Appendix A: Key Medicaid and CHIP Legislation

CHIP and Medicaid change in response to legislative requirements. The following sections include highlights from the 84th Legislature and relevant federal changes to the programs since 1965.

Highlights of the 84th Legislature

H.B. 751 - Generic Equivalents

H.B. 751 allows pharmacists to substitute generic equivalents of biological products unless the practitioner certifies on the prescription that a specific brand of a biological product is medically necessary.

H.B. 839 - Presumptive Eligibility for Certain Youth Leaving the Juvenile Justice System

H.B. 839 certifies a child as presumptively eligible for Medicaid or CHIP upon the child's release from a juvenile justice facility, if the child was receiving Medicaid or CHIP benefits prior to entering the juvenile justice facility.

H.B. 1878 - Reimbursement for School-Based Telemedicine

H.B. 1878 ensures physicians enrolled in Medicaid receive reimbursement for providing telemedicine medical services to a child in a primary or secondary school-based setting, even when the physician is not the child's PCP, if the child's parent or legal guardian consents before the telemedicine medical service is provided.

H.B. 1924 - Delegation to Psychology Interns

H.B. 1924 allows psychologists to delegate certain psychological testing and services to a person enrolled in a formal internship in accordance with Texas State Board of Examiners of Psychologists rules.

H.B. 2280, H.B. 2809, H.B. 2913, H.B. 3175, H.B. 3185, S.B. 1387, S.B. 1587 - County and Municipal Health Care Provider Programs

H.B. 2280, H.B. 2809, H.B. 2913, H.B. 3175, H.B. 3185, S.B. 1387, and S.B. 1587 create county health care provider participation programs in several Texas counties. A county or municipal health care provider participation program authorizes a county or municipality to collect mandatory payments from each institutional health care provider located in the county or municipality to be deposited in a local provider participation fund established by the county or municipality. Money in the fund may be used by the county or municipality to fund indigent care programs and to provide the state with the non-federal share of a Medicaid supplemental payment program, such as the payments required for providers to participate in 1115 Transformation Waiver DSRIP projects.

H.B. 2340 - Prescribed Pediatric Extended Care Center Revisions

H.B. 2340 permits DADS to issue a temporary PPECC license, pending issuance of an initial license, under which the PPECC could serve up to six clients for not more than 180 days.

The bill also specifies:

- PPECC nursing services must be a one-to-one replacement of other skilled nursing services, unless additional nursing services are medically necessary.
- The reimbursement rate for PPECCs, when converted to an hourly rate, cannot exceed 70 percent of the hourly rate for Medicaid PDN.
- The parent, legal guardian, or managing conservator of a minor client is not required to accompany the minor client to services provided at a PPECC.

H.B. 3433 - Perinatal Advisory Council

H.B. 3433 adds two additional rural members to the PAC, bringing the total number of members to 19. The bill extends the dates by which a hospital must have a neonatal level of care designation to receive Medicaid neonatal care reimbursement and a maternal level of care designation to receive Medicaid maternal services reimbursement to September 1, 2018 and September 1, 2020, respectively.

H.B. 3519 - Home Telemonitoring

H.B. 3519 moves the sunset date for Medicaid home telemonitoring services reimbursement from September 1, 2015, to September 1, 2019, so HHSC may continue to determine whether this service reduces chronic disease exacerbations and hospitalizations in eligible clients.

H.B. 3523 - Changes to Managed Care Expansion for Intellectual and Developmental Disability Waiver Programs

H.B. 3523 builds on requirements in S.B. 7, 83rd Legislature, Regular Session, 2013 by:

- Expanding the role of the Intellectual and Developmental Disability System Redesign Advisory Committee.
- Requiring more detailed reports to the Legislature on the implementation of the LTSS system redesign.
- Removing expiration dates on existing regulations regarding NF providers seeking to participate in Medicaid managed care.

The bill delays the transition of TxHmL to Medicaid managed care by one year, to September 1, 2018, and delays the transition of other IDD waivers and ICFs/IIDs to managed care by one year, until September 1, 2021. It also delays the mandated start of the IDD pilot by one year, to September 1, 2017, and removes the requirement that the pilot last at least two years. The bill requires HHSC and the advisory committee to analyze the outcomes of the transition of LTSS under the TxHmL waiver program to Medicaid managed care.

H.B. 4001 - Habilitation Services Licensure Requirements

H.B. 4001 adds habilitation as a service provided by a HCSSA and requires a provider of habilitation to be a licensed HCSSA. Habilitation providers in the HCS and TxHmL waiver programs or the STAR+PLUS or other Medicaid managed care programs are exempt from the licensure requirements. The bill authorizes imposition of administrative penalties for HCS and TxHmL waiver programs.

S.B. 125 - Assessment for Children in State Conservatorship

S.B. 125 requires that all children must receive a trauma-informed CANS within 30 days of being removed from their homes by DFPS.

S.B. 200 - HHS Sunset Review and Transformation

The Texas Sunset Commission began an almost two-year analysis of the HHS system in 2013. The findings and recommendations of the Sunset review formed the basis for the Legislature's directive, via S.B. 200, to consolidate and transform the HHS system.

S.B. 200 takes a phased approach to restructuring the HHS system, including transferring DARS; client services at DADS, DFPS, and DSHS; and certain administrative services to HHSC on September 1, 2016. Regulatory programs as well as SSLCs and state hospitals will transfer to HHSC on September 1, 2017.

S.B. 200 requires HHSC to develop and submit a detailed transition plan for moving all programs and functions to the newly created Transition Legislative Oversight Committee. For more information about Transformation under S.B. 200, please see **Chapter 13**, **Administration**.

S.B. 207 - Sunset Review of HHSC Inspector General

S.B. 207 requires that the HHSC IG will be reviewed by the Sunset Advisory Committee every six years to establish priorities and guide the investigation process. The bill clarifies the role and authority of IG's investigations, audits, payment holds, and general operations, including greater Medicaid managed care oversight.

S.B. 460 - Pharmacy Dispensing Standards During a Disaster

S.B. 460 makes various changes to pharmacy licensure and establishes a pharmacist's authority to dispense a limited supply of a dangerous drug during a disaster. In the event of a natural or manmade disaster, a pharmacist may dispense up to a 30-day supply of a dangerous drug without the prescribing doctor's authorization if all of the following criteria are met:

- Failure to refill the prescription will interrupt the patient's therapeutic treatment or cause the patient to suffer.
- The disaster prohibits the pharmacist from contacting the patient's doctor.
- The Governor has declared a state of disaster.
- The Texas State Board of Pharmacy has notified Texas pharmacies that pharmacists may dispense up to a 30-day supply of a dangerous drug.

S.B. 760 - Medicaid Managed Care Organization Network Standards

S.B. 760 requires HHSC to establish additional minimum provider access standards for Medicaid MCO provider networks in its managed care contracts. These requirements include:

- Developing new minimum distance, travel time, and appointment wait time standards for member access to providers.
- Updating the expedited credentialing process to expand the list of provider types eligible for expedited credentialing.
- Requiring all MCOs to publish provider directories online, with provider information updated at least monthly.

Prior to serving Medicaid recipients, an MCO must demonstrate to HHSC that the MCO provider network offers sufficient access to certain types of care including: primary care; preventive care; specialty care; urgent care; chronic care; LTSS; nursing services; and therapy services. The MCO's provider network must also have the capacity to serve the number of recipients expected to enroll in that MCO's plan.

S.B. 1462 - Opioid Antagonists

S.B. 1462 provides for the prescription, distribution, administration, and possession of an opioid antagonist for the treatment of an opioid-related drug overdose. A provider may prescribe and a pharmacist may dispense an opioid antagonist to:

- A person at-risk for an opioid-related drug overdose.
- A family member, friend, or other person able to assist a person at risk for an opioid-related drug overdose.

The opioid antagonist may be prescribed or dispensed directly or under a standing order. Emergency services personnel may administer an opioid-antagonist. Any person may possess an opioid-antagonist, regardless of whether they have a prescription for it.

S.B. 1664 - Achieving a Better Life Experience (ABLE) Program

S.B. 1664 amends the Education Code to establish the Texas Achieving a Better Life Experience (ABLE) Program administered by the Prepaid Higher Education Tuition Board within the office of the Texas Comptroller of Public Accounts. The federal ABLE Act of 2014 was enacted to assist individuals and

families in saving private funds to support individuals with disabilities to maintain health, independence, and quality of life. S.B. 1664 allows Texas to establish a savings program under which contributions can be made to an ABLE account of a Texas resident. Savings in ABLE accounts are not counted toward a beneficiary's eligibility for state assistance or benefits programs.

S.B. 1880 - DFPS Investigation of Abuse, Neglect, and Exploitation

S.B. 1880 expands DFPS authority to investigate all Medicaid providers of HCBS unless another licensing entity has the authority to conduct the investigation. The bill transfers DADS' authority to investigate allegations of abuse, neglect, or exploitation of a child under 18 receiving HCSSA services to DFPS.

HHSC Rider 50 of the 2016-17 General Appropriations Act - Medicaid Funding Reduction and Cost Containment

Rider 50 requires HHSC to achieve $373 million in general revenue ($870 million all funds) savings in Medicaid for the 2016-17 biennium. The rider proposes a list of 16 cost containment initiatives and permits other initiatives identified by HHSC. In general, the initiatives focus on service delivery and quality improvements, payment reform, and reduction of fraud and waste. Examples of specific areas targeted include managed care contracting, pharmacy services, and better birth outcomes.

The rider specifies that at least $150 million of the total General Revenue funds savings should be related to physical, occupational, and speech therapy services. Of this therapy-related savings, at least $100 million in general revenue funds saving should be achieved through rate reductions, and the remaining $50 million in general revenue funds savings should be achieved through medical policy initiatives or additional rate reductions.

Major Federal Changes to Medicaid and CHIP

Social Security Amendments of 1965

- Amends the Social Security Act of 1935 by adding Title XIX, creating Medicaid.
- Texas implements Medicaid September 1, 1967, as directed by S.B. 2, 60th Legislature, Regular Session, 1967.

Social Security Amendments of 1967

Mandated

- EPSDT program for children's health.
- Freedom of choice of providers.

Public Law 92-223 of 1971

Optional

- Allows states to cover services in an ICF/IID.

Social Security Amendments of 1972

Optional

- Allows states to cover care for Medicaid clients under age 22 in inpatient psychiatric hospitals.

Omnibus Budget Reconciliation Act of 1981 (OBRA)

Optional

- Allows states to provide HCBS to persons who would otherwise require institutional (hospital, ICF/IID, or nursing home) services under 1915(c) or "2176" waivers.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Optional

- Allows states to extend coverage to children with disabilities under age 18 living at home who would be eligible for SSI if in a hospital, ICF/IID, or nursing home.

Deficit Reduction Act of 1984 (DEFRA)

Mandated

- Provides coverage for children up to age five born after September 30, 1983, whose families meet AFDC (now TANF) income and resource limits, even if the family does not qualify for AFDC (i.e., if both parents are in the home). Texas also covers children from ages 6 to 19 in such families.
- Provides coverage of pregnant women in households that would meet AFDC (now TANF) income/resource limits after a child is born, including households with an unemployed "principal wage earner" present.
- Provides automatic coverage of infants born to and living with Medicaid-eligible mothers.

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985

Mandated

- Extends coverage of pregnant women to households with an employed principal wage earner if TANF financial standards are met.
- Discretionary distributions from a "Medicaid-qualifying trust" are countable regardless of whether such distributions are made.

Optional

- Allows states to immediately cover DEFRA children up to age five (no phase-in required).

OBRA of 1986

Mandated

- Provides coverage of emergency care services (including labor and delivery) for undocumented immigrants.
- Provides coverage of homeless persons. Lack of home address may not be grounds for denial of eligibility.

Optional

- Allows states to cover infants up to age one and pregnant women under 100 percent of the FPL. Creates phase-in for children up to age five under 100 percent of the FPL. Also allows coverage for prenatal care while Medicaid application is pending and guaranteed coverage for the full term of pregnancy and postpartum care. Allows states to waive assets tests for this group.

OBRA of 1987

Mandated

- Extends coverage to age seven for children born after September 30, 1983, whose families meet AFDC (now TANF) financial standards, even if the family does not qualify for AFDC (extension to age eight at state's option).
- Makes sweeping changes in NF standards, including the creation of the Preadmission Screening and Resident Review (PASRR) process, a requirement that all current and prospective NF clients be screened to identify persons with mental illness, intellectual disability, or related conditions.

Optional

- Allows states to cover infants up to age one and pregnant women under 185 percent of the FPL and allows immediate coverage (no phase-in) of children up to age five under 100 percent of the FPL.
- Allows states to develop systems of care for home and community-based and institutional LTSS via 1915(d) waivers.

Medicare Catastrophic Coverage Act of 1988

Mandated

- Provides phased-in coverage of out-of-pocket costs (premiums, deductibles, and co-insurance) for QMBs under 100 percent of the FPL.
- Provides phased-in coverage of infants up to age one and pregnant women under 100 percent of the FPL.
- Requires more comprehensive coverage of hospital services for infants.
- Requires the deduction of incurred medical expenses in the post-eligibility treatment of income.
- Establishes minimum standards for income and asset protection for spouses of Medicaid clients in nursing homes.
- Establishes a 30-month penalty period for transfers of assets to establish Medicaid eligibility.
- Expands payments for hospital services for infants in all hospitals and for children up to age six in DSH hospitals.
- Once eligibility is established, coverage of pregnant women may not be terminated until two months postpartum. Infants born to Medicaid-eligible mothers must be covered through their first birthday if the mother remains eligible or if she would be eligible if she were pregnant.

Optional

- Allows states to create home and community care programs for people with disabilities (1929(b) "Frail Elderly") and to apply for funding services for persons with developmental disabilities (1930 Community Supported Living Arrangements).

OBRA of 1989

Mandated

- Does not permit states to limit amount, duration, scope, or availability of state plan services to children on Medicaid.

Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991

Mandated

- Restricts use of voluntary donations from health care providers to state Medicaid programs.
- Caps spending on DSH reimbursement.
- Sets strict standards for taxes on health care providers and ceilings on the share of state Medicaid funds that may be financed through provider taxes.

OBRA of 1993

Mandated

- States must distribute federally-provided vaccines to Medicaid providers.
- States without medically needy spend-down programs for NF services must allow eligibility of persons with certain trusts.
- Sets new standards for participation in and payments under the DSH program.
- Sets stricter standards for transfer-of-assets penalties for NF care and HCBS waiver services. Also sets new standards for the treatment of trusts in determining Medicaid eligibility.

Optional

- States may create a new eligibility category for persons infected with tuberculosis who meet Medicaid financial standards for persons with disabilities.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Mandated

- Requires standardized electronic exchange of administrative and financial health services information for all health plans, including Medicaid.
- Protects the security of electronically transmitted or stored information and the privacy of individuals.
- Implements the NPI to be used in all electronic transactions between providers and health plans.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)

PRWORA, commonly referred to as welfare reform, is federal legislation that requires adult TANF clients to participate in work activities within two years of entering the program and prohibits them from receiving federally funded TANF benefits for more than 60 months over a lifetime. The impact of welfare reform is thought to be partly responsible for the state's Medicaid caseload drop in the mid- to late-1990s. Individuals who qualified for TANF comprised approximately 18 percent of the Medicaid population in 1999, down from 28 percent in 1997.[1]

PRWORA also gave states the option to decide whether or not to continue providing Medicaid to most legal immigrants. Most immigrants entering the U.S. after August 22, 1996, are subject to a five-year

[1] Health Care Financing Administration, 2082 Report, "Statistical Report on Medical Care: Eligible Recipients, Payments, and Services," 1997 and 1999.

"bar" period, during which no federal Medicaid funds can be accessed for their care. The Balanced Budget Act of 1997 restored SSI benefits for legal immigrants who arrived in the U.S. prior to August 22, 1996, but limited the benefit until after the first seven years of a person's residence in the U.S. Beginning in 2003, some persons began to reach the seven-year limit. Those arriving after August 22, 1996, are still ineligible for the SSI program.

Medicaid benefits have never been available to undocumented immigrants, thus PRWORA made no changes in this area. However, states are mandated to reimburse health providers for costs of emergency services to undocumented persons who would otherwise be income-eligible for Medicaid, including costs of labor and delivery.

The Balanced Budget Act (BBA) of 1997

Under the BBA, both Medicaid and Medicare statutes and regulations were significantly altered. Total federal Medicaid spending was cut by $17.2 billion through:

- Reduction of payments to DSH.
- Allowances for states to lower what they paid for Medicare co-payments, deductibles, and coinsurance for QMBs.
- Repeal of the Boren Amendment, eliminating minimum payment guarantees for hospitals, NFs, and community health centers that serve Medicaid clients.[2]

Under the BBA, states no longer needed a waiver, such as an 1115 or 1915(b), to require most Medicaid-eligible pregnant women and children to enroll in managed care plans. A waiver is still required if a state wants to expand Medicaid eligibility, require SSI recipients and foster children to enroll in managed care plans, or expand benefits.[3]

States also gained new eligibility options:

Guaranteed eligibility

This option allows states to choose to guarantee Medicaid coverage for up to 12 months for all children, even if they no longer meet Medicaid income eligibility tests.

Medicaid Buy-In

This option allows states to offer individuals with disabilities and income below 250 percent of the FPL an opportunity to "buy-in" to the

[2] Center on Budget and Policy Priorities, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33," September 8, 1997, http://www.cbpp.org/908mcaid.htm (November 2014).

[3] Center on Budget and Policy Priorities, "Overview of Medicaid Provisions in the Balanced Budget Act of 1997, P.L. 105-33," September 8, 1997, http://www.cbpp.org/908mcaid.htm (November 2014).

Medicaid program. Each state creates guidelines for its own Medicaid buy-in program. In September 2006, Texas implemented a buy-in program that enables working persons with disabilities to receive Medicaid coverage. Individuals with incomes up to 250 percent of the FPL may qualify for the program and pay a monthly premium to receive Medicaid benefits.

Medicaid Buy-In for Children

This option allows states to offer children up to age 19 with disabilities an opportunity to "buy-in" to the Medicaid program. Texas implemented the MBIC program in January 2011. Children with family income less than or equal to 150 percent of the FPL may qualify for the program and pay a monthly premium to receive Medicaid benefits.

Balanced Budget Refinement Act of 1999 (BBRA)

The BBRA provided approximately $17 billion in "BBA relief" over five years. Most of the provisions of the BBRA were focused on rural health care delivery and access to services for rural Medicare beneficiaries; however, there were provisions specific to the Medicaid program. In particular, the BBRA made the following changes:[4]

- Extended the phase-out of cost-based reimbursement for community health centers, and called for a study to evaluate the impact of changing Medicaid reimbursement to community health centers.
- Changed Medicaid DSH payments and rules. The base-year data used to set the DSH allotments in the BBA were flawed for some states and adjustments were made. The DSH transition rule was also made permanent, and states were prohibited from using enhanced federal matching payments under CHIP for DSH.

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA)

- Expands the BBA by creating two optional categorically needy Medicaid buy-in groups for individuals age 16 to 64 who, except for earned income, would be eligible for Medicaid.
- Creates a new demonstration to help people at risk for disability

[4] Rural Policy Research Institute, "Rural Implications of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999: A Rural Analysis of the Health Policy Provisions," December 1999, pp. 2-3.

maintain their independence and employment.

- Extends Medicare coverage for persons with disabilities who return to work.
- Enhances the employment services system by creating a "Ticket to Work Program." This system is intended to enable SSI or Social Security Disability Income beneficiaries to obtain vocational rehabilitation and employment services from participating public or private providers. If the beneficiary goes to work and achieves substantial earnings, providers would be paid a portion of the benefits saved.[5]
- Provides Medicaid Infrastructure Grants to states to develop state infrastructure that supports working individuals with disabilities.

Breast and Cervical Cancer Prevention and Treatment Act of 2000

- Allows states to create a new Medicaid eligibility category for persons screened by the CDC breast and cervical cancer early detection program, found to be in need of treatment for cancer, and not otherwise eligible for Medicaid. Texas implemented this option in 2002.
- Provides federal funds for services at the same enhanced rate as for CHIP.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

- Increased 2001 and 2002 DSH payment state allotments.
- Required new federal rules to be issued by the end of 2000 limiting Medicaid UPL payments to government facilities and provided for a transition period.
- Allowed unspent 1998 and 1999 CHIP funds to be carried forward to subsequent years and allowed up to ten percent of retained 1998 allotments to be used for outreach activities.

Improper Payments Information Act of 2002 (IPIA)

- Requires federal agencies to identify programs that may be susceptible to significant improper payments and conduct annual program reviews, submit estimates to Congress on the amount of improper payments, and report

[5] Centers for Medicare & Medicaid Services, "Employment Initiatives: Ticket to Work and Work Incentives Improvement Act," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html (November 2014).

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on the agencies' actions to reduce improper payments.

- In response to the IPIA, CMS created the Payment Error Rate Measurement (PERM) program for Medicaid and CHIP. The PERM program determines states' error rates for Medicaid and CHIP eligibility determinations and claims payments.
- HHSC Internal Audit Division is responsible for coordination and implementation of the PERM Program across all HHS agencies, including acting as the single point of contact with CMS on PERM issues. Each state is reviewed once every three years.

Jobs and Growth Reconciliation Act of 2003

- Temporarily increased the FMAP for five calendar quarters (April 2003 through June 2004) as part of a "state fiscal relief" package.
- As a condition of receiving the enhanced FMAP, states are required to maintain the same Medicaid eligibility requirements as were in effect on September 2, 2003. This provision prevented states from receiving additional federal funds while simultaneously enacting more stringent eligibility policies to reduce the number of people eligible for their Medicaid programs.

CHIP Allotment Extension

- Allowed states to retain unexpended federal fiscal year 1998-99 federal allocations through federal fiscal year 2004.
- Allowed states additional time to spend 50 percent of unused federal fiscal year 2000 and federal fiscal year 2001 federal allocations (through federal fiscal year 2004 and federal fiscal year 2005, respectively).
- Allowed approximately ten states that had expanded Medicaid prior to the enactment of CHIP to use their CHIP funds to cover the cost of some of those expansions. This provision did not apply to Texas.

Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA)

The most historic feature of the MMA was the creation of an outpatient prescription drug benefit in Medicare, known as Medicare Part D. The bill also changed many provider payments, some of which had been reduced or constrained by previous legislation. Major provisions affecting the Medicaid program include the following:

- Implementation of a voluntary prescription drug discount card program that also provided

a subsidy for low-income beneficiaries. The discount card program was in effect in 2004 and 2005.

- Implementation of a prescription drug benefit offered through private sector plans, which began January 1, 2006. Called Part D, the benefit is available to all Medicare beneficiaries, including those who are also eligible for Medicaid (dual eligibles). Preparation for transitioning Medicaid enrollees to Part D required extensive state involvement and the state has a continuing role in eligibility determination.
- Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare providing drug coverage to dual eligibles (referred to as the "clawback" provision).
- Addition of preventive benefits to Medicare and the elimination of co-pays for home health services, some of which were previously covered by Medicaid.
- Increased premiums for Medicare Part B, which covers physician services, lab services, etc. Medicaid pays these premiums on behalf of certain clients dually eligible for Medicare and Medicaid.
- Increased state allotments for DSH payments for 2004-2010.
- Appropriation of $250 million annually for federal fiscal years 2005-2008 to compensate medical providers for emergency care provided to undocumented immigrants. Payments are made directly by the federal government to providers.

American Jobs Creation Act of 2004 (Sickle Cell Benefit)

- Provides a new optional Medicaid benefit for sickle cell disease.
- Makes federal matching funds available for education and outreach to Medicaid-eligible adults and children with sickle cell disease.

Deficit Reduction Act of 2005 (DRA)

The DRA, a comprehensive budget reconciliation bill, was signed into law February 8, 2006. The federal government estimated that the DRA would reduce federal spending on Medicaid and Medicare by $39 billion for the five-year period 2006-2010 in the following five major categories of spending:

- Prescription drugs.
- Asset transfer changes for long-term care eligibility.
- Fraud, waste, and abuse.
- Cost-sharing and benefit flexibility.

- State financing (including changes in funding targeted case management and restrictions on provider taxes).

Welfare Reform Extensions and Reauthorizations

Various laws have been passed to extend PRWORA beyond its expiration date of September 30, 2002. The DRA reauthorized TANF through September 30, 2010, and continuing resolutions have extended the program since 2010. Most recently, a continuing resolution extended TANF through April 28, 2017. Supplemental grants to states such as Texas were only extended through June 2011. A related program, Transitional Medical Assistance, was extended through March 31, 2015, under the Protecting Access to Medicare Act, and was subsequently made permanent through MACRA.

U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007

The U.S. Troop Readiness, Veteran's Care, Katrina Recovery, and Iraq Accountability Appropriations Act was signed into law May 25, 2007. The Act included $6 billion for Hurricane Katrina relief and requires providers to use tamper-resistant prescription pads/paper when writing prescriptions for any drugs for Medicaid recipients, effective April 2008. Prescriptions transmitted to pharmacies via telephone, fax, or electronically are exempt from this requirement.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

MHPAEA was incorporated into the Emergency Economic Stabilization Act of 2008 that was signed into federal law on October 3, 2008.

- Requires group health plans that offer behavioral health benefits (mental health and SUD benefits) to provide those services at parity with medical and surgical benefits.

- Parity requirements apply to financial requirements (e.g., co-payments), treatment limitations (e.g., number of visits or days of coverage), and availability of out-of-network coverage.
- Behavioral health and medical benefits are required to meet parity based on the following benefit classifications: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.
- MHPAEA does not impact traditional Medicaid FFS; however, the requirements apply to Medicaid managed care and state CHIP programs.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

CHIPRA authorized CHIP federal funding through federal fiscal year 2013 (subsequent legislation has continued CHIP federal funding through federal fiscal year 2017). HHSC implemented the following changes in accordance with federal CHIPRA guidance:

- Applying certain Medicaid managed care safeguards to CHIP.
- Verifying citizenship for CHIP.
- Implementing mental health parity in CHIP.
- Providing federally-matched CHIP and Medicaid coverage to qualified immigrant children.
- Expanding dental services.

The American Recovery and Reinvestment Act (ARRA)

ARRA was signed into law in February of 2009 and provided $762 billion to states in economic stimulus funding for a multitude of new and existing programs.

- Temporarily increased the federal share for Medicaid payment in Texas by approximately 9 to 11 percentage points above the pre-ARRA FMAP rate during the stimulus period. 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. 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.
- Temporarily prohibited states from making changes to any Medicaid eligibility standards, methodologies, or procedures that were more restrictive than those in effect as of July 1, 2008.

- Implemented prompt payment requirements for Medicaid providers.
- Extended the TANF Supplemental Funds, created a new TANF Emergency Contingency Fund, increased the DSH allotment, allocated funding for HIT, and provided supplemental funding for existing public health cooperative agreements and competitive grant opportunities through the Prevention and Wellness Fund.
- Established the Recovery Accountability and Transparency Board to help prevent waste, fraud, and abuse and the Recovery.gov website to foster greater accountability and transparency in the use of funds made available by ARRA.

Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act of 2010 (HCERA)

PPACA was signed into law on March 23, 2010, and HCERA was enacted on March 30, 2010. Together, they are called the Affordable Care Act (ACA).

The ACA makes broad changes to the U.S. health care system, such as:

- Requiring individuals, with limited exceptions, to have health coverage or pay a penalty.
- Requiring states have a health insurance marketplace that assists individuals and small businesses with purchasing affordable health care.
- Providing premium subsidies and cost-sharing reductions for coverage purchased through the marketplace to eligible individuals above 100 percent up to and including 400 percent of the FPL.
- Prohibiting coverage denials, treatment denials, and higher charges based on a pre-existing condition.
- Allowing children to stay on a parent's health insurance plan until age 26.

The following is an overview of many of the ACA requirements applicable to Medicaid and/or CHIP.

Health Insurance Marketplaces

The ACA directs that each state have a health insurance marketplace that assists individuals and small businesses with purchasing health care. States had the option to establish a state-based marketplace, partner with the federal government to establish a marketplace, or have the federal government run the state's marketplace. Texas currently has a federally-facilitated marketplace. Marketplace eligibility

determinations must be streamlined and coordinated with eligibility determinations for the Medicaid and CHIP programs.

Eligibility Changes

States had the option to expand Medicaid eligibility to 133 percent of the FPL for uninsured individuals up to age 65 (Texas has not expanded Medicaid eligibility to adults).

- Requires states to determine financial eligibility for most Medicaid programs and CHIP based on the MAGI methodology, which uses federal income tax rules for determining income and household composition.
- Prohibits assets tests and most income disregards for most Medicaid programs and CHIP. The ACA applies a five percentage point income disregard to individuals subject to the MAGI methodology. Prior to the ACA, Texas applied assets tests and income disregards to most Medicaid programs and CHIP.
- A single, streamlined application form for Medicaid, CHIP, and the marketplace.
- States must redetermine Medicaid eligibility every 12 months and no more frequently than once every 12 months except when a change in circumstance is received by the state that may affect an individual's eligibility.
- An administrative or passive eligibility renewal process for Medicaid and CHIP. To the extent possible, states must use available information to make eligibility redeterminations without requesting information or an application from clients.

Medicaid Benefit Changes

The ACA required that state Medicaid programs:

- Provide concurrent hospice care and treatment services for children enrolled in Medicaid and CHIP. Texas implemented this change August 1, 2010.
- Add birthing centers as a required Medicaid provider. HHSC reinstated birthing centers as a Medicaid provider, effective September 1, 2010.
- Provide Medicaid reimbursement to providers recognized by states as a licensed birth attendant. Texas Medicaid began recognizing licensed midwives as a provider type effective January 1, 2013.
- Implement comprehensive tobacco cessation services for pregnant women. Texas added coverage for tobacco cessation counseling services to Texas' existing coverage of prescription and non-prescription tobacco cessation agents approved by the federal Food and Drug Administration.

Program Integrity

The ACA established new provider screening and enrollment requirements for providers and suppliers enrolling in Medicare, Medicaid, and CHIP. Detail on the numerous ACA program integrity initiatives is described in **Chapter 13, Administration**.

Financing

The ACA made a number of revisions to Medicaid and CHIP financing in support of the ACA policy changes, such as providing federal payment for the first three calendar years for newly eligible adults, for states choosing to implement a Medicaid expansion. This decreases to a 90 percent federal share for 2020 and after. The ACA decreased DSH allotments in anticipation that the uninsured population would decrease in states implementing Medicaid expansions.

The ACA also temporarily increased the federal share of various matching payments, including a one percentage point increase for preventive care services, a two percentage point increase under the BIP program for certain community-based long-term care services for states that made structural changes to their long-term care delivery system, and a 23 percentage point increase through September 2019 in the federal match rate for CHIP. More details are included in **Chapter 14, Finances**.

CHIP Impacts

The ACA authorized federal funding for CHIP through 2015 and made other changes related to CHIP, which are detailed in **Chapter 2, Medicaid and CHIP in Context**.

Pharmacy Changes

The ACA increased the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program. The federal government keeps 100 percent of the increased rebate amount. The ACA also expanded the rebate program to cover claims paid by Medicaid MCOs. For more information, see **Chapter 9, Prescription Drugs**.

Protecting Access to Medicare Act

The Protecting Access to Medicare Act was signed into law on April 1, 2014, and extended a number of Medicare and Medicaid program authorizations.

- Extended the Qualified Individuals, Transitional Medical Assistance, and Maternal, Infant and Early Childhood Home Visiting Programs through March 2015.
- Extended the CHIP Express Lane program option through September 2015.

- Extended the State Abstinence Education Grant and Personal Responsibility Education Programs through federal fiscal year 2015.
- Delayed implementation of previously adopted changes to Medicaid third party liability law to October 1, 2016.
- Delayed transition of the standard code sets from ICD-9 to ICD-10 by one year, to October 1, 2015.
- Delayed scheduled reductions to the Medicaid DSH allotment. The aggregate federal DSH allotment will be reduced by $1.8 billion in federal fiscal year 2017; $4.7 billion in federal fiscal year 2018, federal fiscal year 2019, and federal fiscal year 2020; $4.8 billion in federal fiscal year 2021; $5 billion in federal fiscal year 2022 and federal fiscal year 2023; and $4.4 billion in federal fiscal year 2024.
- Created a demonstration program to improve community mental health services.
- Fully funds state CHIP allotments through September 30, 2017, including funding the 23 percentage-point increase in federal matching funds authorized by the ACA.
- Extends Express Lane Eligibility authorization through federal fiscal year 2017.
- Extends CHIPRA outreach and enrollment grants and CHIPRA quality provisions .
- Maintains MOE for children's coverage in Medicaid and CHIP through 2019.
- Makes permanent the authorization for Transitional Medical Assistance, which provides time-limited Medicaid to low-income parents transitioning to employment at higher wages that otherwise would make them ineligible for Medicaid.

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015

While MACRA is notable to many for the changes it makes to how Medicare pays for physician services and the inclusion of value-based payment approaches, MACRA also has the following impacts on Medicaid and CHIP:

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