Options Schedule

Approved Reduction Amount
$141,630,282

Agency Code: 539			Agency Name: Department of Aging and Disability Services (DADS)									
Rank	Reduction Item		Biennial Application of 10% Percent Reduction						FTE Reductions (FY 2010-11 Base Request Compared to Budgeted 2009)		Revenue Impact? Y/N	Cumulative GR related reduction as a % of Approved Base
	Strat	Name	GR	GR-Dedicated	Federal	Other	All Funds		FY 08	FY 09		
1	1.9.1	Capital Repairs and Renovations	33,525	68,407	-	-	$ 101,932				N	0.0%
2	1.4.3	Promoting Independence Plan	425,866	-	-	-	$ 425,866				N	0.0%
3	1.4.1	Non-Medicaid Services	1,016,023	-	-	-	$ 1,016,023				N	0.1%
4	1.4.4	In-Home and Family Support	1,054,469	-	-	-	$ 1,054,469				N	0.2%
5	1.4.5	Mental Retardation In-Home Services	1,308,001	-	-	-	$ 1,308,001				N	0.3%
6	1.4.2	Mental Retardation Community Services	22,682,322	1,091	-	-	$ 22,683,413				N	1.9%
7	1.3.6	Consolidated Waiver Program	406,589	-	610,751	-	$ 1,017,341				N	1.9%
8	1.3.7	Texas Home Living Waiver	872,153	-	1,310,172	-	$ 2,182,325				N	2.0%
9	1.3.4	Deaf-Blind Multiple Disabilities (DBMD)	658,061	-	987,890	-	$ 1,645,951				N	2.0%
10	1.3.5	Medically Dependent Children Program (MDCP)	3,939,229	-	5,910,194	-	$ 9,849,423				N	2.3%
11	1.3.1	Community Based Alternatives (CBA)	40,705,392	-	61,046,395	-	$ 101,751,787				N	5.2%
12	1.3.3	Community Living Assistance & Support Services (CLASS)	13,497,867	-	20,281,189	-	$ 33,779,056				N	6.1%
13	1.3.2	Home and Community Based Services (HCS)	54,961,286	-	82,423,746	-	$ 137,385,032				N	10.0%
		Agency Biennial Total	**$ 141,560,785**	**$ 69,497**	**$ 172,570,337**	$ -	**$ 314,200,619**		**0.0**	**0.0**		**10.0%**
		Agency Biennial Total (GR + GR-D)		**$ 141,630,282**								

6.I. 10 Percent Biennal Base Reduction Options Schedule

Approved Reduction Amount
$16,991,851

Agency Code: 538			Agency Name: Texas Department of Assistive and Rehabilitative Services								
Rank	Reduction Item		Biennial Application of 10% Percent Reduction					FTE Reductions (FY 2010-11 Base Request Compared to Budgeted 2009)		Revenue Impact? Y/N	Cumulative GR-related reduction as a % of Approved Base
	Strat	Name	GR	GR-Dedicated	Federal	Other	All Funds	FY 08	FY 09		
1	B.2.3	STAP	381				$ 381			N	0.0%
2	B.2.2	I Love Texas		2,404			$ 2,404			N	0.0%
3	A.3.1	Autism ages 3-8	5,000,000				$ 5,000,000			N	2.9%
4	B.1.2	DBS-BEST	98,155				$ 98,155			N	3.0%
5	B.2.1	DHH-Contract Svcs	117,993				$ 117,993			N	3.1%
6	B.2.2	DHH-Education	81,351				$ 81,351			N	3.1%
7	B.1.4	DBS-BET Op	795	307,948	433,801		$ 742,544	(3.0)	(3.0)	Y	3.3%
8	B.3.2	DRS-IL Centers	100,000				$ 100,000			N	3.4%
9	B.3.3	DRS-IL Services	261,196				$ 261,196	(1.0)	(1.0)	N	3.5%
10	B.3.4	DRS-CRS	926,485	2,750,068			$ 3,676,553			N	5.7%
11	B.3.1	DRS-VR	5,791,124		27,188,376		$ 32,979,500	(95.0)	(95.0)	Y	9.1%
12	B.1.3	DBS-VR	1,553,951		9,848,209		$ 11,402,160	(52.0)	(52.0)	Y	10.0%
	Agency Biennial Total		**$ 13,931,431**	**$ 3,060,420**	**$ 37,470,386**	$ -	**$ 54,462,237**	**(151.0)**	**(151.0)**		**10.0%**
	Agency Biennial Total (GR + GR-D)			**$ 16,991,851**							

6.I. 10 Percent Biennal Base Reduction Options Schedule

Approved Reduction Amount
$58,562,306

Agency Code: 530			Agency Name: Department of Family and Protective Services (DFPS)								
Rank	Reduction Item		Biennial Application of 10% Percent Reduction					FTE Reductions (FY 2010-11 Base Request Compared to Budgeted 2009)		Revenue Impact? Y/N	Cumulative GR-related reduction as a % of Approved Base
	Strat	Name	GR	GR-Dedicated	Federal	Other	All Funds	FY 08	FY 09		
1	C.1.2.	CYD Program	15,695,197				$ 15,695,197				2.7%
2	C.1.1.	STAR Program	29,410,247	12,591,476			$ 42,001,723				9.9%
3	C.1.6.	At Risk Prevention Program Support	865,386				$ 865,386	8.1	8.1		10.0%
	Agency Biennial Total		**$ 45,970,830**	**$ 12,591,476**	$ -	$ -	**$ 58,562,306**	**8.1**	**8.1**		**10.0%**
	Agency Biennial Total (GR + GR-D)			**$ 58,562,306**							

6.I. 10 Percent Biennial Base Reduction Options Schedule

Approved Reduction Amount
$277,548,294

Agency Code: 537		Agency Name: Department of State Health Services									
Rank	Reduction Item		Biennial Application of 10% Percent Reduction					FTE Reductions (FY 2010-11 Base Request Compared to Budgeted 2009)		Revenue Impact? Y/N	Cumulative GR-related reduction as a % of Approved Base
	Strat	Name	GR	GR-Dedicated	Federal	Other	All Funds	FY 10	FY 11		
1	2.3.2.	FQHC Infrastructure Grants	3,000,000				$ 3,000,000	0.0	0.0	N	0.11%
1	2.3.4.	County Indigent Health Care Services	7,000,000				$ 7,000,000	0.0	0.0	N	0.36%
2	1.3.2.	Abstinence Education	1,102,164				$ 1,102,164	4.8	4.8	N	0.40%
3	2.3.1.	EMS And Trauma Care System		23,227,000			$ 23,227,000	0.0	0.0	N	1.24%
4	1.2.3.	Infectious Disease Prev, Epi, and Surveillance (Oral Rabies)	789,968				$ 789,968	0.0	0.0	N	1.27%
4	1.4.1.	Laboratory Services	800,865				$ 800,865	0.0	0.0	N	2.16%
4	3.1.3.	MH Hospitals - 2009 Shortfall & Funding Gap/Maintain Current Operations	23,904,315				$ 23,904,315	205.0	205.0	Y	2.16%
4	6.1.3.	Construction: South Texas Health Care System - Harlingen	546,000				$ 546,000	0.0	0.0	N	2.18%
4	6.1.4.	Construction: South Texas Health Care System - Hidalgo	500,000				$ 500,000	0.0	0.0	N	2.19%
4		Various Strategies - Maintain Current Operations	2,509,545				$ 2,509,545	0.0	0.0	N	2.28%
5	1.1.2	Health Registries, Information, and Vital Records	1,518,000	836,000			$ 2,354,000	6.0	6.0	N	2.37%
5	1.2.1.	Immunize Children and Adults	5,474,600	25,400			$ 5,500,000	0.0	0.0	N	2.57%
5	1.2.2.	HIV/STD Prevention	9,643,000				$ 9,643,000	0.0	0.0	N	2.91%
5	1.2.3.	Infectious Disease Prev, Epi, and Surveillance	3,876,000	0			$ 3,876,000	17.0	17.0	N	3.05%
5	1.3.1.	Health Promotion and Chronic Disease Prevention	782,000				$ 782,000	4.5	4.5	N	3.08%
5	1.3.3.	Kidney Health Care	2,350,000				$ 2,350,000	0.0	0.0	N	3.17%
5	1.3.4.	Children with Special Health Care Needs	5,268,000				$ 5,268,000	0.0	0.0	N	3.36%
5	1.3.5.	Epilepsy, Hemophilia Services	222,000				$ 222,000	0.0	0.0	N	3.36%
5	1.4.1.	Laboratory Services	1,460,000	2,422,000			$ 3,882,000	38.0	38.0	Y	3.50%
5	2.1.1.	Provide WIC Services	200,000	43,024,398			$ 43,224,398	0.0	0.0	N	5.06%
5	2.1.2.	Women and Children's Health Services	2,858,000				$ 2,858,000	0.0	0.0	N	5.16%
5	2.1.3.	Family Planning Services	1,410,000				$ 1,410,000	0.0	0.0	N	5.22%
5	2.1.4.	Community Primary Care Services	2,268,000	12,000			$ 2,280,000	0.0	0.0	N	5.30%
5	2.2.1.	Mental Health Services for Adults	30,231,000				$ 30,231,000	0.0	0.0	N	6.74%
5	2.2.2.	Mental Health Services for Children	7,600,000				$ 7,600,000	0.0	0.0	N	6.66%
5	2.2.3.	Community Mental Health Crisis Services	7,216,000				$ 7,216,000	0.0	0.0	N	6.92%
5	2.2.4.	NorthSTAR	6,684,000				$ 6,684,000	0.0	0.0	N	7.16%
5	2.2.5	Substance Abuse Prevention, Intervention, & Treatn	4,034,000				$ 4,034,000	0.0	0.0	Y	7.45%
5	2.2.6.	Statewide Program to Reduce Tobacco Use	204,000	1,500,000			$ 1,704,000	0.0	0.0	N	7.45%
5	2.3.3.	Indigent Care Reimbursement (UTMB)		1,760,000			$ 1,760,000	0.0	0.0	N	7.43%
5	3.1.1.	Texas Center for Infectious Disease	1,548,000	192,000			$ 1,740,000	34.0	34.0	N	7.49%
5	3.1.3.	MH Hospitals	55,302,000				$ 55,302,000	473.0	473.0	Y	9.49%
5	3.2.1	Mental Health Community Hospitals	4,164,000				$ 4,164,000	0.0	0.0	N	9.64%
5	4.1.1.	Food (Meat) and Drug Safety	1,928,000	1,192,000			$ 3,120,000	37.0	37.0	Y	9.75%
5	4.1.2.	Environmental Health	654,000	608,000			$ 1,262,000	15.0	15.0	Y	9.79%
5	4.1.3.	Radiation Control	1,374,000	234,000			$ 1,608,000	40.0	40.0	Y	9.85%
5	4.1.4.	Health Care Professionals	770,000	324,000			$ 1,094,000	20.0	20.0	Y	9.89%
5	4.1.5.	Health Care Facilities	504,000	222,000			$ 726,000	6.0	6.0	Y	9.92%
5	4.1.6.	Texas Online	96,000	88,000			$ 184,000	0.0	0.0	N	9.92%
5	5.1.1.	Central Administration	809,000	78,000			$ 887,000	6.0	6.0	N	9.96%
5	5.1.2.	IT Program Support	644,039				$ 644,039	0.0	0.0	N	9.98%
5	5.1.3.	Other Support Services	325,000	86,000			$ 411,000	0.0	0.0	N	9.99%
5	5.1.4.	Regional Administration	141,200	6,800			$ 148,000	0.0	0.0	N	10.00%
	Agency Biennial Total		**$ 201,710,696**	**$ 75,837,598**	**$ -**	**$ -**	**$ 277,548,294**	**906.3**	**906.3**		**10.0%**
	Agency Biennial Total (GR + GR-D)			**$ 277,548,294**							

6.I. 10 Percent Biennial Base Reduction Options Schedule

Approved Reduction Amount
$180,222,214

Agency Code: 529			Agency Name: Health and Human Services Commission								
Rank	Reduction Item		Biennial Application of 10% Percent Reduction					FTE Reductions (FY 2010-11 Base Request Compared to Budgeted 2009)		Revenue Impact? Y/N	Cumulative GR-related reduction as a % of Approved Base
	Strat	Name	GR	GR-Dedicated	Federal	Other	All Funds	FY 08	FY 09		
1	NA	Reduced Base Request because No Perinates in CHIP	116,600,000				$ 116,600,000	0.0	0.0	N	6.5%
2	1-1-1	Enterprise Oversight and Policy - 1 Time Harris County Payn	4,000,000				$ 4,000,000	0.0	0.0	N	6.7%
3	1-1-1	Enterprise Oversight and Policy - Umbilical Cord Blood Bank	5,000,000				$ 5,000,000	0.0	0.0	N	7.0%
4	2-2-6	Upper Payment Limit - Children Hospitals	25,000,000		35,098,501		$ 60,098,501	0.0	0.0	N	8.4%
5	4-1-1	Eliminate TANF Payments to 2 Parent Families	7,360,000				$ 7,360,000	0.0	0.0	N	8.8%
6	3-1-1	Impose CHIP Rate Reduction	19,300,000		46,910,627		$ 66,210,627	0.0	0.0	N	9.8%
7	3-1-2	Impose Immigrant Health Insurance Rate Reduction	2,965,000		0		$ 2,965,000	0.0	0.0	N	10.0%
	Agency Biennial Total		**$ 180,225,000**	**$ -**	**$ 82,009,128**	**$ -**	**$ 262,234,128**	**0.0**	**0.0**		**10.0%**
	Agency Biennial Total (GR + GR-D)		**$ (2,786)**	**$ 180,225,000**							

G. Health and Human Services Agencies Executive Contact List

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