



Federal Funds Report Fiscal Year 2011

Health and Human Services Commission



Department of Aging and Disability Services



Department of State Health Services



Department of Family and Protective Services



Department of Assistive and Rehabilitative Services

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I. Executive Summary

The Texas Health and Human Services Commission (HHSC) is submitting the *Annual Federal Funds Report for Fiscal Year 2011* in accordance with Section 531.028(c), Government Code. This report highlights the critical role of federal funding in the health and human services (HHS) system in Texas. Five agencies comprise the HHS system:

- Health and Human Services Commission (HHSC)
- Department of Aging and Disability Services (DADS)
- Department of State Health Services (DSHS)
- Department of Family and Protective Services (DFPS)
- Department of Assistive and Rehabilitative Services (DARS)

During fiscal year 2011, HHS agencies spent over \$33.5 billion in All Funds with Federal Funds accounting for approximately 63 percent of agency expenditures, or \$21.2 billion. HHS agencies used 150 different sources of federal funds, with ten of these accounting for 95 percent of the funds. Medicaid is the largest federal funding source for the HHS system at 72 percent (excluding the American Recovery and Reinvestment Act of 2009 [ARRA] Medicaid funds noted below). The next largest federal funding source for the HHS agencies is ARRA funding at nine percent.

When ARRA was signed into law in February of 2009, providing \$787 billion in federal funding through a multitude of new and existing programs, states experienced a significant influx of federal funding. In the Texas HHS system, ARRA funds totaled \$6.6 billion over three years: \$1.8 billion in fiscal year 2009, \$2.9 billion in fiscal year 2010, and \$1.9 billion in fiscal year 2011. Federal Medicaid funding related to increased federal matching rates for a 33-month period makes up the largest share of the ARRA funding in HHS agencies, accounting for 99 percent in fiscal year 2009, 94 percent in fiscal year 2010, and 96 percent in fiscal year 2011. The ARRA Medicaid federal matching assistance percentage (FMAP) rate increase ended on June 30, 2011. While most ARRA grants ended in fiscal year 2011, some grants at HHSC, DSHS, and DADS will continue into future years.

In addition to detailing ARRA funding, this report identifies federal funds management activities undertaken to maximize the amount of federal funds received by HHS agencies such as enhanced federal matching rates for certain medical, transportation, and administrative services; depreciation claiming; retiree insurance benefits claiming; an add-on rate for trauma hospitals; and claims for Temporary Assistance for Needy Families (TANF) Contingency funds. Also, included is a section highlighting current federal issues that could impact state services and funding, such as the potential fiscal year 2013 federal sequester related to deficit reduction and recent appropriations action.

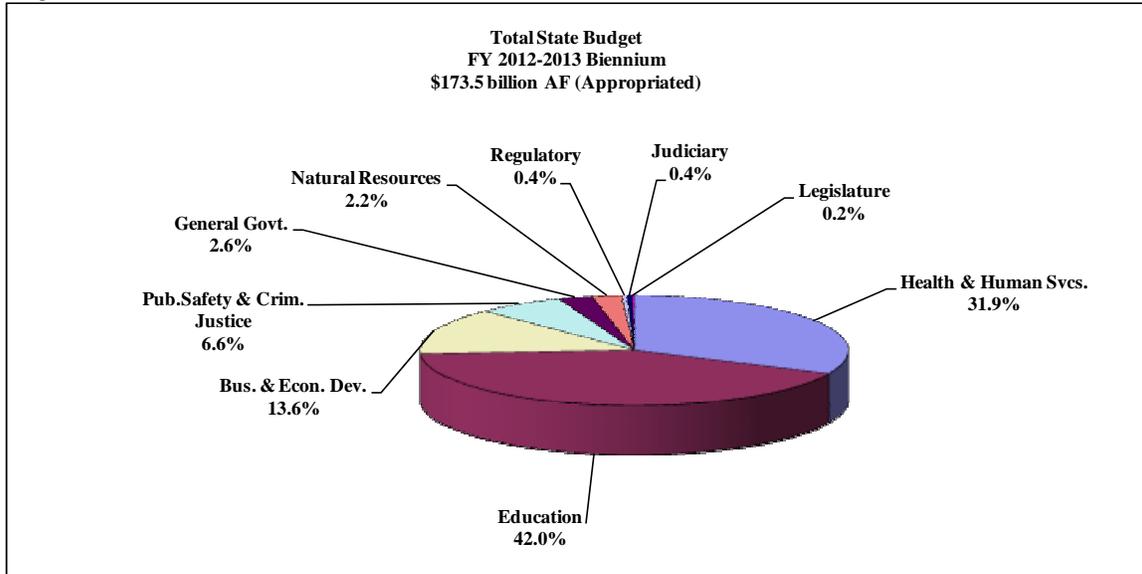
The effort to ensure Texas optimizes federal funding to the extent allowable underpins the financial management of all five HHS agencies. With the development of federal cost allocation plans, implementation of revenue maximization projects, and active monitoring of federal legislation, HHS agencies continually assess opportunities to enhance federal funds for the state.

II. HHS and the State Budget

Overview of 2012-13 Biennial Appropriations

For the 2012-13 biennium, HHS agencies were appropriated \$55.4 billion in All Funds, which represents 32 percent of the total state budget of \$173.5 billion. The figure below shows the HHS system share of the total state budget.

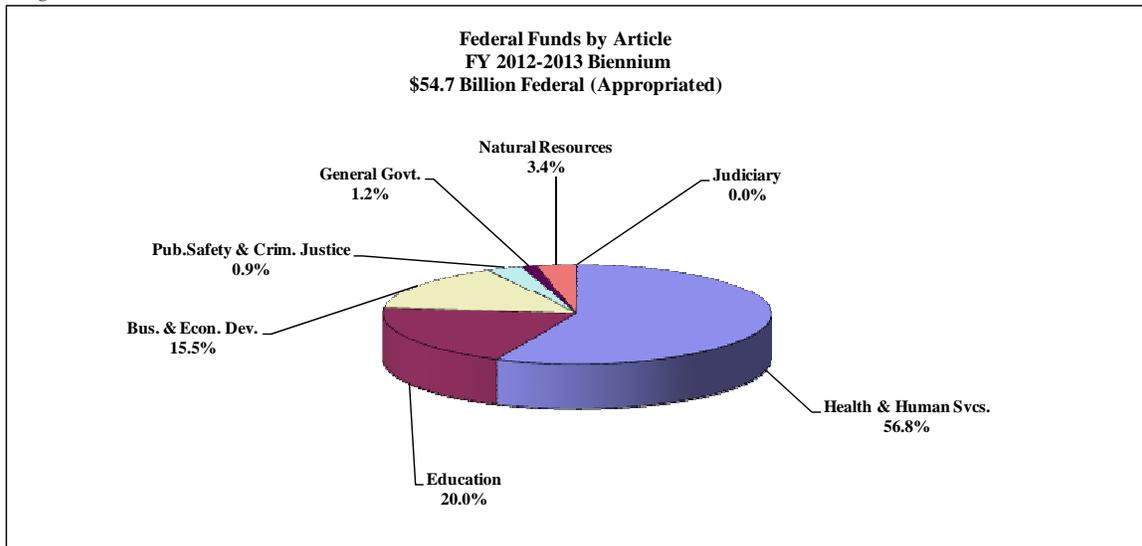
Figure II.1



Source: 2012-2013 General Appropriations Act, 82nd Legislature

As reflected below, Health and Human Services represents approximately 57 percent of the \$54.7 billion in Federal Funds appropriated statewide in the 2012-13 biennium.

Figure II.2



Source: 2012-2013 General Appropriations Act, 82nd Legislature

Fiscal Year 2011 Expenditures by Fund Source

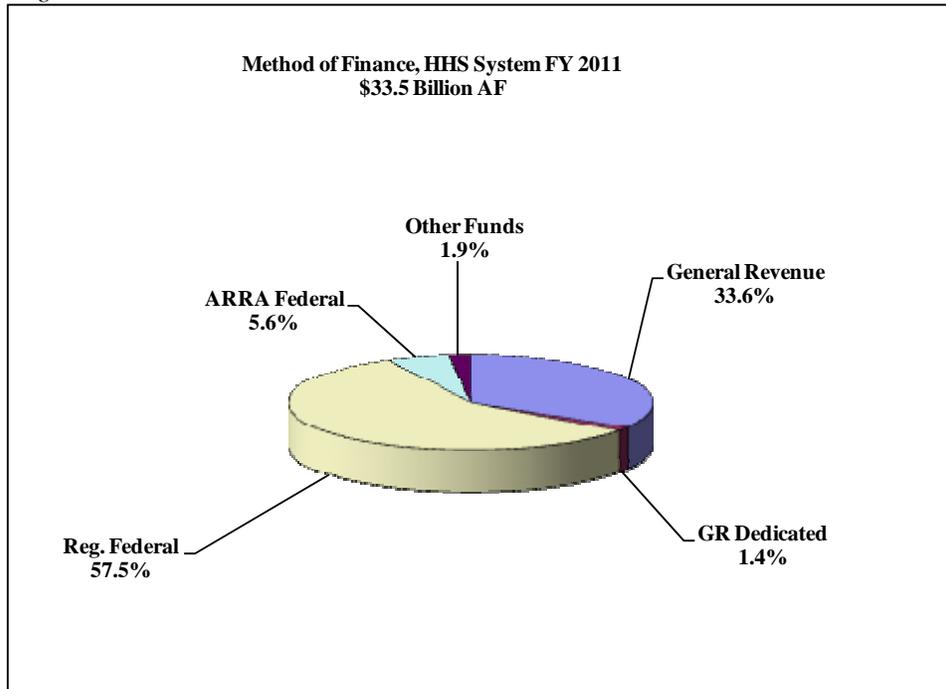
The following table reflects each HHS agency's Method of Finance in fiscal year 2011. To highlight the impact of stimulus funding, federal funding is reported in two categories throughout this report: Regular Federal Funds and ARRA Federal Funds. The data source for HHS System and agency-specific tables and figures included in this report is fiscal year 2012 agency operating budgets.

Table II.1

Method of Finance, HHS System, FY 2011						
Agency	General Revenue	GR Dedicated	Federal Funds		Other Funds	All Funds
			Reg. Federal	ARRA		
HHSC	\$7,155,466,891	\$0	\$12,652,470,365	\$1,383,972,910	\$313,069,472	\$21,504,979,638
DADS	\$2,354,064,917	\$54,564,624	\$4,066,039,567	\$410,959,715	\$69,362,580	\$6,954,991,403
DSHS	\$1,097,428,686	\$395,846,543	\$1,310,590,753	\$18,626,908	\$216,452,388	\$3,038,945,278
DFPS	\$571,140,859	\$7,663,848	\$785,637,994	\$12,329,816	\$6,755,300	\$1,383,527,817
DARS	\$107,415,626	\$14,170,141	\$477,858,544	\$40,609,510	\$18,686,240	\$658,740,061
Total	\$11,285,516,979	\$472,245,156	\$19,292,597,223	\$1,866,498,859	\$624,325,980	\$33,541,184,197
Percent of Total	33.6%	1.4%	57.5%	5.6%	1.9%	100%

The figure below depicts the percentage shares for the Method of Finance comprising the \$33.5 billion in All Funds that HHS agencies spent in fiscal year 2011. At approximately 57 percent of the expenditures, Regular Federal Funds are the largest component of the HHS system Method of Finance. ARRA Federal Funds represent about six percent of HHS agency funding.

Figure II.3



Federal Funds as a Percent of Agency Budgets

Federal Funds represented 63 percent of HHS agency budgets in fiscal year 2011, with Regular Federal Funds representing \$19.3 billion and ARRA Federal Funds accounting for \$1.9 billion for a total of \$21.2 billion. The table below shows the degree to which each agency budget relies on federal funds, from 79 percent at DARS to 44 percent at DSHS.

Table II.2

FY 2011 Federal Funds as a Percent of Agency Budgets					
Agency	All Funds	Regular Federal	ARRA Federal	Total Federal	Percent of Agency Budget
HHSC	\$ 21,504,979,638	\$ 12,652,470,365	\$ 1,383,972,910	\$14,036,443,275	65%
DADS	6,954,991,403	4,066,039,567	410,959,715	4,476,999,282	64%
DSHS	3,038,945,278	1,310,590,753	18,626,908	1,329,217,661	44%
DFPS	1,383,527,817	785,637,994	12,329,816	797,967,810	58%
DARS	658,740,061	477,858,544	40,609,510	518,468,054	79%
Total	\$33,541,184,197	\$19,292,597,223	\$1,866,498,859	\$21,159,096,082	63%

III. Top Ten HHS Agency Federal Funding Sources

Health and human services (HHS) agencies used 150 different sources of federal funds in their fiscal year 2011 budgets. As shown in Table III.1 below, 10 of these federal funding sources represent 95 percent of all federal funds in health and human services. Each agency and their primary federal funding sources are covered in more detail in Section VII. For further details on these ten federal funding sources, please see the October 2010 Legislative Budget Board report on the Top 100 Federal Funding Sources in the Texas State Budget at http://www.lbb.state.tx.us/Federal_Funds/Other_Publications/Top_Federal_Funding_Sources.pdf.

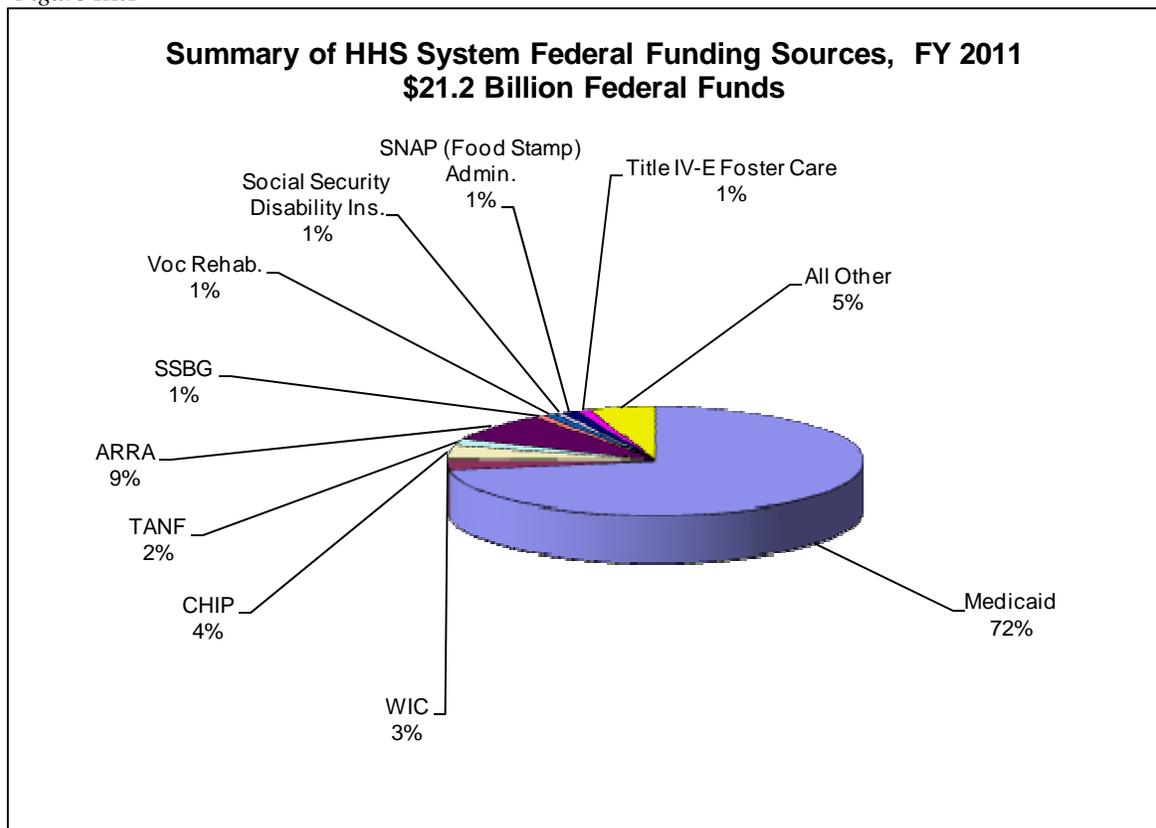
Table III.1

FY 2011 Top 10 HHS System Federal Funding Sources by Agency and CFDA							
CFDA	Federal Fund	HHSC	DADS	DSHS	DFPS	DARS	TOTAL
93.778	Medical Assistance Program (Medicaid)	\$ 11,330,610,414	\$ 3,805,841,365	\$ 111,607,073	\$ 7,563,397	\$ 64,944,152	\$ 15,320,566,401
	ARRA Funds (Medicaid and Other)	1,383,972,910	410,959,715	18,626,908	12,329,816	40,609,510	1,866,498,859
93.767	State Children's Insurance Program (CHIP)	860,983,490					860,983,490
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)			631,601,257			631,601,257
93.558	Temporary Assistance for Needy Families (TANF) & TANF to Title XX	82,340,249		20,498,852	310,523,496	11,783,576	425,146,173
10.561	State Administrative Matching Grants for Supplemental Nutrition Assistance (SNAP) (Food Stamp) Program	244,184,684					244,184,684
93.658	Foster Care Title IV-E				227,397,541		227,397,541
93.667	Social Services Block Grant (SSBG)	64,712,486	85,340,273	12,333,692	32,059,667		194,446,118
84.126	Vocational Rehabilitation Grants to States					189,445,890	189,445,890
96.001	Social Security Disability Insurance					139,096,840	139,096,840
Top Ten Total		\$ 13,966,804,233	\$ 4,302,141,353	\$ 794,667,782	\$ 589,873,917	\$ 445,879,968	\$ 20,099,367,253
All Other Federal		69,639,042	174,857,929	534,549,879	208,093,893	72,588,086	1,059,728,829
Top 10 as % of Agency & HHS System Federal Funds		99.5%	96.1%	59.8%	73.9%	86.0%	95.0%
Total Agency and HHS System Federal Funds		\$ 14,036,443,275	\$ 4,476,999,282	\$ 1,329,217,661	\$ 797,967,810	\$ 518,468,054	\$ 21,159,096,082

Fiscal year 2011 Disproportionate Share Hospital payments (\$957 million federal), Upper Payment Limit (\$1.7 billion federal) and SNAP distributions to clients (\$5.3 billion federal) are excluded from this chart, as these programs are outside the General Appropriations Act and not part of agency operating budgets.

As shown in Figure III.1, Medicaid is the largest federal funding source for HHS agencies, representing approximately 72 percent of federal funding across the HHS system (this figure does not include ARRA Medicaid funds). Taken as a whole, ARRA Federal Funding was the second largest federal funding source for HHS agencies at nine percent, clearly indicating the prominent role ARRA funding played in the delivery of health and human services during fiscal year 2011. The State Children’s Health Insurance Program (CHIP) accounts for four percent of HHS agencies’ federal funding; the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) comprises three percent; Temporary Assistance for Needy Families (TANF) represents two percent; and Social Services Block Grant (SSBG), Vocational Rehabilitation, Social Security Disability Insurance, State Administrative Matching Grants for Supplemental Nutrition Assistance Program (SNAP) (Food Stamps), and Title IV-E Foster Care each represent one percent. The remaining five percent of federal funding for health and human services comes from 140 federal funding sources. As discussed in more detail in Section 5 of this report, ARRA funding totaled \$1.8 billion in fiscal year 2009, and an estimated \$2.9 billion in fiscal year 2010 and \$1.9 billion in fiscal year 2011.

Figure III.1



Fiscal year 2011 Disproportionate Share Hospital payments (\$957 million federal), Upper Payment Limit (\$1.7 billion federal) and SNAP distributions to clients (\$5.3 billion federal) are excluded from this chart, as these programs are outside the General Appropriations Act and not part of agency operating budgets.

IV. Revenue and Federal Funds Enhancement Activities

The state and the HHS agencies work diligently to ensure all federal tax dollars that are available to Texas come to the state to support programs benefiting the citizens of Texas, consistent with state and federal policy objectives and Section 531.028, Government Code. Congressional and regulatory action by federal agencies can impact federal funding; therefore, active monitoring of legislative and regulatory measures is a critical function. 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 HHS agencies have sought to increase federal funding for health care expenditures through a variety of initiatives.

Apart from the initiatives noted below, HHSC has developed a cost allocation function that allocates multi-agency project costs across the system in order to receive the maximum federal funding allowable. Projects which cross multiple agencies, such as information technology systems, regional offices and oversight costs are allocated and billed to participating HHS agencies so that each agency shares in the cost and bills the appropriate federal funding source.

To provide the matching funds needed to make a federal claim for the support costs being billed to them, HHSC must request authority to transfer General Revenue funds initially appropriated to HHSC to the billed agencies. While this creates additional complexity to the process, it illustrates the lengths to which HHS agencies routinely go in order to maximize federal funding.

Retiree Insurance Benefits

An initiative undertaken at HHSC to maximize retiree insurance benefits claiming has resulted in an estimated \$43 million in additional federal funds through fiscal year 2010, with another \$11.5 million anticipated by the end of fiscal year 2011 for a total of approximately \$54.5 million in federal funds (see Table IV. 1 below).

The Employees Retirement System of Texas (ERS) pays a portion of insurance costs on behalf of retired HHS System employees. HHSC has reviewed the procedures in place at HHS System agencies to ensure that all agencies are maximizing the amount of federal claiming for these allowable costs. Since ERS was making the payment for these cost items, there was no expenditure of funds on each agency's individual accounting systems, which was a contributing factor in some agencies failing to make these claims. In some cases, agencies were only partially claiming these allowable expenditures.

Issues between the state and the federal HHS Division of Cost Allocation related to the methodology ERS used to allocate Retiree Benefit insurance costs to each individual agency were resolved in order to allow the claiming of matching funds for fiscal years 2007, 2008, and 2009. All future annual claims should receive matching federal funds. The actual and

projected increased federal dollars recovered are listed below. The state can expect approximately \$11.5 million per year in increased federal dollars as a result of the maximization of retiree insurance benefits claiming.

Table IV.1

Retiree Insurance Benefits Federal Claiming Initiative	
Fiscal Year	Additional Federal Funds
2007 (actual)	\$12,400,538
2008 (actual)	\$12,729,766
2009 (actual)	\$6,286,189
2010 (actual)	\$11,512,856
2011 (projected)	\$11,500,000
Total	\$54,429,349

Depreciation Review

HHSC has developed a process to calculate allowable claims for depreciation on capital items initially purchased with state dollars. As per federal regulations, these costs are allowable for federal reimbursement as long as claimed over a period of the useful life of the asset. This process has resulted in an increased federal claim of approximately \$2.0 million for fiscal year 2011. Procedures have been developed to ensure that federal dollars will be received on a regular basis.

Childhood Lead Poisoning Prevention Program (CLPPP)

The Texas Department of State Health Services (DSHS) currently operates and manages the Childhood Lead Poisoning Prevention Program (CLPPP) which was partially funded from fiscal year 1997 to fiscal year 2011 by a grant from the federal Centers for Disease Control and Prevention (CDC). The CDC ended the grant on August 31, 2011 and funding ceased. DSHS and HHSC explored the possibility of claiming federal Medicaid administrative funds to replace the grant funds. Effective July 1, 2011, DSHS began claiming federal Medicaid administrative funds, with over \$200,000 in federal funds anticipated in fiscal year 2011 to enable DSHS to maintain their previous administrative and staff levels.

Department of State Health Services (DSHS) Pursuit of Federal Grants

DSHS applied for 29 new grants from federal agencies in fiscal year 2011. Of those 29 grants, 16 (about 55 percent) were awarded, totaling approximately \$56.6 million. 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.

CHIP Coverage for School Employee Children and Children Previously Enrolled in SKIP

Previously, federal policy excluded a child from participating in the federally-matched Children's Health Insurance Program (CHIP) if the child's family was eligible for a state health benefits plan due to employment with a public agency (even if the family declined the coverage). As a result, children of state and school employees with access to the state benefit plans could not participate in the federally funded program and instead were provided similar health coverage funded with general revenue funds only.

The Patient Protection and Affordable Care Act (PPACA) of 2010 provided an exception to this exclusion and allowed states to provide federally-matched CHIP to the children of public employees effective March 23, 2010, if the state health benefits plan met maintenance of effort (MOE) requirements or the child qualified for a hardship exception. HHSC has evaluated cost-sharing requirements in benefit plans provided by the Teacher Retirement System and the Employee Retirement System (ERS), and determined that in both plans, the cost-sharing amounts, which include annual premiums, deductibles, copayments and co-insurance, would exceed five percent of annual income for families at 200 percent of the federal poverty level (FPL), and, therefore, children in the both plans would qualify for a hardship exception.

School Employee Children

In January of 2011, HHSC submitted a request for a hardship exception to the Centers for Medicare and Medicaid Services (CMS) to allow the state to claim federal match for children of public education employees effective September 1, 2010. The program provides coverage to approximately 17,330 children. The agency estimates that \$20.6 million in federal funds became available in fiscal year 2011, and \$21.8 million in federal funds will be available in fiscal year 2012.

State Kids Insurance Program (SKIP)

In summer of 2011, HHSC submitted an amendment to the Texas CHIP state plan requesting a hardship exception for children of state employees effective September 2011. The agency estimated that approximately 12,130 children who were previously enrolled in SKIP and whose services were funded with general revenue funds would enroll in federally funded CHIP in fiscal year 2012. Based on this enrollment projection, the state would receive \$14.7 million in federal funds in fiscal year 2012 and \$15.1 million in federal funds in fiscal year 2013 as a result of federal match.

Enhanced Federal Match for Medicaid Coverage of Qualified Immigrants

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 allows states the option to provide Medicaid coverage for certain qualified alien children and extends Medicaid eligibility to additional groups of qualified alien and non-immigrant children. Most of these children were receiving CHIP benefits through a state funds-only program.

Effective May 1, 2010, the state allowed certain additional qualified alien and non-immigrant alien children to qualify for Medicaid and CHIP through the month of their 19th

birthday, regardless of their date of entry. These children will receive care through the Medicaid delivery system, but the federal match rate will be the higher CHIP match rate. The agency estimates that \$9.2 million in federal funds became available in fiscal year 2010, and \$27 million in federal funds became available in fiscal year 2011.

Medical Transportation Waiver

Full-Risk Broker

To comply with the federal Deficit Reduction Act of 2005 and the 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 61), HHSC anticipates awarding two contracts (one for the Houston/Beaumont area and one for the Dallas/Fort Worth area) to a full-risk broker (FRB) that must render services to eligible clients for an agreed-upon Per-Medicaid-Enrollee-Per-Month (PMEPM) payment. It is anticipated that the FRB model will be implemented in March 2012, and that it will generate an estimated general revenue savings of \$4.3 million in the 2012-13 biennium.

1915(b) Waiver

In April 2011, the Centers for Medicare and Medicaid Services approved a Section 1915(b) waiver that allows the state to preserve the current nonemergency medical transportation service delivery model originated in 2006. It also increases federal financial participation (FFP) for demand response services from 50 percent to 60 percent to provide some fiscal relief to the state while maintaining the current service model.

The agency plans to amend the waiver to adjust the original full-risk services areas to align with the managed care expansion areas. As a result of the increase in FFP, the state anticipates it will draw down an additional \$10.4 million in federal funds for medical transportation in the 2012-13 biennium.

Trauma Facilities Rate Add-on

Chapter 780, Health and Safety Code, created the Designated Trauma Facility and Emergency Medical Services (DTS-EMS) account as a dedicated account in the General Revenue Fund to fund designated trauma facilities, county and regional emergency medical services, and trauma care systems. DSHS administers the DTS-EMS account and is required to use 96 percent of the funds in the account to fund a portion of uncompensated trauma care provided at hospitals designated as state trauma facilities or a hospital meeting “in active pursuit” requirements.

The 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011, authorized the transfer of funds from the DTS-EMS account administered by DSHS to HHSC to support the establishment and maintenance of trauma and emergency care facilities across the state by maximizing the availability of federal funds to reimburse trauma hospitals. The transfer of the trauma funds to the Medicaid inpatient hospital standard dollar amount will be implemented to assure that reimbursements to a hospital using those funds and the combination of the remaining uncompensated trauma funding will

not be less than the amount the hospital otherwise would have received for uncompensated trauma care from the DTS-EMS account.

The DTS-EMS account was appropriated approximately \$57 million in general revenue funds for the 2012-13 biennium. In an effort to maximize federal funding for hospital services, HHSC estimated that the proposed standard dollar amount (SDA) add-on for trauma designated hospitals would require approximately \$26 million in general revenue funds. DSHS will transfer \$26 million in general revenue from the DTS-EMS account to HHSC to use as the Medicaid match for the federal funds to support approximately \$63 million in expenditures for the Medicaid Trauma add-on, an increase of \$37 million in federal funds. These trauma funds allowed the \$26 million in SDA funding to be re-allocated back into base SDA funding to reduce the overall cut in hospital funding for all hospitals.

Although the trauma funds were transferred from the DTS-EMS account, with the combination of the Medicaid trauma add-on and the remaining trauma funds, each trauma hospital will retain the same level of funding without the transfer to Medicaid or increased funding with the combination. Additionally, the increase in the Medicaid hospital SDA funding helps mitigate the impact of appropriation reductions for all hospitals.

TANF Contingency Fund

The TANF block grant provides a fixed funding amount to states regardless of economic conditions. To provide additional TANF funds to states in times of economic downturn, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) created the TANF Contingency Fund that can be accessed when states reach high levels of unemployment and/or food stamp caseloads. Texas has met the threshold, based on Supplemental Nutrition Assistance Program (SNAP) caseload, and has applied for TANF Contingency Funds during federal fiscal year 2012. The TANF Contingency Funds are separate and apart from the TANF Emergency Contingency Fund (ECF) created by ARRA.

TANF Contingency Funds can be used for any purpose for which regular TANF funds are used but must be spent in the fiscal year in which they are received. States wishing to access these funds were able to submit requests beginning September 1, 2011. Funds are awarded on a first come first serve basis. Certain conditions, including a maintenance of effort (MOE), must be met in order to receive and retain the funds. A state qualifies for each month of the fiscal year that a state is eligible for Contingency Funds; the state may receive up to 1/12th of 20 percent of its annual State Family Assistance Grant applicable for that fiscal year. The exact amount of Contingency Funds awarded to the state is not determined until after the fiscal year ends, even though payments may have been processed. There is a reconciliation done at the end of the fiscal year.

Texas has applied for all 12 months of federal fiscal year 2012. Texas could be eligible for a maximum of \$8.1 million per month, or \$97.3 million, in TANF Contingency Funds for federal fiscal year 2012.

Disproportionate Share Hospital (DSH) Program

Federal law requires that state Medicaid programs make special payments to hospitals serving 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 uninsured 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 Table IV.2 below, Texas has three active DSH programs that have generated \$9.1 billion in federal funding since fiscal year 2002. In fiscal year 2011, DSH programs are expected to generate approximately \$957.3 million in federal funding. CMS has published an amendment to its administrative rule governing the DSH program to implement Section 1001 of the Medicare Modernization Act. The rule establishes new reporting and annual auditing requirements for states with Medicaid DSH programs. 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 Upper Payment Limit (UPL) programs. Table V.2 represents the allocations for the interim DSH payments and the unaudited payment amounts. DSH program years are audited approximately three years after the program year is finished and began with program year 2005. The audits are not expected to change the total amount of DSH funding Texas receives, but the audits may reallocate the total amount of DSH funding among participating hospitals.

Table IV.2

Disproportionate Share Hospital (DSH) Programs: Active, FY 2002-2011											
Federal Funds (\$ in millions)											
<i>DSH Programs</i>	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY 11	FY02-2011 Total
Non-State Hospitals	566.3	504.3	516.5	540.9	701.2	616.8	594.3	759.3	800.5	758.4	6,358.5
State-Owned Teaching Hospitals	123.1	117.9	193.9	181.7	81.5	109.8	85.6	29.7	26.3	32.2	981.7
Other State-Owned Hospitals	166.6	170.2	162.2	183.9	193.4	149.6	189.3	172.3	161.2	166.7	1,715.4
Total	\$856.0	\$792.4	\$872.6	\$906.5	\$976.1	\$876.2	\$869.2	\$961.3	\$988.0	\$957.3	\$9,055.6

Active Upper Payment Limit (UPL) Initiatives

There are two parts to the Upper Payment Limit (UPL) program.

1. Federal regulations at 42 CFR Section 447.271 impose a hospital specific limit providing that Medicaid payments may not exceed a hospital’s charges to the general public.
2. In addition, 42 CFR Section 447.272 establishes aggregate hospital limits by class of hospital: state government owned or operated, non-state government owned or operated, and privately owned and operated hospitals.

In accordance with this regulation, Medicaid payments made to all hospitals within a class cannot exceed a reasonable estimate of what Medicare would pay for these services. These regulations collectively are known as the Medicaid UPL. Medicaid hospital reimbursement rates in the aggregate are less than rates paid by the Medicare program. The deficiency in Medicaid rates (relative to Medicare or hospital charges) provides an opportunity to provide supplemental or enhanced payments up to the aforementioned UPL, thus increasing federal participation in the funding of Medicaid eligible services provided by hospitals. The supplemental or enhanced payments represent the difference between current Medicaid reimbursement levels and the lesser of what Medicare would reasonably pay for the service or the hospital charges.

As shown on Table IV.3 below, Texas has seven active UPL programs that have generated \$9.7 billion in federal funding since fiscal year 2002. In the first three quarters of fiscal year 2011, UPL programs are expected to generate another \$1.7 billion in federal funding.

Table IV.3

Upper Payment Limit (UPL) Programs: Active, FY 2002-2011											
Federal Funds (\$ in millions)											
	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY 11	FY02-2011 Total
<i>Active UPL Programs</i>											
Large Urban Public Hospital UPL *	170.2	216.9	410.9	497.4	442.4	547.4	588.6	560.5	676.6	740.2	4,851.1
State-Owned Hospital UPL *	-	-	29.4	39.7	49.4	87.8	87.8	41.7	68.1	56.1	460.0
Rural Hospital UPL *	14.1	20.1	29.1	41.4	46.1	46.3	41.2	51.9	78.5	14.8	383.5
Private Hospital UPL *	-	-	-	5.2	143.5	334.2	423.9	759.6	984.1	850.3	3,500.8
Public Physician UPL *	-	-	28.1	69.4	56.9	57.0	56.8	31.7	37.9	40.3	378.1
Private Physician UPL *	-	-	-	1.5	3.7	2.3	1.5	2.1	3.6	3.3	18.0
Children's Hospital UPL	-	-	-	-	19.3	19.4	19.2	27.9	30.5	22.4	138.7
Total	\$184.3	\$237.0	\$497.5	\$654.6	\$761.3	\$1,094.4	\$1,219.0	\$1,475.4	\$1,879.3	\$1,727.4	\$9,730.2

*With the exception of the Children's Hospital UPL, the 2011 federal funds are an estimate as the 4th qtr payment calculations have not been completed.

Beginning October 1, 2011 and pending approval by CMS, the 1115 Demonstration Waiver will supersede previous Upper Payment Limit programs in the state of Texas. The Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver allows former UPL funding, managed care savings, and negotiated funding to go into a statewide pool. Funding from the pool will be distributed to hospitals based on reported uncompensated care costs and incentive payments for transformation of service delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness. Except in the 2012 transition year when payments will be based on historical UPL payments, hospitals and physician groups will receive payments under the waiver.

V. American Recovery and Reinvestment Act of 2009 (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law in February of 2009, providing \$787 billion in economic stimulus funding through a multitude of new and existing programs. As detailed by agency on Table V.1 below, ARRA federal funds in the HHS system totaled approximately \$6.6 billion over the three year period from fiscal year 2009 through 2011 as follows: \$1.8 billion in fiscal year 2009, \$2.9 billion in fiscal year 2010, and \$1.9 billion in fiscal year 2011.

Table V.1

HHS Agency ARRA Funding: FY 2009 - FY 2011					
CFDA #	Agency/Grant Name	Exp. FY 2009	Exp. FY 2010	Exp. FY 2011	Total
Health and Human Services Commission					
93.778	Medicaid	\$ 1,263,963,582	\$ 1,931,217,931	\$ 1,363,971,294	\$ 4,559,152,807
10.561	Food Stamps (SNAP) Administration	13,843,316	13,987,018	0	\$ 27,830,334
93.714	TANF Emergency Contingency Fund	0	19,795,011	14,283,563	\$ 34,078,574
93.710	Community Services Block Grant	0	0	481,481	\$ 481,481
93.719	State Grants to Promote State Health Info. Tech.	0	974,955	5,236,572	\$ 6,211,527
Subtotal, HHSC		\$ 1,277,806,898	\$ 1,965,974,915	\$ 1,383,972,910	\$ 4,627,754,723
Department of Aging and Disability Services (DADS)					
93.778	Medicaid	\$ 515,740,696	\$ 728,692,755	\$ 410,457,977	\$ 1,654,891,428
93.707	Sr Nutrition Pgm -Congregate Meals	0	3,955,122	57,095	\$ 4,012,217
93.705	Sr. Nutrition Pgm-Home Delivered Meals	0	1,918,519	56,725	\$ 1,975,244
93.725	Chronic Disease Self Management	0	51,631	387,918	\$ 439,549
Subtotal, DADS		\$ 515,740,696	\$ 734,618,027	\$ 410,959,715	\$ 1,661,318,438
Department of Assistive and Rehabilitative Services (DARS)					
84.393	IDEA, Part C	\$ -	\$ 40,322,190	\$ 4,132,177	\$ 44,454,367
84.390	Vocational Rehabilitation	0	13,201,679	31,609,289	\$ 44,810,968
93.778	Medicaid	4,894,548	1,531,163	2,842,131	\$ 9,267,842
84.399	Indep. Living Svcs.(ILS) for Elderly/Blind	0	954,429	1,327,032	\$ 2,281,461
84.398	ILS Grants	0	362,554	698,881	\$ 1,061,435
Subtotal, DARS		\$ 4,894,548	\$ 56,372,015	\$ 40,609,510	\$ 101,876,073
Department of Family and Protective Services (DFPS)					
93.716	TANF Supplemental Funds	\$ -	\$ 47,982,709	\$ -	\$ 47,982,709
93.658	Foster Care - Title IV-E FMAP	12,647,747	16,178,002	5,296,180	\$ 34,121,929
93.659	Adoption Asst.- Title IV-E FMAP	7,615,269	10,000,271	4,352,656	\$ 21,968,196
93.713	Child Care Dev. BlockGrant	0	13,716,482	2,671,751	\$ 16,388,233
93.090	Title IV-E Guardianship Assistance	0	0	9,229	\$ 9,229
Subtotal, DFPS		\$ 20,263,016	\$ 87,877,464	\$ 12,329,816	\$ 120,470,297
Department of State Health Services (DSHS)					
93.778	Medicaid	\$ 11,916,537	\$ 17,875,890	\$ 5,878,206	\$ 35,670,633
10.578	WIC Grants to States: Tech. Grants/EBT	0	6,815,179	3,962,746	\$ 10,777,925
93.712	Immunization Program	0	2,996,545	2,994,598	\$ 5,991,143
93.716	TANF Supplemental	0	4,200,000	0	\$ 4,200,000
84.397	Stabilization Fund	0	833,334	1,299,383	\$ 2,132,717
93.720	Survey & Cert. Ambulatory	0	494,296	76,319	\$ 570,615
93.717	Preventing Healthcare Infections	0	502,744	502,744	\$ 1,005,488
93.414	State Primary Care Offices	0	53,795	4,570	\$ 58,365
93.723	Communities Putting Prevention to Work	0	1,879,651	3,908,342	\$ 5,787,993
Subtotal, DSHS		\$ 11,916,537	\$ 35,651,434	\$ 18,626,908	\$ 66,194,879
Grand Total		\$ 1,830,621,695	\$ 2,880,493,855	\$ 1,866,498,859	\$ 6,577,614,410

Source: FY 2012 Operating Budgets

HHSC and DADS account for approximately 98 percent of the ARRA funds in the HHS system in fiscal year 2009, 94 percent in fiscal year 2010, and 96 percent in fiscal year 2011, the majority of which is Medicaid. ARRA funds were also allocated through various categorical funding areas such as the Supplemental Nutrition Assistance Program (SNAP), the Individuals with Disabilities Education Act (IDEA) Part C (Early Childhood Intervention), Congregate and Home Delivered Meals, and the Child Care and Development Block Grant. Additionally, ARRA increased the Disproportionate Share Hospital (DSH) allotment, created a new TANF Emergency Contingency Fund, allocated funding for Health Information Technology (HIT), and provided supplemental funding for existing public health cooperative agreements and numerous competitive grant opportunities through the Prevention and Wellness Fund. ARRA was also the legislative vehicle for extending three programs: TANF Supplemental Funds, the Transitional Medical Assistance Program (TMA), and Qualified Individuals (QI) – see Section V.I for more information.

As mentioned previously, federal funding related to the temporary increase in federal Medicaid and Title IV-E FMAP matching rates makes up the largest share of ARRA funding in HHS agencies and is discussed in more detail below.

ARRA FMAP Increase and Six Month Phased-Down ARRA FMAP Extension

ARRA provided for a temporary increase in the Federal Medical Assistance Percentage (FMAP), which is used in determining the amount of federal matching funds for the Medicaid program and for the Title IV-E program. The FMAP rates for states were increased during the 27-month recession adjustment period, from October 2008 through December 2010. Congress later extended the FMAP increase for an additional six months at phased-down rates. In all, the FMAP increase spanned a 33-month period and ended on June 30, 2011. For Texas, the ARRA FMAP increase affected 11 months of state fiscal year 2009, 12 months of state fiscal year 2010, and 10 months of state fiscal year 2011.

The federal formula used to calculate the increase in FMAP provides a hold harmless and an across-the-board increase to all states. Additionally, states could qualify for a tiered unemployment adjustment depending on the percentage increase in unemployment in the state. Title IV-E funded programs (DFPS Foster Care and Adoption Assistance) are not eligible for the tiered unemployment adjustment, as ARRA provided that only the hold harmless and the across-the-board increase would apply to these programs.

Prior to the passage of ARRA, the Texas FMAP was 59.53 in state fiscal year 2009. During the stimulus period, the increased federal share for Medicaid in Texas ranged from approximately 9 to 11 percentage points above the pre-ARRA FMAP rate. When the ARRA FMAP adjustment period ended on June 30, 2011, the FMAP returned to the regular fiscal year 2011 FMAP rate of 60.56.

To receive the FMAP increase, Medicaid eligibility standards, methodologies, or procedures could not be more restrictive than those in effect as of July 1, 2008. Additionally, a state was not eligible for the across-the-board increase or the additional unemployment adjustment if any amounts attributable (directly or indirectly) to such increase are deposited

into any state reserve or rainy day fund. Prompt payment requirements for Medicaid providers also had to be met.

ARRA Grants Continuing Beyond Fiscal Year 2011

While most ARRA grants ended in fiscal year 2011, all eight of the DSHS grants, one grant at DADS, and two grants at HHSC will continue beyond fiscal year 2011. The largest continuing grants are HHSC's Health Information Technology Grants and they are highlighted below. An update is also provided on the TANF Emergency Contingency Fund, as there are three claims pending approval by the federal Administration for Children and Families (ACF).

State Health Information Exchange (HIE) Cooperative Agreement Program

The State Health Information Exchange (HIE) Program established by ARRA allows each state to enter into a cooperative agreement with the Office of the National Coordinator for Health Information Technology (ONC) through which each participating state receives a formula-funded allotment to support the development and implementation of strategic and operational plans for statewide HIE. The Texas allotment is \$28.8 million and the program period is four years, ending March 2014. Every state and territory, including Texas, is participating in the program. The development of the Texas state strategic and operational plans was coordinated by the Texas Health Services Authority, under contract with HHSC, and subsequently approved by ONC. The Texas strategic and operational plans identify three primary strategies for establishing HIE capacity throughout the state – general state level operations, including a state-level planning and governance structure for HIE and state-level technical services; a network of local HIE networks; and a subsidized marketplace for health information service providers to provide light HIE connectivity to health care providers in areas of the state without local HIE networks.

Medicaid Electronic Health Record (EHR) Incentive Payment Program

Per the provisions of ARRA, incentive payments will be made to qualifying Medicaid providers for the meaningful use of certified electronic health records (EHRs) with the goal of improving patient care. States receive 100 percent federal financial participation for the incentive payments to providers, and may obtain 90 percent federal matching funds to develop and administer the EHR incentive payment program. In December 2009, Texas received CMS approval for the planning phase (\$4.0 million all funds and \$0.4 million general revenue). In December 2010, HHSC received CMS conditional approval of their plan to provide incentives to health providers for adopting meaningful use of EHRs; final approval from CMS was received in February 2011 resulting in implementation funding for administering the program through August 2012 (\$8.0 million all funds and \$0.8 million general revenue). Incentive payments to Texas eligible providers began in May 2011. As of mid-November 2011, a total of over \$216 million in incentive payments have been made to Texas providers. The program anticipates that incentive payments will be dispersed through and including 2021.

TANF Emergency Contingency Funds (ECF)

ARRA authorized \$5.0 billion in new TANF Emergency Contingency Funds (ECF). A state's potential award is capped at half of its annual TANF grant (\$243 million for Texas).

The ECF provides 80 percent reimbursement for qualified spending increases in one of the three following categories: basic assistance, non-recurrent short-term benefits, and subsidized employment. Texas has the following approved TANF ECF claims totaling \$90.2 million:

- Basic Assistance Grant (HHSC)
- Non-Recurrent Short Term Benefits (Food Banks, HHSC)
- Subsidized Employment (Texas Workforce Commission)

At this time, there are three additional claims totaling approximately \$27.3 million in the non-recurrent short term benefits category that are pending Administration for Children and Families (ACF) approval:

- Public Utility Commission
- Food Banks
- Family Violence

ACF denied the Texas claim for charity care at local hospitals and recently issued guidance that charity care expenditures are not allowable claims under TANF ECF.

VI. Other Current Federal Issues

Temporary Assistance for Needy Families (TANF) Supplemental Funds

The Temporary Assistance to Needy Families (TANF) block grant established in the 1996 welfare reform law (PRWORA, P.L. 104-193) included supplemental grants for a select number of relatively poor or rapidly growing states. This TANF supplemental funding is provided to 17 states that meet criteria of high rates of population growth and/or low historic benefit levels. The grants were initially set to expire in 2001, but have been extended through a series of federal acts over the last decade. ARRA extended TANF supplemental grants through fiscal year 2010. A fiscal year 2011 Continuing Resolution then extended the grants for a partial year through June 30, 2011, resulting in a decreased allotment. Texas received \$34.9 million in fiscal year 2011 rather than the \$52.7 million it received in prior years. To date, the TANF supplemental grants have not been reinstated; however, Congress has the ability to authorize another extension of the grants through legislation or during the fiscal year 2012 appropriations process. Legislation has been filed in the current Congress that would restore funding and place the supplemental grants on the same renewal timetable as the regular TANF block grant; however, this legislation has yet to receive a hearing. HHSC continues to monitor congressional activity in relation to funding and/or policy changes of the TANF supplemental grants.

Transitional Medical Assistance

The 1988 Family Support Act required states to offer Medicaid coverage for up to 12 months to families who lost their welfare (now referred to as TANF) eligibility due to increased earnings. This continuation of coverage, known as Transitional Medical Assistance (TMA), was created to assist former welfare recipients by providing Medicaid coverage after they enter the workforce. Welfare recipients may enter low-wage jobs that do not offer health insurance or offer insurance that is unaffordable to individuals transitioning off TANF. Because lack of access to affordable health insurance is a potential disincentive for seeking employment, states were required to provide at least four and up to twelve months of transitional Medicaid benefits for qualifying individuals. As of September 2011, there were 11,338 individuals in Texas receiving transitional Medicaid coverage.

The Medicare and Medicaid Extenders Act of 2010 extended TMA through December 2011. If TMA is not extended beyond December 31, 2011, the anticipated effects are as follows:

- Individuals who lose Medicaid would have only 4 months of transitional Medicaid, rather than the 12 months currently provided.
- Texas would incur administrative costs related to eligibility system changes to change the number of months of allowed TMA coverage.

Legislation that includes a one-year extension of TMA, through December 31, 2012, is currently pending before Congress.

Qualified Individuals (QIs)

The Balanced Budget Act of 1997 created the Qualified Individual (QI) program, mandating that state Medicaid programs pay Medicare Part B premiums for elderly persons and persons with disabilities who have incomes between 120 percent and 135 percent of the federal poverty level. Under the QI program, states receive 100 percent federal reimbursement for paying Medicare Part B premiums up to an annual allotment (\$1 billion in federal fiscal year 2011). Administration is matched 50/50. The Medicare and Medicaid Extenders Act of 2010 extended the QI program through December 31, 2011. As of July 31, 2011, there were approximately 31,264 individuals in Texas receiving QI benefits.

If the QI program is not extended beyond December 31, 2011, the anticipated effects are as follows:

- Beginning January 1, 2012, payment for the program would be from general revenue (approximately \$3.1 million monthly) until the individuals are manually denied.
- Texas would incur administrative costs related to eligibility system changes to eliminate the QI program.

Legislation that includes a one-year extension of QI, through December 31, 2012, is currently pending before Congress. The measure would also reduce the capped allotment states receive to administer the program from \$1 billion in federal fiscal year 2011 to \$730 million in federal fiscal year 2012.

Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver

The 82nd Texas Legislature directed HHSC to expand managed care to achieve savings and to preserve hospital access to funding consistent with upper payment limit (UPL) funding. The best approach to meet legislative mandates, preserve hospital funding, expand managed care, achieve savings, and improve quality was to negotiate a five-year 1115 waiver that will begin December 2011. The overarching goals of the waiver are to:

- Expand risk-based managed care statewide.
- Support the development and maintenance of a coordinated care delivery system.
- Improve outcomes while containing cost growth.
- Protect and leverage financing to improve and prepare the health care infrastructure to serve a newly insured population.
- Transition to quality based payment systems in managed care and in hospital payments.
- Provide a mechanism for investments in delivery system reform including improved coordination in the current indigent care system in advance of health care reform.

Under the new waiver, supplemental hospital funding, managed care savings, and negotiated funding will go into a statewide pool now estimated at about \$29 billion over five years. Funding from the pool will be distributed to hospitals to support the following objectives: (1) an uncompensated care (UC) pool to reimburse hospitals and providers for uncompensated care costs as reported in the annual UC cost report; and (2) a Delivery System Reform Incentive Pool (DSRIP) to incentivize hospitals to transform their service

delivery practices to improve quality, health status, patient experience, coordination, and cost-effectiveness.

DSRIP will be structured with regional healthcare partnerships (RHPs), which are collaborations among hospitals and other providers that are led by public hospitals and local governmental entities responsible for funding the non-federal share of DSRIP payments. Each RHP will be responsible for developing a four-year plan that outlines projects and interventions in support of delivery system reforms tailored to the needs of the communities and populations served by the hospitals and other providers. DSRIP payments to participating RHP hospitals will be tied to achieving milestones and metrics for each project/intervention included in the plan.

The waiver provides additional new federal funding which Texas can access contingent upon having Intergovernmental Transfer (IGT) or other state share and meeting waiver guidelines. Over time, total waiver funding distributions will gradually shift a larger percentage of payments from uncompensated care towards hospital transformation.

S.B. 7 Medicaid Waiver

S.B. 7, 82nd Legislature, First Called Special Session, 2011 requires that HHSC pursue a Medicaid Reform Waiver. This waiver would allow Texas to implement reforms to Medicaid eligibility, benefits, and long-term care services, as well as implement Medicaid copayments. S.B. 7 also establishes a Medicaid Reform Waiver Legislative Oversight Committee to facilitate reform waiver efforts. The legislative oversight committee for this waiver has not yet been named.

Staff is working to develop a framework for a reform waiver that will do the following:

- Provide flexibility to design Medicaid benefits.
- Encourage use of the private health benefits coverage market.
- Establish co-payments for Medicaid.
- Establish health savings accounts for Medicaid.
- Establish vouchers for consumer-directed services.
- Consolidate federal funding streams.
- Provide flexibility in the use of state funds used to obtain federal match.
- Redesign long-term care services to increase access to cost-effective patient-centered care.

Health Care Reform

The Affordable Care Act (ACA) is comprised of two pieces of legislation, the Patient Protection and Affordable Care Act (PPACA), enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA). If fully implemented, pending current litigation, the ACA will make significant changes to the health care market.

Federal direction is pending on many of ACA provisions, and several provisions are not effective until 2014. HHSC has begun working on the requirements and options that have

earlier effective dates, and work on many of the larger provisions is in progress or will begin during the 2012-13 biennium.

Medicaid Expansion and Medicaid and CHIP Eligibility Changes and Interfaces with the Health Benefit Exchange (Exchange)

The ACA changes eligibility for Texas Medicaid and CHIP. Beginning January 1, 2014, the ACA effectively increases Medicaid eligibility to 138 percent of the federal poverty level (FPL) (133% + 5% disregard), and requires streamlined eligibility between Medicaid, CHIP, and the Health Benefit Exchange (Exchange) based on modified adjusted gross income (MAGI). Under law states are required to maintain existing level of Medicaid eligibility until January 2014 for adults and October 2019 for children.

Effective January 1, 2014, states must expand Medicaid eligibility to individuals under age 65 with incomes up to 133 percent of FPL. New Texas Medicaid client populations will include: parents and caretakers between 14 percent and 133 percent of FPL; childless adults up to 133 percent of FPL, Emergency Medicaid expansion, foster-care children through age 25; and children aged 6-18 between 100 percent and 133 percent of FPL (who are currently CHIP eligible). Texas will experience caseload growth both from newly eligible individuals and those individuals who are currently eligible but not enrolled. It is estimated that Texas Medicaid caseload will grow by approximately 1.2 million newly eligible individuals and 600,000 individuals who are currently eligible but not enrolled.

As shown below, for the first three calendar years of the mandated expansion, the federal government bears the full cost of coverage for new eligibles. The federal share begins decreasing in 2017.

- 100% FMAP - 2014 – 2016
- 95% FMAP - 2017
- 94% FMAP - 2018
- 93% FMAP - 2019
- 90% FMAP - 2020 and beyond

Administrative simplification for enrollment includes changing financial eligibility requirements for Medicaid. States must use –MAGI and may not use assets tests or income disregards (with some exceptions). Also, states must use a 5 percent income deduction allowance, making the effective ceiling 138 percent of FPL (133% +5%). Applications through the Exchange must be “deemed” to Medicaid and CHIP with no additional required action by the applicant. Per ACA, Medicaid, CHIP and Exchange must interface. Texas’ plans related to the Exchange are unknown at this time.

Benchmark Benefit for Medicaid Expansion Population

States are required to create a Secretary-approved benchmark benefit package for newly eligible Medicaid groups by January 2014, which may result in different benefit packages for existing and expansion Medicaid populations. Federal guidance on benchmark benefit requirements is expected in January 2012.

Provider Screening Requirements

The ACA included 19 program integrity provisions that impact Medicaid and CHIP. HHSC is in compliance with or has implemented several of these provisions. Work is currently in progress to implement new provider screening requirements, which encompass 9 of the 19 program integrity provisions and change provider enrollment requirements in Medicare, Medicaid and CHIP; change claims payment processes; increase audit activities; and increase state reporting requirements to CMS. Staff is working to estimate the cost of implementing and operating these new requirements. The estimated implementation date for these new requirements is Spring 2013.

Women's Health Waiver

The Women's Health Program (WHP) covers family planning services provided to women ages 18 to 44 with incomes at or below 185 percent of the federal poverty level (FPL). S.B. 747, 79th Legislature, Regular Session, 2005, directed HHSC to establish WHP. The waiver authorizing the program became effective January 1, 2007, and expires December 31, 2011. The 2012-13 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session, 2011 (Article II, Health and Human Services Commission, Rider 62) directed HHSC to renew the WHP waiver. HHSC submitted the WHP waiver renewal application to CMS on October 25, 2011, and it is currently pending approval.

The intent of WHP is to reduce expenditures for Medicaid-paid births by increasing low-income women's access to family planning services. Services provided under the WHP receive a 90/10 federal financial participation rate. HHSC estimates that in calendar year 2009, the WHP averted 10,300 Medicaid-paid births and saved about \$46.1 million all funds. The state share of the reduction in Medicaid costs totaled approximately \$22.9 million general revenue, and the net state share of savings after paying WHP expenditures totaled approximately \$19.9 million general revenue.

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires certain group health plans that offer behavioral health benefits (mental health and substance use disorder treatment) to provide those services at parity with medical and surgical benefits. MHPAEA does not apply to Medicaid fee-for-service programs; it does, however, apply to Medicaid managed care organizations. The CHIP Reauthorization Act of 2009 (CHIPRA) further applies MHPAEA requirements to all state CHIP programs.

Texas is in compliance with the MHPAEA and CHIPRA requirements. Effective September 1, 2010, Texas Medicaid managed care came into compliance with MHPAEA. And since March 1, 2011, CHIP has been in compliance with CHIPRA; to offset increased costs in the CHIP program, HHSC increased certain cost-sharing amounts.

CHIP Reauthorization

The CHIP Reauthorization Act of 2009 (CHIPRA) signed into law on February 4, 2009, authorized CHIP federal funding through federal fiscal year 2013. CHIPRA increased the amount of federal CHIP funding available to Texas and included significant policy changes that have impacted Texas.

For fiscal year 2011 the federal CHIP allotment for Texas was \$832.7 million. The CHIP allotment is adjusted annually based upon a formula that takes into account actual CHIP expenditures, child population growth, and a measure of health care inflation. Texas has two years to spend its CHIP allotment.

HHSC has implemented the following policy changes in accordance with federal CHIPRA guidance:

- Requiring CHIP health maintenance organizations to pay federally-qualified health centers and rural health centers their full encounter rates;
- Applying certain Medicaid managed care safeguards to CHIP;
- Verifying citizenship for CHIP;
- Implementing mental health parity in CHIP (see additional information included above).
- Providing federally-matched CHIP and Medicaid coverage to qualified immigrant children (see additional information included below).

CHIPRA also required all state CHIP programs to cover dental services “necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.” To comply with this requirement, Texas CHIP will be required to cover certain dental services not previously covered, including periodontic and prosthodontic services.

Effective March 1, 2012, the current three-tier benefit packages will be eliminated and all CHIP members will receive up to \$564 in dental benefits per enrollment period. Emergency dental services are not included under this cap. Members also will be able to receive certain preventive and medically necessary services beyond the \$564 annual benefit limit through a prior authorization process. To offset the costs of covering additional dental services, HHSC is raising CHIP cost-sharing amounts.

CHIP Perinatal

As of October, 2011, the CHIP Perinatal program serves approximately 36,393 women per month with incomes up to 200 percent of FPL who do not qualify for Medicaid coverage. Prior to September 1, 2010, Medicaid paid the facility (e.g., hospital) fees for CHIP Perinatal newborns at or below 185 percent of FPL and then, once the newborns were discharged, they were enrolled in CHIP for the remainder of the 12-month coverage period. CMS informed HHSC that these children, if Medicaid eligible, must be covered by Medicaid instead of CHIP. On September 1, 2010, pursuant to CMS direction, HHSC began enrolling newborns in Medicaid for 12 months continuous coverage. HHSC understands from CMS that it would not make retroactive adjustments for the period prior to

August 2010, when the Texas Medicaid State Plan amendment implementing this change was approved.

Title IV-B Reauthorization

On September 30, 2011, President Obama signed the Child and Family Services Improvement and Innovation Act (P.L. 112-34). The Act reauthorizes Title IV-B subpart 1 through fiscal year 2016, amends several plan requirements, and continues the title IV-B, subpart 1 funding at the current authorization level of \$325 million. The Act reauthorizes, through fiscal year 2016, the title IV-B, subpart 2 Promoting Safe and Stable Families Program as well as funding for research, training and technical assistance, the court improvement program, State monthly caseworker visit formula grants and competitive regional partnership grants and amends plan requirements. It authorizes \$345 million in mandatory funds and up to \$200 million in discretionary funds for programs under title IV-B, subpart 2 of the Act. The methodology for counting caseworker visits was modified in a way that will be easier for States to meet the benchmarks. Effective October 1, 2012 the act adds a new section, Title IV-B, subpart 3 which requires that HHS must regulate standard data elements for information that title IV-B agencies are required to report under title IV-B (section 440(a) of the Act).

The law also renews the waiver authority of the secretary of the federal Department of Health and Human Services (HHS) to grant approval of up to 10 new demonstration projects per year for three years (fiscal years 2012-2014). This waiver authority had expired in 2006. A new provision in the child welfare waiver authority allows HHS to terminate a demonstration project if, within three years, the state has not made significant progress in implementing child welfare improvement policies. The law also maintains the provision requiring the demonstration to be cost neutral to the federal government.

Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) Reauthorization

The SNAP program requires reauthorization every five years. The vehicle for reauthorization is the Farm Bill, filed as Senate Bill 1658 and House Resolution 3111, which are identical. Currently, the bills partially repeal categorical eligibility by limiting it to those receiving cash benefits from another qualifying program. If categorical eligibility is limited, a significant number of households that currently qualify for SNAP will no longer be eligible. Households currently exempt because their resources add up to no more than \$5,000 would no longer be eligible as the households will need to meet the \$2,000/\$3,000 resource limit, and vehicle exemption will be reduced from \$15,000 fair market value to \$4,650. Data is not collected on the households with resources over the federal \$2,000/\$3,000 resource limit but below the current \$5,000 limit; therefore, the number of households impacted cannot be determined. Households would also be subject to a lower gross income test. The categorical eligibility gross income limit of 165 percent of the federal poverty level would be reduced to 130 percent. As of October 2011, 5.6 percent of the caseload (81,755 cases) was in the 130-165 percent income range.

This bill also eliminates SNAP bonus payments made to states with low quality control error rates, does not allow states in liability status to reinvest funds, and eliminates funding for an

employment and training program administered by the Texas Workforce Commission and funded through the federal Food and Nutrition Service (FNS). The two bills were submitted to the Joint Select Committee on Deficit Reduction as debt reduction proposals. However, because the Committee was unable to reach a consensus on reducing the deficit by \$1.2 trillion, the Farm Bill will be taken up through the regular legislative process in the spring of 2012.

TANF Reauthorization

The Temporary Assistance for Needy Families (TANF) program was set to expire on September 30, 2011. H.R. 2943, the Short-Term TANF Extension Act, was passed on September 30, 2011, which authorized the continuance of current appropriations levels for TANF through December 31, 2011. By the end of December 2011, the TANF program must be reauthorized or another extension granted.

In addition to reauthorizing the regular TANF appropriations to the states, TANF reauthorization must address funding for TANF Supplemental grants and TANF Contingency Funds. Funding for TANF Supplemental grants is provided to states that experienced increases in their populations and/or had low levels of welfare spending per recipient in the mid 1990s. The TANF Contingency Fund provides a funding reserve which can be used to assist states that meet certain criteria intended to reflect economic distress such as an increase in unemployment or an increase in SNAP recipients. Funding for the TANF Contingency Fund is set to expire at the end of fiscal year 2012.

Legislation that includes an extension of the regular TANF block grant through September 30, 2012 is currently pending before Congress.

TANF/Work Requirements

The TANF program is administered by both HHSC and the Texas Workforce Commission (TWC). HHSC determines eligibility and provides cash assistance for the TANF program while TWC provides employment training and child care services for TANF recipients.

Federal law requires each state to meet a 50 percent work participation rate for all families receiving assistance, and a separately calculated 90 percent participation rate for two-parent families receiving assistance in federal or state-funded separate state programs that count toward the TANF maintenance of effort (MOE) requirement. Texas currently funds its two-parent program through state general revenue so the state is not required to meet or report the two-parent rate.

Federal TANF law includes a caseload reduction credit (CRC), which provides that work participation rate standards are reduced one percentage point for each one percent decline in the TANF caseload. The Deficit Reduction Act of 2005 (DRA) revised the CRC so states only receive credit for caseload declines that occur from fiscal year 2005 forward. Texas is reporting a 43.5 percent caseload reduction credit for fiscal year 2012 which means Texas will meet the federal "all families" rate of 50 percent if they reach a work participation rate of 6.5 percent.

The DRA did not change the penalty for failure to meet federal work participation requirements. Under the penalty structure, the first year in which a state fails to meet the “all families’ work participation rate can result in the state’s block grant being reduced by up to 5 percent. The non-adjusted State Family Assistance Grant (SFAG) for fiscal year 2011 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.

A federal participation rate penalty results not only in the loss of TANF federal funds but requires the state to expend state funds in an amount equal to the penalty amount. In addition, the TANF MOE requirement is 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.

Pending State Plan Amendments (SPAs)

Currently, HHSC has 15 state plan amendments (SPAs) pending with the Centers for Medicare and Medicaid Services (CMS). Pending rate reduction SPAs include those for tuberculosis clinics, inpatient hospital reimbursement, outpatient hospital reimbursement, pharmacy dispensing fee, and birthing centers. The other pending SPAs are related to supplemental payments for governmental ambulance providers, supplemental payments for publicly owned dental providers, consumer-directed services, a fee schedule update for durable medical equipment, the Public Assistance Reporting Information System (PARIS), Day Activity and Health Services (DAHS), non-emergency medical transportation, Medicare coinsurance and deductibles for dual eligible clients (Medicare equalization), and two SPAs related to Pre-Admission Screening and Resident Review (PASRR).

Immunization

In fiscal year 2011, the Section 317 immunization discretionary vaccine purchasing allocation for Texas (direct assistance) was projected to be approximately \$20 million. In order to increase national vaccine stockpile levels, the CDC reduced federal fiscal year 2011 Section 317 vaccine funding for all grantees; Texas was reduced to \$15 million. Texas’ discretionary vaccine budget from the CDC is anticipated to be \$12.3 million for federal fiscal year 2012 (an estimated net reduction of \$7.7 million from the targeted federal fiscal year 2011 budget). The reduction in available vaccine purchasing ability may result in limiting eligibility for DSHS provision of vaccines to children and adults in Texas.

Ryan White HIV/AIDS Treatment Modernization Act

President Obama signed the Ryan White HIV/AIDS Treatment Extension Act of 2009 on October 30, 2009 which continued the Ryan White HIV/AIDS Program through federal fiscal year 2013. This legislation authorizes funding for the delivery of outpatient medical care and psychosocial support services, and includes funding for the AIDS Drug Assistance Program (ADAP) that provides HIV treatment drugs for low income, uninsured or underinsured residents. The base Part B award is formula based, and the ADAP earmark is supplemented by a needs-based award. The law kept the 2006 reauthorization largely intact while making some minor changes to the program.

Overall, the authorization level for the program increased five percent annually. While the law increased the authorization level, the actual funding level will be determined by the appropriations. The law maintains the hold-harmless provision for Part A Eligible Metropolitan Areas (EMAs) and Part B formula funds at the rate of 95 percent of fiscal year 2009 funding in fiscal year 2010, 100 percent of fiscal year 2010 funding in the 2011-2012 biennium, and 92.5 percent of fiscal year 2012 funding in fiscal year 2013.

The future outlook for federal funds presents some issues for Texas:

- The authorizing legislation sunsets in 2013. In light of the substantial expansion of Medicaid and subsidized insurance access incorporated into the Patient Protection and Affordable Care Act (PPACA) and potential legislative or judicial actions regarding the PPACA, the future focus of the Ryan White Program and levels of necessary appropriation are in question.
- Eighteen states currently have wait lists or reduced ADAP services. Congress and the Health Resources and Services Administration have responded by making \$100M over the 2010 and 2011 fiscal years available to address these needs. As Texas has not instituted eligibility restrictions or wait lists, it has received only minor allocations of these additional funds (≈ \$1.5M in fiscal year 2011). Simultaneously, the number of states eligible to receive supplemental, needs-based ADAP funds increased, reducing Texas' share (≈ \$4M reduction from fiscal year 2010 to 2011). Texas can expect to receive reduced supplemental funds in fiscal year 2012 unless appropriations for Part B are increased.
- Three of the former Ryan White Title I Eligible Metropolitan Areas (EMAs) lost this designation under the 2009 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.

Public Health Preparedness

DSHS receives monies to fund critical public health infrastructure necessary for response to natural disasters such as hurricanes, emerging infectious diseases such as the novel H1N1flu pandemic, and man-made health threats like bioterrorism. Additional federal resources are needed for public health preparedness and response capacity. This includes bio-surveillance capabilities to detect emerging threats and public health and medical response such as medical and non-pharmaceutical interventions, as well as medical surge. A reduction of approximately \$5.5 million occurred for fiscal year 2011. In addition, the federal government state-local matching funds requirement increased from 5% in fiscal year 2009 to 10% for subsequent years.

Preventive Health & Health Services

The Preventive Health and Health Services Block Grant (PHHSBG) has provided states the flexibility to prioritize the use of funds for 29 years to fill funding gaps in public health programs that dealt with leading causes of death and disability, to prevent and control

chronic diseases such as heart disease, diabetes, and arthritis, as well as the ability to respond rapidly to emerging health issues including outbreaks of foodborne infections and water borne diseases. The funds allowed states to respond to the diverse, complex, and constantly changing public health needs of their communities and were the major source of funding to public health agencies to address health needs and problems such as immunization, tuberculosis, cancer and heart disease. In 2011, the block grant to Texas was decreased by 21% from \$4.1 million to \$3.2 million, resulting in elimination of public health programming and reducing public health infrastructure and capacity by decreasing the number of positions at the state, regional and local levels. The PHHSBG is not funded in the proposed President's Budget for fiscal year 2012.

Bi-National Health Issues

Historically, in awarding federal grant monies, the bi-national health problems present in Texas that are not experienced by other non-border states are not sufficiently recognized and considered. For example, additional federal support is needed for the treatment of persons who have active tuberculosis and make numerous crossings into the U.S. along the 1,200-mile Texas/Mexico border. Although these individuals are not U.S. citizens (or Texas residents), they enter and work in Texas with a highly communicable disease that requires treatment to prevent its transmission into Texas and into other states.

Women, Infants and Children (WIC)

When FY 2012 WIC appropriations were passed, funds were not set aside as in previous years for information systems and special projects. Funds for these purposes will be available after the participation demands of WIC are met. The federal agency is also required to produce a report on strategies to increase efficiencies within WIC by January 31, 2012.

International Classification of Diseases (ICD-10) Project

The ICD is a system for coding diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases, as classified by the World Health Organization. The ICD is used world-wide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. ICD-10-CM (Clinical Modification) is used in the coding of healthcare diagnoses. ICD-10-CM will replace ICD-9-CM, the version now used in the United States.

In addition, the ICD serves as the foundation for development of ICD-10-PCS (Procedure Coding System) which contains Current Procedural Terminology (CPT) coding and the Healthcare Common Procedure Coding System (HCPCS) code sets. ICD-10-PCS is a code set designed to replace Volume 3 of ICD-9-CM for inpatient procedure reporting. It will be used by hospitals and by payers and will not affect coding of physician services in their offices. However, physicians should be aware that documentation requirements under ICD-CM-PCS are quite different, so their inpatient medical record documentation will be affected by this change. ICD-10-PCS replaces ICD-9-CM, Volume 3.

The U.S. Department of Health and Human Services' final rule specifies a compliance date of October 1, 2013. The HHSC HIPAA Project Management Office (PMO) has begun the HHS Enterprise planning activities for implementation of the HIPAA Modification for Electronic Transaction Standards (5010) rule which is a pre-requisite for the ability to submit ICD-10 codes.

Title XX Social Services Block Grant (SSBG) Emergency Disaster Relief Funding

Hurricanes Ike and Dolly

HHSC received \$218.9 million of SSBG Emergency Disaster Relief Funding in fiscal year 2009 to provide a wide array of human services, including the provision of health care and rebuilding assistance to citizens of Texas impacted by Hurricanes Ike and/or Dolly. The SSBG Emergency Disaster Relief Funding may be spent directly on repairs, renovation and construction of health facilities, including mental health facilities, child care centers, and other social services facilities. The funding was allocated as follows:

Six Regional COGs:	\$ 125.9 million
U.T. Medical Branch at Galveston:	\$ 53.3 million
Uncompensated Care for Hospitals and other medical providers:	\$ 25.8 million
DADS, DSHS, DFPS and HHSC:	<u>\$ 13.9 million</u>
	\$ 218.9 million

Allocations to the six COGs were based on the number of FEMA assistance applications submitted by citizens impacted by one or more of the hurricanes and the population of each COG service area. All of the available SSBG Emergency Disaster Relief Funding was utilized for allowable services provided during the period September 13, 2008 – September 30, 2011, with approximately \$92.5 million of the SSBG Emergency Disaster Relief Funding expended in fiscal year 2011.

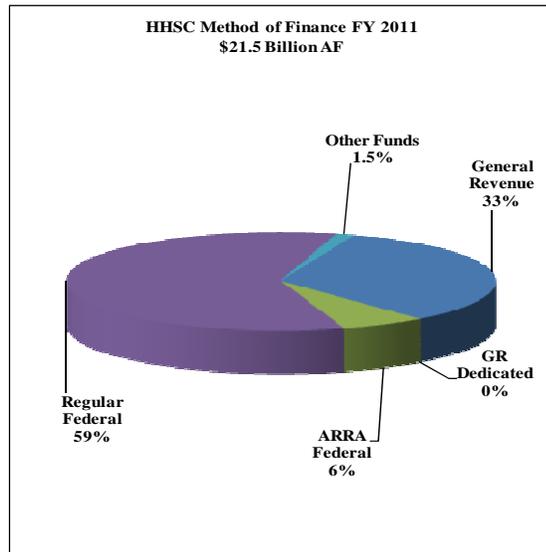
VII. Method of Finance and Key Federal Funding Sources by Agency

This section includes a chart displaying each HHS agency's method of finance and a brief discussion of each agency's key federal funding sources in fiscal year 2011.

Health and Human Services Commission (HHSC)

HHSC's \$21.5 billion budget includes 59 percent Regular Federal Funds and 6 percent ARRA Federal Funds. Of the \$14 billion in federal funding HHSC receives, 99.5 percent comes from four sources: Medicaid, ARRA, CHIP, and SNAP (Food Stamps) Administrative Matching Grants. Medicaid comprises 81 percent of HHSC's federal funding, ARRA represents 10 percent, CHIP accounts for 6 percent, and SNAP administration accounts for 2 percent.

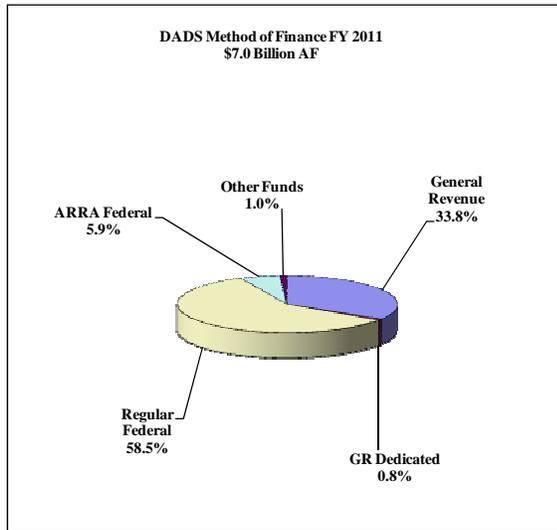
Figure VII.1



Department of Aging and Disability Services (DADS)

DADS' \$7.0 billion budget includes 59 percent Regular Federal Funds and 6 percent ARRA Federal Funds. Three sources, Medicaid, ARRA, and the Social Services Block Grant represent 96 percent of DADS' federal funding.

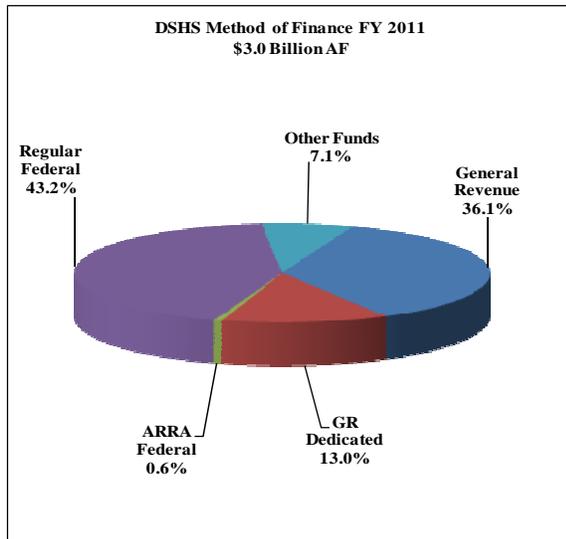
Figure VII.2



Department of State Health Services (DSHS)

The Method of Finance for DSHS includes 57 percent Regular Federal Funds and one percent ARRA Federal Funds. Of the approximately \$1.3 billion in Federal Funds received by DSHS, seven sources account for approximately 82 percent: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Block Grants for Prevention, Medicaid, HIV Care Formula Grant, Public Health Emergency Preparedness, Maternal and Child Health and Bioterrorism. DSHS receives more types of federal grants than any other HHS agency, with over 85 federal funding sources used in fiscal year 2011.

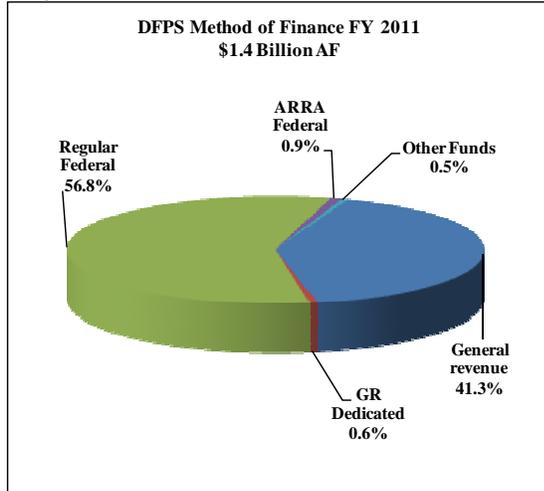
Figure VII.3



Department of Family and Protective Services (DFPS)

The DFPS budget includes 57 percent Regular Federal Funds and one percent ARRA Federal Funds. Three funding sources, TANF, Title IV-E Foster Care, and Title IV-E Adoption Assistance make up 79 percent of the agency’s \$798 million in federal funds.

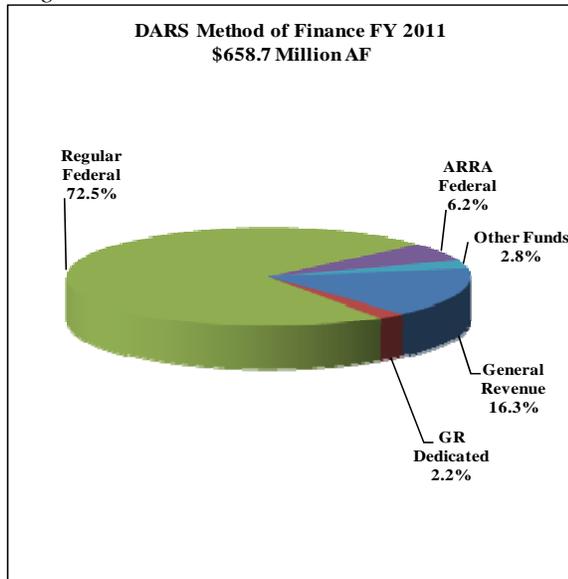
Figure VII.4



Department of Assistive and Rehabilitative Services (DARS)

The DARS budget includes 73 percent Regular Federal Funds and six percent ARRA Federal Funds. Vocational Rehabilitation, Social Security Disability Insurance, and Special Education Grants represent 74 percent of the \$518.5 billion in federal funding at DARS.

Figure VII.5



VIII. Federal Budget Outlook

Fiscal 2012 Appropriations

To keep the federal government “operating”, 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 and allows mandatory spending (Medicaid, SNAP, Title IV-E & F, CHIP, TANF, and SSBG) to proceed under the general authorizing law. The practice of enacting CRs in lieu of appropriations bills is increasingly common.

In late September 2011, Congress passed an initial CR, funding fiscal year 2012 through November 18, 2011. The CR allows discretionary government programs and agencies to continue operating at an annualized rate that is 1.5 percent less than fiscal year 2011 spending levels. That reduced funding rate is intended to ensure that the government adheres to the \$1.043 trillion cap on domestic spending for fiscal year 2012 set by the Budget Control Act of 2011.

On November 17, 2011, President Obama signed the first appropriations bill for fiscal year 2012, a “minibus” measure that includes funding for the departments and related agencies under Agriculture, Commerce-Justice-Science, Transportation, and Housing and Urban Development (HUD). Working off the \$1.043 trillion cap on fiscal year 2012 discretionary spending set by the Budget Control Act, the three appropriations bills combined provide \$128 billion in discretionary spending. With associated mandatory spending and funds from the transportation trust fund, the measure provides almost \$300 billion in total spending. The measure also includes \$2.3 billion in emergency disaster relief that is exempt from the discretionary cap, and it extends through December 16, 2011, current stopgap funding for departments and agencies that are not covered by this bill. The second continuing resolution operates under the original terms and conditions of the first CR, meaning that programs and agencies must operate at an annualized rate that is 1.5 percent less than fiscal year 2011 spending levels.

Congress is slated to take up the remaining nine annual appropriations bills for fiscal year 2012 before December 16, 2011, the expiration date of the current CR. Despite the success of utilizing the smaller “minibus” strategy for the first three appropriations bills, the remaining measures have been combined into a single omnibus bill. A conference committee has been appointed to reach a compromise on the omnibus measure. Due to some contentions budgetary and policy issues in the measure, the committee may extract certain sections of the bill and continue funding these departments under a CR through the remainder of the fiscal year. In the event that Congress votes to fund some departments through a CR, the annualized rate of 1.5 percent less than fiscal year 2011 spending levels would apply. Appropriations bills that may be continued through a continuing resolution include Labor/HHS/Education, Financial Services and Interior-Environment.

In addition to passing a fiscal year 2012 budget, Congress is currently assessing how to reduce the federal deficit by as much as \$1.2 trillion over the next ten years. The Budget

Control Act of 2011 created the Joint Select Committee on Deficit Reduction, which was required to make recommendations to Congress that would reduce the deficit by \$1.2 trillion over the next decade. Despite three months of negotiations, the Select Committee was unable to reach an agreement to cut the deficit by any amount. Therefore, as prescribed in the law, a process known as sequestration is scheduled to take effect on January 2, 2013. The sequestration mechanism would make across the board budget cuts to achieve any deficit savings not agreed upon by the Select Committee. The spending cuts would fall equally on defense and non-defense accounts, including both discretionary spending and some entitlement spending. Programs targeting low-income individuals and families would largely be exempt from the sequester. Medicare cuts would be restricted to no more than two percent of the program's outlays, and would only affect payments to providers, not beneficiaries. The Budget Control Act of 2011 states that automatic spending cuts would be triggered to achieve the desired savings and spread spending cuts equally across nine fiscal years (2013-2021).

Although the Select Committee did not reach an agreement on reducing the deficit, Congress is afforded the opportunity to make deficit reduction recommendations and vote upon such measures through the legislative process. Congress may also seek to amend the structure of the cuts so that certain departments, such as the Department of Defense, do not endure a disproportionately higher budget cut. Ultimately, any sequester that would occur in January 2013 would be equal to the portion of the \$1.2 trillion savings target that was not achieved by Congress or the Joint Select Committee on Deficit Reduction.

Texas will actively monitor federal program, policy, and appropriation activities to help provide additional perspectives and options, and to evaluate the impact of federal activities on the state's ability to administer effective and efficient programs and to seek equitable funding distribution to our growing state.