



**TEXAS**

Health and Human Services Commission

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**HHS SYSTEM ANNUAL  
FEDERAL FUNDS REPORT**

for

**State Fiscal Year 2015**

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**Health and Human Services Commission (529)**

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**Department of Family and Protective Services (530)**

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**Department of State Health Services (537)**

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**Department of Assistive and Rehabilitative Services (538)**

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**Department of Aging and Disability Services (539)**

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**January 2016**

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# I. EXECUTIVE SUMMARY

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The Texas Health and Human Services Commission is submitting the *Annual Federal Funds Report for State Fiscal Year 2015* in accordance with Government Code, Section 531.028(c). This report highlights the critical role of federal funding in the health and human services system in Texas.

Five state agencies comprise the health and human services (HHS) system:

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

During state fiscal year 2015, the health and human services agencies spent approximately \$38.3 billion in All Funds. Federal funds comprised approximately 57.6% or \$22.1 billion of agency expenditures (see Figure 1).

Figure 1.

**HHS System Federal Funds Expenditures for State Fiscal Year 2015**  
*(\$ in millions)*

Agency	Federal Funds*	All Funds	\$FF % of \$AF
HHSC	\$16,448.8	\$27,517.1	59.8%
DFPS	\$845.9	\$1,581.5	53.5%
DSHS	\$1,172.7	\$3,232.5	36.3%
DARS	\$468.2	\$609.6	76.8%
DADS	\$3,121.9	\$5,356.0	58.3%
<b>TOTAL</b>	<b>\$22,057.5</b>	<b>\$38,296.7</b>	<b>57.6%</b>

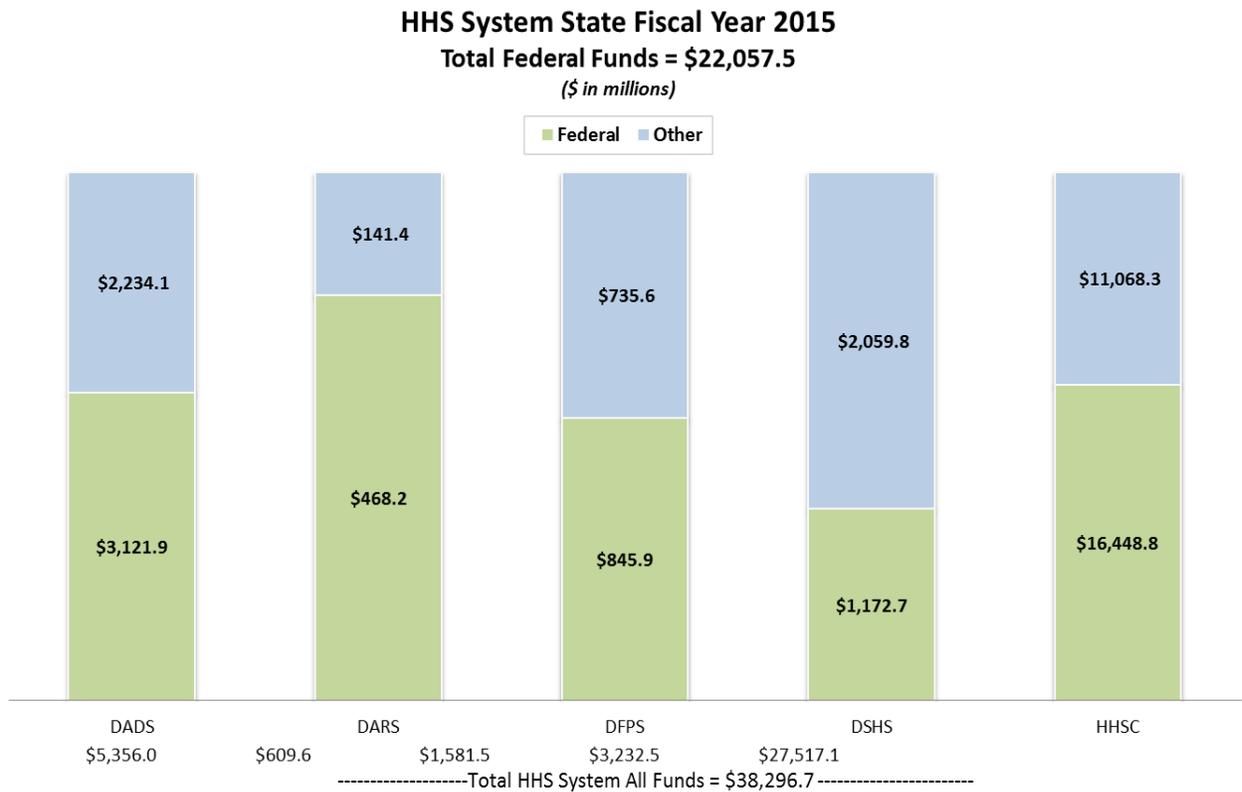
\*Excludes employee benefits, certain payments made as a result of local funding sources (Intergovernmental Transfers), and the value of SNAP benefits.

Source: FY2016 Operating Budget/ABEST 12.01.15

The HHS system agencies utilized almost 200 different sources of federal funds. Of those sources, the top 30 major federal funding streams accounted for approximately 99 percent of all federal funds to the HHS agencies. Medicaid is the largest federal funding source at 82 percent. The next largest is Children's Health Insurance Program (CHIP) at 4 percent. A table of the top 30 federal funding sources used by the Texas health and human services system is attached as Appendix A.

In FY 2015, the five HHS system agencies leveraged \$22.1 billion in federal funds and \$16.2 billion in general revenue and other funds (totaling \$38.3 billion in all funds) to maximize their efforts to address and promote the health and well-being of the people of Texas (see Figure 2).

Figure 2.



This report also outlines key federal issues which challenge the health and human services agencies and identifies federal funds management practices undertaken to maximize receipt of federal funds to meet the mission of each health and human services agency. Also, included are highlights of the current federal budget outlook, pending program authorizations, and agency specific issues associated with federal appropriations or actions.

The effort to ensure Texas optimizes federal funding consistent with state policy goals to the extent allowable is a basic premise in the financial management of all five HHS agencies. With the development of federal cost allocation plans, active analysis of federal legislation, and careful assessment of opportunities to enhance federal funds for the state, HHS agencies are continually monitoring federal funding opportunities to ensure efficient and effective use of those dollars as well as any associated general revenue.

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## **II. FEDERAL FUNDS: CURRENT ISSUES**

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Current issues affecting federal funding, such as fragmented continuing resolutions due to delays in passage of federal appropriation bills, the Budget Control Act of 2011 (sequester), and rising caseloads for Medicaid and other entitlement programs, can impact the state's ability to receive federal funds for services to clients.

In addition, the HHS system agencies are implementing state legislative actions, particularly those related to agency consolidation, and assessing potential implications to federal funding streams to ensure continuity of services, seamless transitions for clients, accountability for reporting requirements, and, compliance with state and federal rules and regulations. In addition, agencies are examining the cost allocation methods associated with the federal share of administrative costs for federally funded health and human services programs to ensure the state is maximizing the use of federal funds.

### **A. FEDERAL BUDGET OUTLOOK**

#### **1. Federal Appropriations**

In December 2015, Congress passed a short-term continuing resolution to keep the federal government open while finalizing the omnibus appropriations bill, the Consolidated Appropriations Act 2016, which funded the remainder of federal fiscal year 2016. This measure allocated level funding to most major health and human services programs for 2016. As in FY2015, appropriations were passed in short term continuing resolutions followed by a comprehensive bill that funded the remaining federal fiscal year. The 2017 federal budget is due to be released in February 2016 and level funding is anticipated for major health and human services programs.

#### **2. Future Sequestration Impact**

The Budget Control Act of 2011 requires funding reductions to achieve savings and to limit the size of the federal budget; this is commonly referred to as sequestration. Reductions under the Act were extended an additional two years by the Bipartisan Budget Act of 2013 requiring cuts over federal fiscal years 2013-2023. If Congress enacts appropriations that exceed the caps set in legislation, a sequestration is automatically triggered to reduce appropriations to within the required limits.

Both discretionary and mandatory federal programs are subject to sequester; however, some programs are exempt, including Medicaid, CHIP, and Temporary Assistance for Needy Families (TANF). Factors, such as level of growth in mandatory programs, and rule exceptions for certain programs, such as a limit on reductions to Medicare, may impact the calculations for the reductions. Additionally, Congress could enact legislation at any time that repeals the law or modifies the exemptions or rules associated with sequestration.

If future decreases in federal funding occur to discretionary and mandatory programs covered under sequestration, it may result in reductions in numbers of clients served and levels of services provided by Texas HHS system agencies. Estimates of future year reductions are not possible as the exact

reduction depends on the factors applied and the base determined as subject to sequestration after applying defined exemptions and special rules.

The HHS system agencies continue to monitor and analyze available information and assess the potential impact of a future federal sequestration to clients and services. Federal agencies have not provided specific guidance about future sequestration reductions.

## **B. AGENCY SPECIFIC FEDERAL ISSUES**

This section includes information on federal funding issues affecting specific Texas HHS agencies.

### **1. Title IV Part E Foster Care and Adoption Assistance (DFPS)**

Texas continues to experience a decline in federal financial participation for the federal Title IV-E program which helps to provide safe and stable out-of-home care for children. The methodology for claiming funds uses a population ratio which is the percentage of each state's foster care caseload that qualifies for federal financial participation. The population ratio is calculated by dividing the number of children in DFPS conservatorship by the number of Title IV-E eligible children in Title IV-E eligible placements.

The ratio is used to determine the amount of federal Title IV-E administrative claiming available for child protective services direct delivery staff. The average annual rate for fiscal year 2015 was 34.5 percent as compared with fiscal year 2014 at 37.0 percent.

There are two major factors contributing to this decline:

- Income eligibility for Title IV-E is linked to standards from the 1996 Aid to Families with Dependent Children (AFDC). These standards can only be adjusted through a federal law change. To qualify for IV-E funds today, a child has to come from a poorer household than he or she would have had to in 1996; and
- Relative placements are not Title IV-E eligible placements since they have not been verified as a foster home. As the percentage of children in conservatorship who are in relative placements increases, the population ratio decreases.

### **2. Title IV Part E Waiver (DFPS)**

DFPS submitted a request for a federal Title IV-E Waiver to the Administration of Children and Families in 2014 to improve outcomes for foster care children in Harris County. Texas was recently authorized to participate as a Title IV-E waiver state and federal guidance concerning implementation is pending. Under the Title IV-E waiver, the federal government essentially issues "block grant" funding for the waiver area requiring reinvestment of any savings.

### **3. Workforce Innovation and Opportunity Act (DARS)**

The Workforce Innovation and Opportunity Act (WIOA), enacted in 2014 superseded the Workforce Investment Act (WIA) of 1998 and amended the Adult Education and Family Literacy Act, the Wagner-Peyser Act, and the Rehabilitation Act Amendments of 1998. The amendments to the Rehabilitation Act, in Title IV of WIOA, made significant improvements for individuals with disabilities, including youth with disabilities as they make the transition from education to employment. Specifically these changes ensured students would have opportunities to acquire the skills and training they need to maximize their potential and enter competitive integrated employment. WIOA increased the accountability of core programs, including the vocational rehabilitation (VR) program, placing emphasis on results through the establishment of common employment outcome measures across the core WIOA programs. WIOA also promoted better alignment among job training programs through the requirement of a Unified (or Combined) State Plan.

In addition to programmatic changes, the Act transferred the State Independent Living Services Program (IL, Part B) and the Centers for Independent Living Program (IL, Part C) from the Department of Education to the Administration for Community Living (ACL) in the federal Department of Health and Human Services and eliminated the In-Service Training Program.

WIOA was effective on July 1, 2015; however, Title IV of WIOA (which includes the Rehabilitation Act amendments) went into effect on the date the act was signed into law on July 22, 2014. The Act included several provisions that would be effective on other dates. For example, states must submit Unified (or Combined) State Plans pertaining to workforce investment programs, adult education and VR by April 1, 2016. WIOA performance accountability provisions for all core programs take effect on July 1, 2016.

In April 2015, the Department of Labor (DOL) and the Department of Education (ED) published Notices of Proposed Rulemaking to implement WIOA. In November 2015, the U.S. Department of Health and Human Services (HHS) published a Notice of Proposed Rulemaking to implement WIOA. Comments are due on the proposed rules by January 29, 2016. Final Rules from DOL and ED are anticipated in June 2016. Final rules timeframes from HHS have not been announced.

Federal agencies continue to publish guidelines and provide detailed technical assistance on the WIOA. DARS formed a cross agency workgroup with the Texas Workforce Commission (TWC) to assess the implications and impacts of WIOA on Texas and to develop a Unified (or Combined) State Plan. VR programs, including the Older Individuals who are Blind program, Criss Cole Rehabilitation Center, and the Business Enterprises of Texas, currently operated by DARS are being transferred to TWC effective on September 1, 2016.

#### **4. Disability Determination Services Program (DARS)**

The Disability Determination Services (DDS) program in DARS is 100 percent federally funded by the Social Security Administration (SSA) and is exempt from the sequestration legislation.

The DDS program has operated under a federal hiring freeze the last few years. Staffing levels have been down more than 230 filled positions since 2010. While the program continues to perform better than the national average for case processing times, DARS remains concerned about the inability to replace the staffing losses and continues to discuss staffing levels and case assignments with the SSA.

#### **5. Public Health Preparedness (DSHS)**

The 2013 reauthorization of the 2006 Pandemic All-Hazards Preparedness Act provided states and independently funded jurisdictions with funding for public health and medical preparedness programs, such as the Hospital Preparedness Program and the Public Health Emergency Preparedness Cooperative Agreement grants. Additionally, the act provided increased flexibility in allowing states to temporarily deploy federally funded state personnel, funded in programs other than preparedness, to meet critical community needs in a disaster. Texas uses dollars from these federally funded programs to fund public health and medical preparedness activities at the local, regional and state level.

In FY2015, level funding to Texas sustained public health and healthcare systems preparedness activities. Texas also received one-time supplemental Ebola preparedness funding. These funds supported hospital preparedness activities including establishing regional treatment centers, assessment hospitals, and health care coalitions to ensure overall health care system preparedness for Texas; development of a national network for Ebola patient care, including establishing UTMB as one of approximately ten federally designated regional Ebola and other special pathogen treatment centers; and, purchase of regional stockpiles of personal protective equipment.

DSHS is monitoring activities at the federal level in order to assess potential future impact to public health preparedness funding to Texas. If future federal allocations are reduced to Texas it may diminish state, regional and local public health and healthcare partners' capacity in an all-hazards response. Such capacity may include, but is not limited to, epidemiologic surveillance, investigation and response to disease outbreaks and environmental health concerns; provision of medical surge of essential healthcare providers and services; and, planning efforts for mitigating the health impact of natural and man-made disasters.

#### **6. Title V Maternal and Child Health Services Block Grant (DSHS)**

The federal Maternal and Child Health Block Grant is authorized under Title V of the Social Security Act and is the longest-standing public health legislation in American history. The original authorization occurred in 1935. There continue to be maternal and child health needs that are not addressed solely through recent changes to public and private health insurance. The Title V block grant funds those essential services while maintaining state flexibility in determining priority needs to improve the health and well-being of women and children.

The federal Health Resources and Services Administration (HRSA) determines the allocation formula for the Title V Maternal and Child Health Services Block Grant using the American Community Survey poverty estimates. The formula is based on the number of children living in poverty (in an individual state) as compared to the total number of children living in poverty in the United States.

In 2015, HRSA released new guidance for the block grant which restructured the application and annual reporting of performance and budget information to document compliance. The new process reduced reporting burden and duplication across sections of the application and annual report and integrated a five-year needs assessment summary. These revisions are built on the premise that they will serve as drivers to addressing the state's unique needs, state-identified priorities, and national and state performance measures.

## **7. Affordable Care Act Funding to the HHS System (HHSC/DSHS/DADS)**

In 2010, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Affordability Reconciliation Act of 2010, collectively known as the Affordable Care Act (ACA), were signed into federal law.

Beginning in calendar year 2014, ACA required covered entities under Section 9010 to pay the ACA health insurance provider (HIP) fee. The fee is an excise tax, and therefore is non-deductible for federal tax purposes. The 2014 payment was paid on September 30, 2014 and was based on premiums paid to the affected Managed Care Organizations (MCOs) and Dental Maintenance Organizations (DMOs), or “insurers,” in calendar year 2013. The total state fiscal year 2015 ACA HIP fee payment to all MCOs/DMOs (including HHSC and DSHS programs) was approximately \$210 million, of which \$86.1 million was state general revenue.

The payments to the affected MCOs/DMOs included three parts:

- The amount of the health insurance provider fee attributable to Texas Medicaid and CHIP premiums
- The federal income tax liability, if any, that the insurer incurs as a result of receiving HHSC’s payment for the amount of the ACA HIP Fee
- Texas state premium tax attributable to the capitation adjustment

Certain insurers are exempt from the ACA HIP Fee. Notably, insurers that are non-profit, owned by public entities, or have greater than eighty percent of gross revenues from government supported programs that target low-income, elderly, or disabled populations.

The federal Consolidated Appropriations Act, 2016, included a one-year moratorium in calendar year 2017 on the ACA health insurance providers fee. The moratorium pertains to calendar year 2016 premium revenue, which in Texas Medicaid/CHIP would have been paid in state fiscal year 2018 if the current process for reimbursing MCOs continues.

Beginning in June 2015 under ACA, certain public and mental health activities were covered by private health insurance plans. These activities included: infectious disease control, prevention, and treatment; health promotion and chronic disease prevention; laboratory services; primary care and nutrition services; behavioral health services; community capacity; and state-owned and privately-owned hospital services.

The health and human services system agencies continued implementing ACA-related programs and initiatives during FY2015, such as: the Balancing Incentives Program, Community First Choice, Disproportionate Share Hospital Program, and Presumptive Eligibility. The status of these programs or initiatives is addressed in this section.

**a. Balancing Incentives Program - BIP (HHSC/DADS/DSHS)**

The Balancing Incentive Program (BIP) increased the federal medical assistance percentage (FMAP) available to participating states through September 2015 in exchange for states implementing certain structural reforms to increase access to Medicaid community based long-term services and supports (LTSS). These structural reforms included implementing a “no wrong door” eligibility and enrollment system, core standardized assessment instruments and conflict free case management activities. Texas began drawing down a two percent enhanced FMAP for all Medicaid community-based LTSS expenditures in 2012.

**b. Community First Choice - CFC (HHSC/DADS)**

The Community First Choice (CFC) federal program allows states to receive a six percent increase in federal matching funds to provide home and community-based attendant services and supports as a state plan benefit for individuals with disabilities who are enrolled in Medicaid and require an institutional level of care.

Beginning in FY2015, Texas provided the following CFC services:

- Personal assistance services,
- Habilitation services;
- Emergency response services; and,
- Support consultation services.

The six percent increase in federal matching funds would also be received for services that are currently provided to individuals meeting intermediate care facility level of care criteria for individuals with an intellectual disability or related condition through four intellectual and developmental disability waivers administered by DADS. The CFC services are provided as a state plan service rather than as a waiver benefit.

**c. Disproportionate Share Hospital Program-DSH (HHSC)**

States make Medicaid Disproportionate Share Hospital (DSH) payments to hospitals serving a disproportionate share of low income patients and experiencing high levels of uncompensated care costs. The Affordable Care Act, as amended by the Bipartisan Budget Act and the Medicare Access and CHIP Reauthorization Act of 2015, included reductions to state DSH allotments beginning fiscal year 2018 through fiscal year 2025. The Affordable Care Act provisions related to expanded coverage through private insurance and Medicaid are expected to reduce the amount of uncompensated care covered by hospitals and providers.

The federal government released disproportionate share hospital allocations for federal fiscal year 2015. The allocation for Texas was \$1.78 billion, as compared to the federal fiscal year 2014 allocation of \$1.74 billion.

**d. Primary Care Rate Increase (HHSC)**

The ACA provided a temporary rate increase for certain primary care providers and services for the period of January 1, 2013, through December 31, 2014. Texas began issuing supplemental payments to providers in 2014 to cover the difference between the regular Medicaid rate and the temporary increase. As of April 2015 Texas issued fee for service and managed care payments to providers totaling \$657 million.

**e. Presumptive Eligibility (HHSC)**

Presumptive Eligibility was implemented in Texas in February 2015. The ACA mandated that states allow qualified hospitals the option to determine Medicaid presumptive eligibility for pregnant women, children, low-income caretaker relatives, and foster care groups. States are prohibited from requiring qualified hospitals to verify eligibility criteria and only have the option to require the hospital to ask the applicant to attest to the applicants U.S. citizenship/alien status and residency. Qualified hospitals must make the eligibility determination based on information provided by the applicant.

**f. Provider Enrollment Fee (HHSC/DADS)**

In FY 2015, HHSC delegated authority to DADS to collect this fee for Long-Term Services and Supports providers. The provider screening and enrollment fees are defined as payments from medical providers and suppliers required by the federal Centers for Medicare and Medicaid Services (CMS) as a condition for enrolling as a provider in the Medicaid and CHIP programs. The state collects and receives the funds as Appropriated Receipts - Match for Medicaid. Collected funds may be expended as authorized by federal law to support provider enrollment. In the event revenues collected are greater than expenditures, any unused fee balances shall be disbursed to the federal government as required by federal law.

## **8. Healthcare Transformation and Quality Improvement Program 1115 Waiver (HHSC)**

Texas received approval for the Section 1115 Transformation Waiver in December 2011. The five-year demonstration waiver allowed Texas to expand its use of Medicaid managed care to achieve program savings while preserving locally funded supplemental payments to hospitals. The state, local communities and hospitals face significant uncompensated care costs which make this waiver so necessary for Texas. The waiver was designed to build on existing Texas health care reforms and redesign health care delivery in Texas and stabilize spending growth.

The major components of the waiver program include:

- Medicaid managed care services delivery expanded statewide through the STAR, STAR+PLUS, and Children's Medicaid Dental Services programs.
- Delivery System Reform Incentive Payment (DSRIP) program established twenty Regional Healthcare Partnerships to increase access to care and test innovative care.
- Uncompensated Care program offset uncompensated costs of hospitals and other providers serving Medicaid and uninsured populations.

Texas designed innovative policies to ensure Medicaid services were provided in a cost-effective manner through managed care. The waiver, which provided \$29 billion over the five-year demonstration period for Uncompensated Care and DSRIP, expires in September 2016. In September 2015, Texas requested an extension of all components of the waiver in order to continue the savings and efficiencies achieved in each program.

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## III. PENDING FEDERAL AUTHORIZATIONS

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Many of the health and human services system federal grant programs are pending program authorizations, some reauthorizations have been pending for many years. Historically, the federal grant program authority is extended as part of the annual federal appropriations measures passed by Congress for each federal fiscal year.

The following summarizes the status of key health and human services programs pending federal reauthorizations:

### 1. **Children's Health Insurance Program - CHIP (HHSC)**

Federal allotments for the CHIP program were authorized through federal fiscal year 2017 (September 30, 2017). CHIP contingency funds have also been extended through federal fiscal year 2017. States are allowed to expend allotments during a two year period.

The Affordable Care Act provided an increase in the Enhanced Federal Medical Assistance Percentage (EFMAP) for CHIP by 23 percentage points (certain expenditures were excluded) beginning in federal fiscal year 2016 and continuing through fiscal year 2019. The Medicare Access and CHIP Reauthorization Act of 2015 maintained this increase for EFMAP and reduced the allotments available in federal fiscal year FY 2018 by one-third. The formula for state allotments may be adjusted to account for the higher federal matching rate. Guidance to states is pending from the Centers for Medicaid and Medicare Services regarding the formula allotments for federal fiscal year 2016.

### 2. **Child Nutrition Reauthorization Update (DSHS)**

The Child Nutrition Reauthorization legislation drafted every five years sets policy for the WIC program and other child nutrition programs. The previous Child Nutrition Reauthorization bill, called the Healthy, Hunger Free Kids Act, expired in federal fiscal year 2015, and was extended as part of the Consolidated Appropriations Act 2016.

The Senate Committee on Agriculture, Nutrition & Forestry plans to markup the 2015 version of the Child Nutrition Reauthorization bill. The markup session originally scheduled to occur in September 2015 was postponed and official rescheduling is pending at this time.

### 3. **Temporary Assistance for Needy Families - TANF (HHSC)**

The TANF program was created in 1996 (P.L. 104-193) and replaced the Aid to Families with Dependent Children (AFDC). TANF is administered by the U.S. Department of Health and Human Services and is an entitlement to the states.

TANF has four program goals to: provide assistance to needy families so that children can be cared for in their own homes or in the homes of relatives; end the dependence of needy parents on government benefits by promoting job preparation, work and marriage; prevent and reduce the incidence of out of wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and encourage the formation and maintenance of two-parent families.

Since program authorization expired in 2010, Congress has extended TANF with short-term extensions rather than a full reauthorization. The most recent extension was part of the Consolidated Appropriations Act 2016 and extended TANF through federal fiscal year 2016.

The Consolidated and Further Continuing Appropriations Act, 2015 (P.L. 113-235) authorized TANF Contingency Funds through September 30, 2016.

#### **4. Ryan White HIV/AIDS Treatment Extension Act of 2009 (DSHS)**

The Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87) authorized the program which is the largest federal program specifically dedicated to providing HIV care and treatment. The legislation was first enacted in 1990. The program has been extended through the federal appropriations process since expiring in 2013.

Despite no reauthorization from Congress, appropriations can continue because the Act is not a self-repealing appropriation. The program has been adjusted with each reauthorization to accommodate new and emerging needs, such as increased emphasis on core medical services and changes in funding formulas. DSHS continues to monitor appropriations and assess the implementation of the Affordable Care Act to determine potential fiscal impact to the state.

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## **IV. FEDERAL FUNDS ENHANCEMENT INITIATIVES**

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The Texas HHS agencies were successful in efforts to enhance revenue and maximize the use of Federal Funds during the last fiscal year. By working with various federal agencies, the state identified expenditures where additional federal funds could be accessed and qualified for new opportunities to bring additional dollars to Texas. Agencies continue to seek available funding and identify innovative ways for increasing access to federal funds to support the state's mission and interests related to health and human services.

### **1. Minimum Payment Amounts Program (HHSC)**

Effective March 1, 2015, upon carve-in of nursing facilities (NF) to managed care, HHSC created a new minimum payment to eligible NFs to be made through the managed care organizations. This program referred to as the Minimum Payment Amounts Program (MPAP) was developed in an effort to continue a certain level of funding to NFs that had previously participated in the NF upper payment limits (UPL) program, a program which is prohibited by federal regulations in a managed care environment. MPAP currently provides increased funding to 287 NFs to improve the quality of the care they provide to Medicaid NF residents. The non-federal share for this program is provided by intergovernmental transfers from the non-state governmental entities that own the NFs. MPAP is expected to provide over \$325 million in additional federal funds to participating NFs for state fiscal year 2016.

### **2. Network Access Improvement Program (HHSC)**

Effective March 1, 2015 several health plans implemented programs aimed at improving network access for Medicaid members. The Network Access Improvement Program (NAIP) is designed to further the state's goal of increasing the availability and effectiveness of primary care for Medicaid beneficiaries by incentivizing various institutions to provide high quality, well-coordinated, and continuous care. NAIP is expected to provide over \$302 million in additional federal funds in state fiscal year 2016.

### **3. TANF Contingency Fund (HHSC)**

The Temporary Assistance for Needy Families (TANF) Contingency fund provides states with additional federal funds to assist in meeting of low income families during periods of economic downturn. States access TANF Contingency funds when they reach high levels of unemployment and/or SNAP/food stamp caseloads. Contingency funds may be used only in the fiscal year for which they are awarded and may not be carried over for use in a succeeding fiscal year.

To draw upon Contingency funds, a state must both (1) meet a test of “economic need” and (2) spend from its own funds more than what the state spent in fiscal year 1994 on cash, emergency assistance, and job training in TANF’s predecessor programs. A state meets the “economic need” test if its seasonally adjusted unemployment rate averaged over the most recent three-month period is at least 6.5 percent *and* at least ten percent higher than its rate in the corresponding three-month period in either of the previous two years; *or* its SNAP/ food stamps caseload over the most recent three-month period is at least ten percent higher than the adjusted caseload in the corresponding three-month period in fiscal year 1994 or fiscal year 1995.

In 2015 Texas applied for and received approximately \$52.2 million in additional funds requested through the TANF Contingency Funds grant. These funds are separate and apart from the TANF Emergency Contingency Funds.

Unlike the regular TANF block grant which provides a fixed funding amount to states regardless of economic conditions, the TANF Contingency Fund provides additional TANF funds to states in times of economic downturn when states reach high levels of unemployment and/or food stamp caseloads. Texas met the threshold, based on SNAP caseload. TANF Contingency Funds can be used for any purpose for which regular TANF funds are used but must be spent in the fiscal year they are received. If the state remains eligible, HHSC will continue to apply for TANF Contingency Funds.

**Appendix A - FY 2015 Top 30 Health and Human Services System Federal Funding Sources (\$ in millions)**

Rank	Federal Agency	CFDA	Federal Grant Title	FY 2015	HHSC	DFPS	DSHS	DARS	DADS
1	HHS-CMS	93.778	Title XIX - Medicaid (multiple grants)	\$18,157.3	\$15,149.6	\$10.7	\$97.1	\$31.6	\$2,868.3
2	HHS-CMS	93.767	State Children's Health Insurance Program/CHIP	\$942.9	\$942.9				
3	USDA	10.557	Special Supplemental Nutrition Program for Women, Infants, and Children/WIC (multiple grants)	\$575.8			\$575.8		
4	HHS-ACF	93.558	Title IV - Temporary Assistance for Needy Families/TANF & TANF to Title XX	\$488.3	\$77.2	\$375.3	\$21.2	\$14.7	
5	DOE	84.126	Vocational Rehabilitation Grants to States	\$216.6				\$216.6	
6	HHS-ACF	93.658	Title IV-E Foster Care (multiple grants)	\$185.5		\$185.5			
7	USDA	10.561	State Administration for Supplemental Nutrition Assistance Program/SNAP	\$182.1	\$182.1				
8	HHS-SAMHSA	93.959	Substance Abuse Prevention and Treatment Block Grant	\$142.8			\$142.8		
9	HHS-ACF	93.667	Title XX Social Services Block Grant	\$127.8	\$1.3	\$30.6	\$7.0		\$88.8
10	HHS-ACF	93.659	Title IV-E Adoption Assistance (multiple grants)	\$118.3		\$118.3			
11	SSA	96.001	Disability Determinations	\$117.0				\$117.0	
12	HHS-HRSA	93.917	HIV Care Formula Grants	\$81.8			\$81.8		
13	HHS-ACF	93.566	Refugee and Entrant Assistance (multiple grants)	\$59.6	\$40.5	\$5.1	\$14.0		
14	HHS-CDC	93.074	Public Health Preparedness (multiple grants)	\$53.8			\$53.8		
15	DOE	84.181	Special Education Grants	\$51.0				\$51.0	
16	HHS-CMS	93.791	Money Follows Person Rebalancing Demonstration	\$43.7	\$11.9		\$1.6		\$30.2
17	HHS-SAMHSA	93.958	Community Mental Health Services Block Grant	\$37.1			\$37.1		
18	HHS-ACL	93.045	Title III Part C-Special Programs for the Aging-Nutrition Services	\$35.3					\$35.3
19	HHS-HRSA	93.994	Title V - Maternal and Child Health Services Block Grant	\$34.2			\$34.2		
20	HHS-ACF	93.556	Title IV Part B-Promoting Safe and Stable Families (multiple grants)	\$31.9		\$31.9			
21	HHS-ACF	93.575	Child Care and Development Block Grant	\$31.2		\$31.2			
22	SSA	96.000	SSA-VR Reimbursement	\$30.4			\$2.3	\$28.1	
23	HHS-CMS	93.777	State Survey and Certification of Health Care Providers and Suppliers (Title XVIII) Medicare	\$29.7			\$4.5		\$25.2
24	HHS-ACF	93.645	Child Welfare Services Program	\$24.7		\$24.7			
25	HHS-ACL	93.044	Title III Part B-Special Programs for the Aging-Supportive Services and Senior Centers	\$24.3					\$24.3
26	HHS-CMS	93.796	State Survey Certification of Health Care	\$20.7	\$0.5				\$20.1
27	HHS-CDC	93.268	Immunization Grants	\$18.0			\$18.0		
28	HHS-ACF	93.505	Maternal Infant and Early Childhood Home Visiting Program	\$17.0	\$17.0				
29	HHS-CDC	93.940	HIV Prevention Programs (multiple grants)	\$15.8			\$15.8		
30	HHS-ACL	93.053	Nutrition Services Incentive Program	\$11.4					\$11.4
			<b>Subtotal - Top 30 Federal Funding Sources:</b>	<b>\$21,906.1</b>	<b>\$16,423.0</b>	<b>\$813.3</b>	<b>\$1,107.1</b>	<b>\$458.9</b>	<b>\$3,103.7</b>
			All Other Federal Funds:	\$151.4	\$25.8	\$32.5	\$65.6	\$9.3	\$18.3
			<b>TOTAL All Federal Funds FY2015:</b>	<b>\$22,057.5</b>	<b>\$16,448.8</b>	<b>\$845.9</b>	<b>\$1,172.7</b>	<b>\$468.2</b>	<b>\$3,122.0</b>
			Percent Top 30 of All Federal Funds	99.31%	99.84%	96.15%	94.41%	98.02%	99.41%

Source: FY2016 Operating Budget/ABEST 12.01.15 (excludes employee benefits, certain payments made as a result of local funding sources (Intergovernmental Transfers), and the value of SNAP benefits.)