



## **Federal Funds Report Fiscal Year 2009**

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**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**

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The Annual Federal Funds Report for FY 2009 is a statutory requirement that 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); and
- Department of Assistive and Rehabilitative Services (DARS).

During fiscal year 2009, HHS agencies spent over \$29.1 billion in All Funds with Federal Funds accounting for approximately 64 percent of agency expenditures, or \$18.5 billion. HHS agencies used 133 different sources of federal funds, with ten of these accounting for 94 percent of the funds. Medicaid is the largest federal funding source for the HHS system at 70 percent (excluding ARRA Medicaid noted below). The next largest federal funding source for health and human services agencies is American Recovery and Reinvestment Act of 2009 (ARRA) funding at ten percent.

When ARRA was signed into law in February of 2009, providing \$787 billion in economic stimulus 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 \$1.8 billion in fiscal year 2009 with an additional \$2.8 billion estimated in fiscal year 2010. Federal Medicaid funding related to increasing the federal matching rates for a period of 27 months, makes up the largest share of the ARRA funding in HHS agencies, accounting for 98 percent in fiscal year 2009 and 92 percent in fiscal year 2010.

In addition to detailing ARRA funding, the Annual Federal Funds Report identifies federal funds management activities undertaken to maximize the amount of federal funds received by HHS agencies, such as the retiree insurance benefits claiming project which resulted in an estimated \$37 million in additional federal funds through fiscal year 2009. Also, included is a section highlighting current federal issues with the potential to impact state services and funding, such health care reform and recent appropriations action.

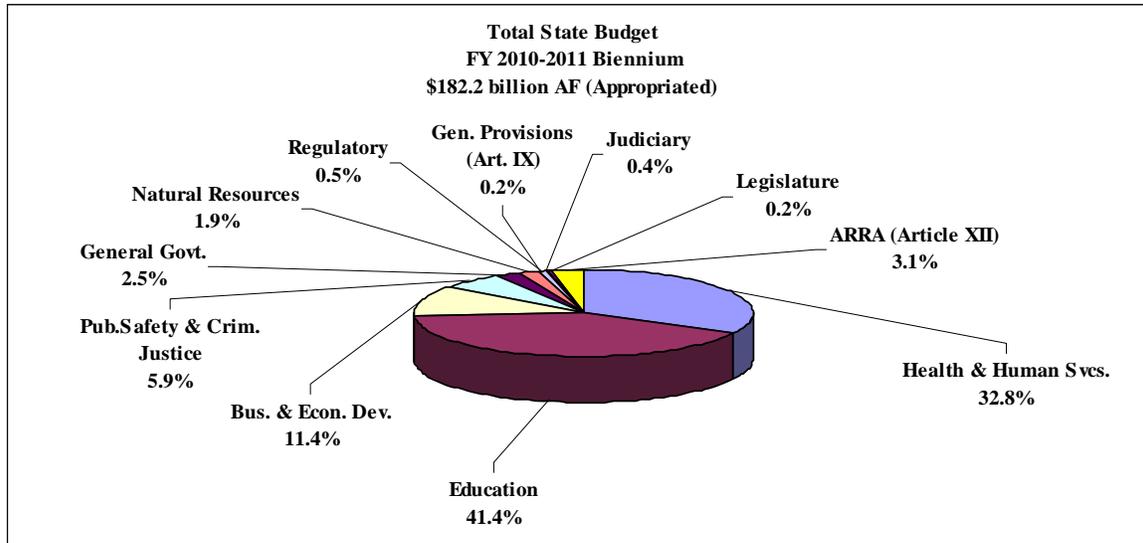
The effort to ensure Texas optimizes federal funding to the extent allowable underpins the financial management of all five HHS agencies. With the management of ARRA funding, the development of federal cost allocation plans, implementation of revenue maximization projects, and active monitoring of federal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

## II. HHS and the State Budget

### *Fiscal Year 2010-2011 Biennium Appropriations Overview*

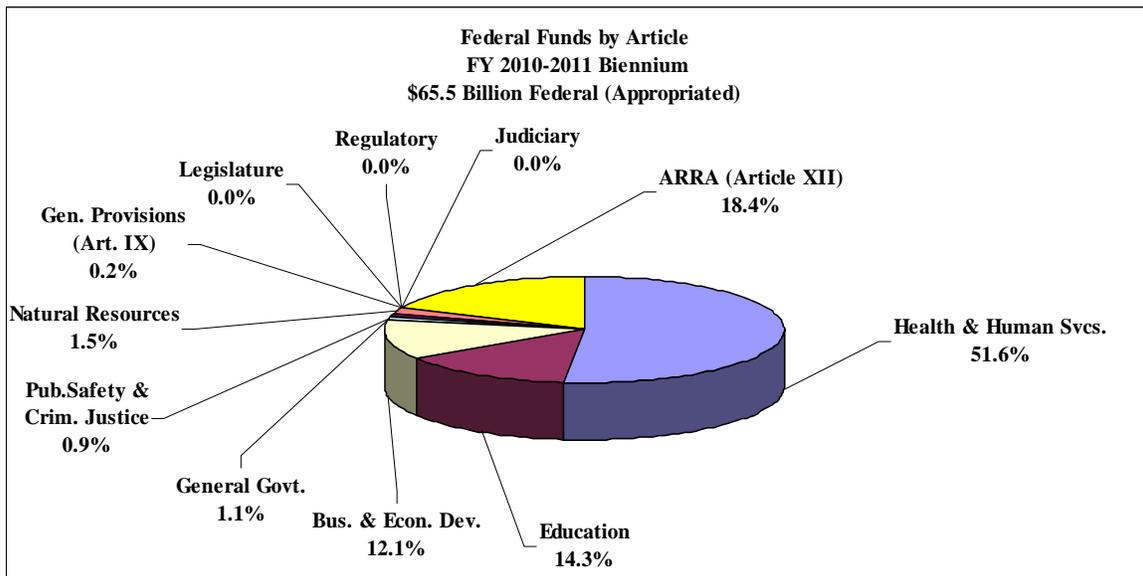
For the fiscal year 2010-2011 biennium, HHS agencies were appropriated \$59.7 billion in All Funds, which represents 33 percent of the total state budget of \$182.2 billion. The figure below shows the HHS system share of the total state budget. ARRA appropriations are shown separately.

Figure II.1



As reflected below, Health and Human Services represents approximately 52 percent of the \$65.5 billion in Federal Funds appropriated in the FY 2010-2011 biennium. ARRA Federal Funds accounted for over 18 percent of appropriated Federal Funds.

Figure II.2



***FY 2009 Method of Finance***

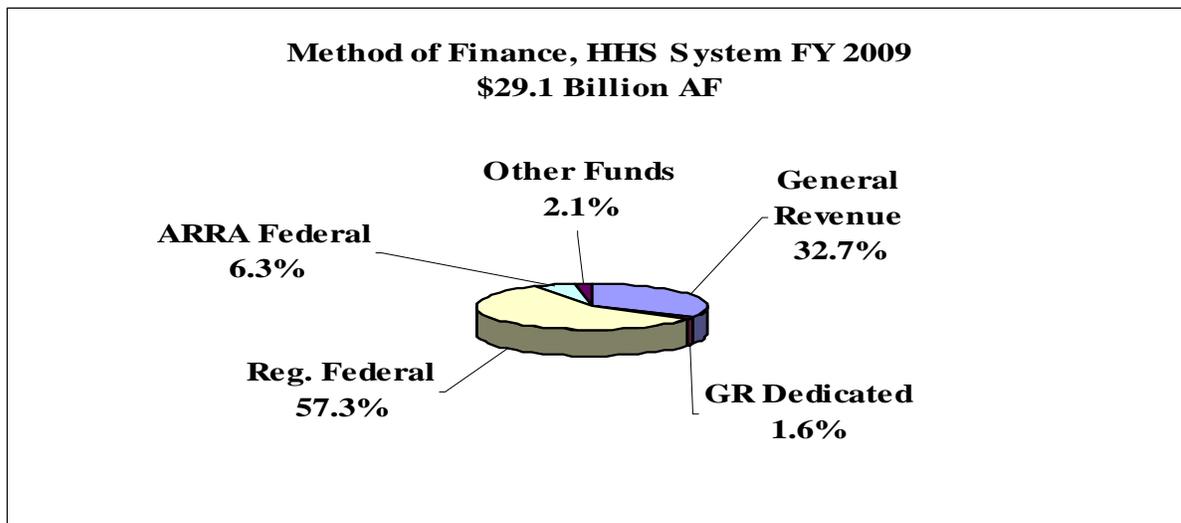
The following table reflects each HHS agency’s Method of Finance in fiscal year 2009. To highlight the impact of stimulus funding, federal funding is reported in two categories throughout this report: Regular Federal Funds and ARRA Federal Funds. The data source for HHS System and agency-specific tables and figures included in this report is FY 2010 agency operating budgets.

*Table II.1*

<b>Method of Finance, HHS System, FY 2009</b>						
<b>Agency</b>	<b>General Revenue</b>	<b>GR Dedicated</b>	<b>Federal Funds</b>		<b>Other Funds</b>	<b>All Funds</b>
			<b>Reg. Federal</b>	<b>ARRA</b>		
<b>HHSC</b>	\$ 5,889,356,809	\$ 18,395,932	\$ 10,540,146,963	\$1,278,027,514	\$363,843,149	\$ 18,089,770,367
<b>DADS</b>	1,947,834,410	55,514,180	3,646,078,932	507,984,085	72,645,289	6,230,056,896
<b>DSHS</b>	1,069,096,421	380,205,483	1,251,877,656	11,916,537	157,755,445	2,870,851,542
<b>DFPS</b>	524,521,832	6,989,791	768,528,680	20,115,231	7,029,415	1,327,184,949
<b>DARS</b>	101,060,633	13,445,213	468,034,053	4,652,078	19,635,764	606,827,741
<b>Total</b>	<b>\$ 9,531,870,105</b>	<b>\$ 474,550,599</b>	<b>\$ 16,674,666,284</b>	<b>\$1,822,695,445</b>	<b>\$620,909,062</b>	<b>\$ 29,124,691,495</b>
<b>Percent of Total</b>	<b>32.7%</b>	<b>1.6%</b>	<b>57.3%</b>	<b>6.3%</b>	<b>2.1%</b>	<b>100%</b>

The figure below depicts the percentage shares for the Method of Finance comprising the \$29.1 billion in All Funds that HHS agencies spent in fiscal year 2009. 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 6 percent of HHS agency funding.

*Figure II.3*



***Federal Funds as a Percent of Agency Budgets***

Federal Funds represented 64 percent of HHS agency budgets in fiscal year 2009, with Regular Federal Funds representing \$16.7 billion and ARRA Federal Funds accounting for \$1.8 billion for a total of \$18.5 billion. The table below shows the degree to which each agency budget relies on federal funds, from 78 percent at DARS to 44 percent at DSHS.

*Table II.2*

<b>FY 2009 Federal Funds as a Percent of Agency Budgets</b>					
<b>Agency</b>	<b>All Funds</b>	<b>Regular Federal</b>	<b>ARRA Federal</b>	<b>Total Federal</b>	<b>Percent of Agency Budget</b>
<b>HHSC</b>	\$ 18,089,770,367	\$10,540,146,963	\$1,278,027,514	\$11,818,174,477	<b>65%</b>
<b>DADS</b>	6,230,056,896	3,646,078,932	507,984,085	4,154,063,017	<b>67%</b>
<b>DSHS</b>	2,870,851,542	1,251,877,656	11,916,537	1,263,794,193	<b>44%</b>
<b>DFPS</b>	1,327,184,949	768,528,680	20,115,231	788,643,911	<b>59%</b>
<b>DARS</b>	606,827,741	468,034,053	4,652,078	472,686,131	<b>78%</b>
<b>Total</b>	<b>\$ 29,124,691,495</b>	<b>\$16,674,666,284</b>	<b>\$1,822,695,445</b>	<b>\$18,497,361,729</b>	<b>64%</b>

### III. Top Ten HHS Agency Federal Funding Sources

Health and human service agencies used 133 different sources of federal funds in their FY 2009 budgets. As shown on the table below, ten of these funds represent 94 percent of all federal funds in health and human services. For further details on these ten federal funding sources, please see the May 2008 Legislative Budget Board report on the Top 100 Federal Funding Sources in the Texas State Budget. [http://www.lbb.state.tx.us/Federal\\_Funds/Top\\_Federal\\_Funding\\_Sources\\_0508.pdf](http://www.lbb.state.tx.us/Federal_Funds/Top_Federal_Funding_Sources_0508.pdf) Each agency and their primary federal funding sources are covered in more detail in Section VII.

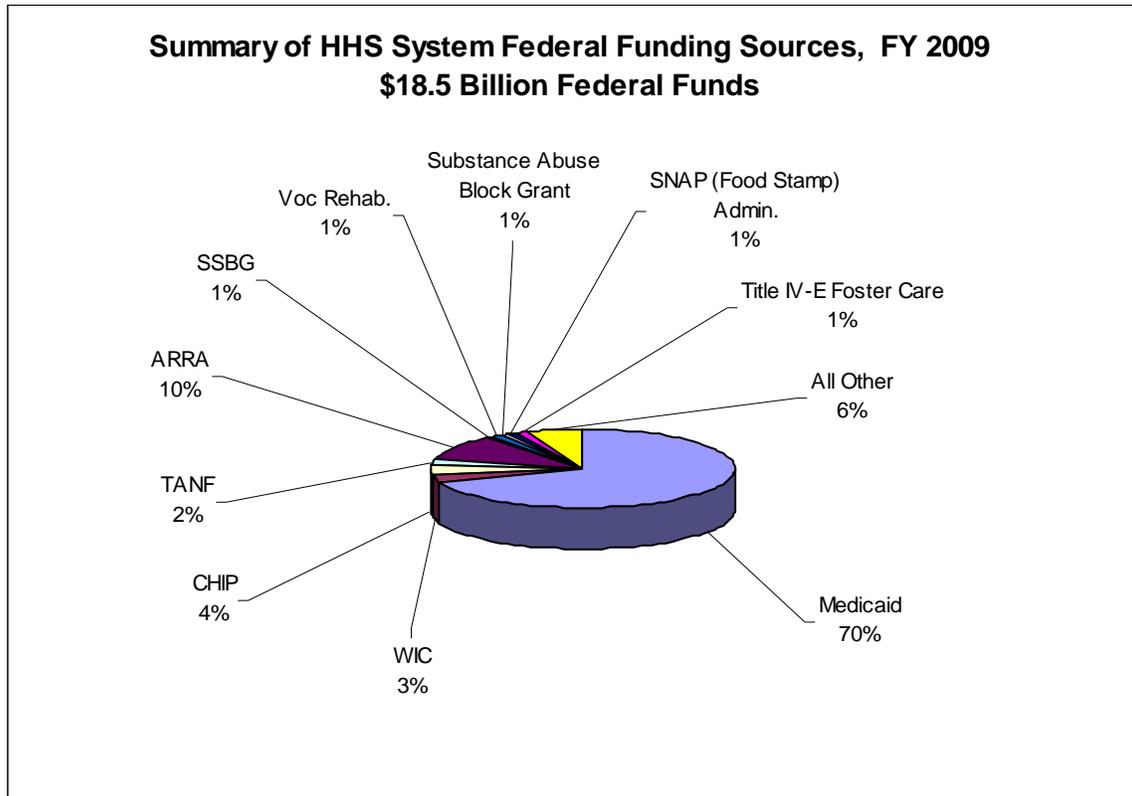
Table III.1

FY 2009 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)	\$ 9,284,155,022	\$ 3,428,189,118	\$ 98,240,501	\$ 7,533,120	\$ 36,647,550	\$ 12,854,765,311
	ARRA Funds (Medicaid and Other)	1,278,027,514	507,984,085	11,916,537	20,115,231	4,652,078	1,822,695,445
93.767	State Children's Insurance Program (CHIP)	773,950,411					773,950,411
10.557	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)			576,326,144			576,326,144
93.558	Temporary Assistance for Needy Families (TANF) & TANF to Title XX	101,151,696		20,459,640	319,599,207	16,102,792	457,313,335
93.658	Foster Care Title IV-E				221,724,035		221,724,035
93.667	Social Services Block Grant (SSBG)	40,352,356	88,010,839	10,866,946	34,020,682		173,250,823
84.126	Vocational Rehabilitation Grants to States					172,873,737	172,873,737
10.561	State Administrative Matching Grants for Supplemental Nutrition Assistance (SNAP) (Food Stamp) Program	168,071,808					168,071,808
93.959	Block Grants for Prevention and Treatment of Substance Abuse			137,799,337			137,799,337
<b>Top Ten Total</b>		<b>\$ 11,645,708,807</b>	<b>\$ 4,024,184,042</b>	<b>\$ 855,609,105</b>	<b>\$ 602,992,275</b>	<b>\$ 230,276,157</b>	<b>\$ 17,358,770,386</b>
All Other Federal		172,465,670	129,878,975	408,185,088	185,651,636	242,409,974	1,138,591,343
Top 10 as % of Agency & HHS System Federal Funds		99%	97%	68%	76%	49%	94%
<b>Total Agency and HHS System Federal Funds</b>		<b>\$ 11,818,174,477</b>	<b>\$ 4,154,063,017</b>	<b>\$ 1,263,794,193</b>	<b>\$ 788,643,911</b>	<b>\$ 472,686,131</b>	<b>\$ 18,497,361,729</b>

FY 2009 Disproportionate Share Hospital payments (\$961 million federal), Upper Payment Limit programs (\$1.5 billion federal) and Food Stamp distributions to clients (\$4.3 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 on the figure following, Medicaid is the largest federal funding source for health and human services, representing approximately 70 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 system agencies, at ten percent clearly indicating the prominent role ARRA funding played in the delivery of health and human services during the last fiscal year. Similar amounts are expected for fiscal year 2010. 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, Substance Abuse Prevention and Treatment Block Grant, State Administrative Matching Grants for Supplemental Nutrition Assistance Program (SNAP) (Food Stamps), and Title IV-E Foster Care represent one percent of federal funding for health and human services. The remaining six percent of federal funding in health and human services is made up by 123 federal funding sources. As discussed in more detail in the ARRA section on page 7 of this report, ARRA funding totaled \$1.8 billion in fiscal year 2009 and an estimated \$2.8 billion in fiscal year 2010.

Figure III.1



Fiscal year 2009 Disproportionate Share Hospital payments (\$961 million federal), Upper Payment Limit (\$1.5 billion federal) and SNAP distributions to clients (\$4.3 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**

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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 statutory requirements of Section 531.028. 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 and regional offices, 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 will result in an estimated \$37 million in additional federal funds through fiscal year 2009, with another \$24 million anticipated by the end of fiscal year 2011 for a total of approximately \$61 million (see table 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.

An issue also existed between the State and the HHS Division of Cost Allocation (DCA) over the methodology that ERS was using to attribute Retiree Benefit insurance costs to each individual agency. This contributed to some agencies being reluctant to claim these federal dollars. Since these costs are allowable for federal reimbursement per OMB

Circular A-87, the decision was made that the best course of action was to submit the claims and force DCA to either approve or deny the claims. The claims were made and the expenditures received federal matching funds.

Claims were made in fiscal year 2009 for fiscal years FY 2007 and 2008. The years reflected below indicate the original expense years, not when the claims were made. The actual and projected increased federal dollars recovered are listed below. The State can expect approximately \$12 million per year in increased federal dollars as a result of the maximization of retiree insurance benefits claiming.

*Table IV.1*

<b>Retiree Insurance Benefits Federal Claiming Initiative</b>	
<b>Fiscal Year</b>	<b>Additional Federal Funds</b>
2007 (actual)	\$ 12,400,538
2008 (actual)	12,729,766
2009 (projected)	11,353,767
2010 (projected)	11,921,455
2011 (projected)	12,517,528
<b>Total</b>	<b>\$ 60,923,054</b>

***Depreciation Review***

HHSC is reviewing the procedures used to calculate and claim 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. To ensure that HHS System agencies are fully maximizing the federal claiming of these expenditures, HHSC is working to revise procedures in order to ensure maximum claiming of these dollars. While HHS System agencies are entitled to make additional federal claims for these capital items, an estimated increased federal funds is not yet available.

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

DSHS applied for 24 new grants from federal agencies in fiscal year 2009. Of those grants 54 percent or 13 new grants were awarded totaling approximately \$12 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.

Texas has been successful in increasing the number of Federally Qualified Health Centers (FQHCs) from 32 to 58 centers in the state. DSHS uses State Incubator Grant funds to prepare FQHCs to operate, provide services, and submit competitive and fundable applications for federal funding. The investment of these state incubator funds has

increased federal funding for FQHCs to the extent that each \$1 invested in state funds brings in approximately \$5 in federal funding.

***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 the table below, Texas has three active DSH programs that have generated \$7.1 billion in federal funding since fiscal year 2002. In fiscal year 2009, DSH programs are expected to generate approximately \$961.3 million in federal funding. Approximately \$23.5 million related to the ARRA increase was paid in September 2009 (FY 2010); another \$47.6 million in ARRA funds will be paid in September 2010 (FY 2011).

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 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 IV.2*

<b>Disproportionate Share Hospital (DSH) Programs: Active, FY 2002-2009</b>									
<b>Federal Funds (\$ in millions)</b>									
<i>DSH Programs</i>	<b>FY02</b>	<b>FY03</b>	<b>FY04</b>	<b>FY05</b>	<b>FY06</b>	<b>FY07</b>	<b>FY08</b>	<b>FY09</b>	<b>FY02-09 Total</b>
Non-State Hospitals	566.3	504.3	516.5	540.9	701.2	616.8	594.3	759.3	4,799.6
State-Owned Teaching Hospitals	123.1	117.9	193.9	181.7	81.5	109.8	85.6	29.7	923.2
Other State-Owned Hospitals	166.6	170.2	162.2	183.9	193.4	149.6	189.3	172.3	1,387.5
<b>Total</b>	<b>\$856.0</b>	<b>\$792.4</b>	<b>\$872.6</b>	<b>\$906.5</b>	<b>\$976.1</b>	<b>\$876.2</b>	<b>\$869.2</b>	<b>\$961.3</b>	<b>\$7,110.3</b>

\*Not included on this table are ARRA DSH amounts paid in September 2009 (SFY 2010) totaling \$23.5 million and approximately \$47.6 million in ARRA DSH funds that will be paid in September 2010 (SFY 2011).

***Active Upper Payment Limit (UPL) Initiatives***

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

generated \$6.1 billion in federal funding since fiscal year 2002. In fiscal year 2009, UPL programs are expected to generate approximately \$1.5 billion in federal funding.

Table IV.3

<b>Upper Payment Limit (UPL) Programs: Active, FY 2002-2009</b>									
<b>Federal Funds (\$ in millions)</b>									
<i>Active UPL Programs</i>	<b>FY02</b>	<b>FY03</b>	<b>FY04</b>	<b>FY05</b>	<b>FY06</b>	<b>FY07</b>	<b>FY08</b>	<b>FY09</b>	<b>FY02-09 Total</b>
Large Urban Public Hospital UPL	170.2	216.9	410.9	497.4	442.4	547.4	588.6	560.5	3,434.3
State-Owned Hospital UPL	-	-	29.4	39.7	49.4	87.8	87.8	41.7	335.8
Rural Hospital UPL	14.1	20.1	29.1	41.4	46.1	46.3	41.2	51.9	290.2
Private Hospital UPL	-	-	-	5.2	143.5	334.2	423.9	759.6	1,666.4
State Physician Practice Plan UPL*	-	-	28.1	69.4	56.9	57.0	56.8	31.7	299.9
Tarrant County Physician UPL	-	-	-	1.5	3.7	2.3	1.5	2.1	11.1
Children's Hospital UPL	-	-	-	-	19.3	19.4	19.2	27.9	85.8
<b>Total</b>	<b>\$184.3</b>	<b>\$237.0</b>	<b>\$497.5</b>	<b>\$654.6</b>	<b>\$761.3</b>	<b>\$1,094.4</b>	<b>\$1,219.0</b>	<b>\$1,475.4</b>	<b>\$6,123.5</b>

Amounts include the ARRA related FMAP increase.

\*The 2009 federal funds are an estimate as the 4th qtr payment calculations have not been completed.

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

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The American Recovery and Reinvestment Act of 2009 (ARRA) was enacted on February 17, 2009 to provide economic stimulus funding through spending programs, tax cuts and other provisions. ARRA's combined spending and tax provisions will cost an estimated \$787 billion over 10 years. Approximately \$580 billion in additional federal spending and about \$207 billion in tax reductions are being provided directly to federal agencies and also distributed to states, localities, other entities, and individuals through a combination of formula and competitive grants and direct assistance. State and local governments will administer about \$280 billion of the funds. According to the General Accounting Office (GAO), Medicaid accounted for approximately 63 percent of ARRA expenditures in fiscal year 2009.

### *Texas ARRA Allocations*

Estimated ARRA allocations to Texas assumed in the state supplemental appropriations bill for SFY 2009 (H.B. 4586) and the General Appropriations Act for SFY 2010-2011 total approximately \$15.2 billion, with health and human services representing about 29 percent:

- Health and Human Services \$4.4 billion
- State Fiscal Stabilization Funds \$4.0 billion
- Transportation \$2.7 billion
- Education \$2.3 billion
- Housing and Infrastructure \$1.2 billion
- Labor \$0.4 billion
- Criminal Justice \$0.2 billion

### ARRA Funding in Fiscal Year 2009 and Fiscal Year 2010

As detailed by agency on the table below, ARRA federal funds in the HHS system totaled \$1.8 billion in fiscal year 2009 and an estimated \$2.8 billion in fiscal year 2010. HHSC and DADS account for approximately 98 percent of the ARRA funds in the HHS system in fiscal year 2009 and 92 percent in fiscal year 2010, the majority of which is Medicaid.

Table V.1

HHS Agency ARRA Funding: Expended FY 2009; Budgeted FY2010				
Agency	CFDA #	Grant Name	Exp. FY 2009	Bud. FY 2010
HHSC	93.778.014	Medicaid	\$ 1,264,184,198	\$ 1,880,681,149
HHSC	10.561.003	Food Stamps (SNAP) Administration	13,843,316	13,987,018
HHSC	93.714.000	TANF Emergency Contingency Fund	0	5,295,838
<b>Subtotal, HHSC</b>			<b>\$ 1,278,027,514</b>	<b>\$ 1,899,964,005</b>
DADS	93.778.014	Medicaid	\$ 507,984,085	\$ 687,719,806
DADS	93.707.000	Sr Nutrition Pgm -Congregate Meals	0	4,000,000
DADS	93.705.000	Sr. Nutrition Pgm-Home Delivered Meals	0	2,000,000
<b>Subtotal, DADS</b>			<b>\$ 507,984,085</b>	<b>\$ 693,719,806</b>
DARS	84.393.000	IDEA, Part C	\$ -	\$ 44,454,366
DARS	84.390.000	Vocational Rehabilitation	0	37,350,528
DARS	93.778.014	Medicaid	4,652,078	1,417,274
DARS	84.399.000	Indep. Living Svcs.(ILS) for Elderly/Blind	0	1,283,550
DARS	84.398.000	ILS Grants	0	558,052
<b>Subtotal, DARS</b>			<b>\$ 4,652,078</b>	<b>\$ 85,063,770</b>
DFPS	93.716.000	TANF Supplemental Funds	\$ -	\$ 47,982,709
DFPS	93.658.099	Foster Care - Title IV-E FMAP	12,527,455	18,015,584
DFPS	93.659.099	Adoption Asst.- Title IV-E FMAP	7,587,776	9,857,210
DFPS	93.713.000	Child Care Dev. BlockGrant	0	16,388,233
<b>Subtotal, DFPS</b>			<b>\$ 20,115,231</b>	<b>\$ 92,243,736</b>
DSHS	93.778.000	Medicaid	\$ 11,916,537	\$ 17,683,447
DSHS	10.578.001	WIC Grants to States: Tech. Grants/Misc Proj.	0	9,827,925
DSHS	93.712.000	Immunization Program	0	6,988,994
DSHS	93.716.000	TANF Supplemental	0	4,200,000
DSHS	84.397.000	Stabilization Fund	0	974,033
DSHS	93.720.000	Survey & Cert. Ambulatory	0	405,872
DSHS	93.717.000	Preventing Healthcare Infections	0	952,667
DSHS	10.578.000	WIC Grants to States: Elec. Benefits Transfer	0	950,000
DSHS	93.414.000	State Primary Care Offices	0	58,365
DSHS	93.667.000	Social Svcs. Block Grant	0	(4,200,000)
<b>Subtotal, DSHS</b>			<b>\$ 11,916,537</b>	<b>\$ 37,841,303</b>
<b>Grand Total</b>			<b>\$ 1,822,695,445</b>	<b>\$ 2,808,832,620</b>

NOTE: This table does not reflect ARRA expenditures and budgeted amounts for the following items: Disproportionate Share Hospital Services, Upper Payment Limit Services, Medicaid Electronic Health Record Initiative, State Health Information Exchange Cooperative Agreement Program, and Prevention and Wellness Fund – *Communities Putting Prevention to Work*.

**ARRA Medicaid FMAP and Title IV-E FMAP**

Medicaid and Title IV-E FMAP funds account for 99 percent of ARRA funds in fiscal year 2009 and 93 percent in fiscal year 2010. The table below reflects Medicaid and Title IV-E funds by agency.

Table V.2

<b>ARRA Medicaid FMAP and Title IV-E FMAP Funds by Agency</b>			
<b>Agency</b>	<b>Grant</b>	<b>FY 2009</b>	<b>FY 2010</b>
HHSC	Medicaid	\$1,264,184,198	\$1,880,681,149
DADS	Medicaid	507,984,085	687,719,806
DARS	Medicaid	4,652,078	1,417,274
DFPS	Title IV-E Adoption Assistance & Foster Care	20,115,231	27,872,794
DSHS	Medicaid	11,916,537	17,683,447
<b>Total</b>		<b>\$1,808,852,129</b>	<b>\$2,615,374,470</b>

**Other ARRA Funds**

Other ARRA funds account for one percent of the ARRA funds in FY 2009, totaling \$13.8 million, and seven percent of the ARRA funds in FY 2010, totaling \$193.5 million. The table below provides a summary of Other ARRA funds by agency.

Table V.3

<b>Other ARRA Funds by Agency</b>			
<b>Agency</b>	<b>Grant</b>	<b>FY 2009</b>	<b>FY 2010</b>
HHSC	SNAP Admin, TANF Emergency Contingency Fund	\$ 13,843,316	\$ 19,282,856
DADS	Senior Nutrition	0	6,000,000
DARS	Independent Living, IDEA Part C, Vocational Rehab.	0	83,646,496
DFPS	TANF Supplemental, Child Care & Development Block Grant	0	64,370,942
DSHS	WIC Tech. Grants, TANF Suppl., Immuniz., Prev. & Wellness, Misc.	0	20,157,856
<b>Total</b>		<b>\$ 13,843,316</b>	<b>\$ 193,458,150</b>

**Temporary FMAP Increase**

The 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 ARRA temporarily increases FMAP rates for states during the 27 month recession adjustment period, from October 2008 through December 2010. For Texas, this increase affects 11 months of state fiscal year 2009, 12 months of state fiscal year 2010, and four 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 can 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 the ARRA provided that only the

hold harmless and the across-the-board increase would apply to these programs. *See Table A.1 in the Appendix for more detail on Title IV-E FMAP rates.*

During the stimulus period, the increased federal share for Medicaid will range from approximately seven to ten percentage points above the pre-ARRA FMAP rate. Prior to passage of the ARRA, Texas FMAP was 59.53 in SFY 2009. When the recession adjustment period ends in December 2010, the FMAP will return to the regular FY 2011 FMAP rate of 60.56.

To receive the FMAP increase, Medicaid eligibility standards, methodologies, or procedures cannot be more restrictive than those in effect as of July 1, 2008. Additionally, a state is 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 must be met.

#### ***FMAP Unemployment Adjustment Tiers***

The criterion for Texas to qualify for the tiered unemployment adjustment is a three-month average unemployment rate. Below are the three-month average unemployment rates needed by Texas to attain each Tier along with the resulting FMAP rate. The resulting FMAP rates include the hold harmless, the across-the-board increase, and the respective TIER increase.

- TIER I: 5.9 percent unemployment rate; resulting FMAP is 68.76
- TIER II: 6.9 percent unemployment rate; resulting FMAP is 69.85
- TIER III: 7.9 percent unemployment rate; resulting FMAP is 70.94

*Table A.2 in the Appendix shows the Texas FMAP for each month of the recession adjustment period.* Texas qualified for the TIER I FMAP unemployment adjustment during the first ten months of state fiscal year 2009. Beginning in July of state fiscal year 2009, Texas qualified for TIER II FMAP.

Beginning in October of state fiscal year 2010, Texas qualified for TIER III FMAP. Because ARRA requires recalculation of the tiers for the last two federal quarters of the FMAP adjustment, HHSC assumes a TIER II adjustment beginning in July 2010. During 2010-11, estimated additional federal funds for the TIER III and TIER II FMAP unemployment adjustment are an estimated \$568 million above the \$2.5 billion appropriated.

#### ***Federal and State Reporting***

Section 1512 of the ARRA specifies quarterly reporting requirements for recipients of ARRA funds; however, the reporting requirements do not apply to entitlement/mandatory programs, programs contained in Division B of the Act (including TANF), and other programs providing benefits to individuals. Section 1512 requires recipients to report on the use of ARRA funding no later than the 10th day after the end of each calendar quarter

(October 10; January 10; April 10; and July 10 each year). Meeting the Section 1512 reporting deadline is crucial, as compliance with these reporting requirements is a condition of receipt of ARRA funds.

Special Provisions in Article XII of the 2010-11 General Appropriations Act (S.B. 1, 81st Legislature, Regular Session, 2009) specify state reporting requirements for ARRA funds and the Comptroller of Public Accounts (CPA) has also issued ARRA reporting requirements. ARRA intended use plans were submitted as required by S.B. 1. and are posted on HHSC's website: <http://www.hhsc.state.tx.us/FederalStimulus.shtml> Ongoing state reports include a weekly ARRA expenditure report to CPA and quarterly reports to the Governor, Legislative Budget Board (LBB), CPA, and State Auditor's Office (due December 31; March 31; June 30; and September 30 each year).

### ***Accountability and Transparency***

The ARRA assigns the Government Accountability Office (GAO) a range of responsibilities to help promote accountability and transparency including bi-monthly reviews of the use of funds by selected states and localities. Texas is one of the 16 selected states.

Federal inspectors general across government are expected to audit the programs, grants, and projects funded under the ARRA, both within their particular agency or department and collectively to address the ARRA accountability and transparency provisions. The ARRA also established the Recovery Accountability and Transparency Board (RATB) to help prevent waste, fraud, and abuse.

The ARRA established the Recovery.gov website to foster greater accountability and transparency in the use of funds made available by the Act. The website's primary mandate is to allow taxpayers to see what entities receive ARRA funds and how and where the money is spent, from a larger national overview down to individual projects in specific zip codes. The site also provides an online way for reporting any suspected fraud, waste or abuse related to Recovery funding and projects. Recovery.gov will update data and information as recipients of ARRA funds file quarterly spending and project status reports, including the number of jobs created and/or saved. Recovery.gov is operated by the RATB.

### ***Other ARRA Funds***

In addition to Medicaid and Title IV-E FMAP funds, the ARRA also allocated stimulus funds through various categorical funding areas such as SNAP Administration, IDEA Part C, Congregate and Home Delivered Meals, and Child Care and Development Block Grant. Additionally, the ARRA extended the TANF Supplemental Funds, created a new TANF Emergency Contingency Fund, increased the Disproportionate Share Hospital (DSH) allotment, allocated funding for Health Information Technology (HIT), and provided supplemental funding for existing public health cooperative agreements, competitive grant opportunities through the Prevention and Wellness Fund and other ARRA provisions as highlighted below.

### ***TANF Supplemental Funds***

ARRA was the legislative vehicle used to extend TANF supplemental grants provided to seventeen states through fiscal year 2010. The supplemental grants were set to expire at the end of fiscal year 2009. This supplemental funding is provided to states that meet criteria of high rates of population growth and/or low historic benefit levels. Since these funds have been appropriated annually since 1996, this funding is likely to continue in the future. Texas currently receives approximately \$52 million in TANF supplemental funds annually.

### ***TANF Emergency Contingency Funds***

States are eligible for TANF Emergency Contingency Funds equal to 80 percent of the increase in state expenditures in three areas: basic assistance (also requires increase in caseload), non-recurrent short-term benefits, or subsidized work programs. Spending increases are determined on a quarterly basis by comparing expenditures to those from the same quarter in a base year of either federal fiscal year 2007 or federal fiscal year 2008. The Legislature authorized HHSC to increasing the August back to school TANF payment by \$75 in FY 2009 and FY 2010 to maximize the 80 percent reimbursement award. For FY 2010, HHSC will receive \$5.2 million.

### ***Disproportionate Share Hospital (DSH) Allotment Increase.***

The ARRA increases States' federal fiscal year 2009 and 2010 Medicaid DSH allotments by 2.5 percent. As with other "matching" Medicaid programs, the federal government and the state each pay a share of the total DSH program costs. In Texas, the state share is funded from intergovernmental transfers from eight hospital districts and with state-appropriated funds from state-owned hospitals. Texas DSH Hospitals would receive an estimated \$23.5 million in additional federal funding in state fiscal year 2010 and \$47.6 million in state fiscal year 2011 over current fiscal year 2009 levels.

### ***Health Information Technology***

ARRA included approximately \$2 billion in funding to the Office of the National Coordinator (ONC) for Health Information Technology for investing in health information technology infrastructure. The ONC has allocated approximately \$28.8 million over four years to Texas for the State Health Information Exchange (HIE) Cooperative Agreement Program. Contingent upon meeting federally required milestones such as approval of the strategic plan and the implementation plan, states anticipate receiving most of the funds within the first two years.

In addition, approximately \$20.8 billion (net including savings) was appropriated nationally for the Electronic Health Record (EHR) incentive payments to Medicaid providers of up to \$65,000 over a five-year period. HHSC has received initial guidance from CMS on planning for this program and further guidance will be forthcoming later this year. Incentive payments to providers would be made no sooner than January 2011.

### ***Prevention and Wellness Fund***

The ARRA provided \$1 billion nationally for a “Prevention and Wellness Fund,” which included three broad components:

- \$650 million to carry out evidence-based clinical and community based prevention and wellness strategies as determined by HHS that deliver specific, measurable health outcomes that address chronic disease rates; and
- \$300 million to carry out the immunization program;
- \$50 million provided to states to carry out activities to implement healthcare associated infections reduction strategies.

Each of the components is discussed in further detail below. Funds are appropriated for one-time use. Funds are to be used according to the public health priorities of the HHS Secretary and the director of the Centers for Disease Control and Prevention (CDC).

**Evidence-Based Strategies:** HHS released guidance associated with the \$650 million to carry out strategies that deliver specific, measurable health outcomes that address chronic disease rates. This component of the Prevention and Wellness Fund included two funding opportunities released in September 2009 entitled *Communities Putting Prevention to Work*.

One opportunity was available to states with existing cooperative agreements for collaborative chronic disease prevention activities and included a competitive component. DSHS submitted the state supplemental request based on the formula award to Texas in the amount of \$4.3 million for obesity and tobacco prevention, and three competitive proposals for up to a possible \$3 million maximum.

The second was a competitive grant opportunity for local health departments. DSHS submitted two State-Coordinated competitive applications (maximum allowed per state), one for obesity on behalf of Laredo and Tyler, and one for tobacco on behalf of Corpus Christi and Nacogdoches. Each competitive State-Coordinated application could include a maximum of two communities.

**Immunization Program:** Of the \$300 million in Recovery Act funds allocated nationally to the Section 317 program for immunization operations and infrastructure necessary to implement a comprehensive immunization program, \$250 million will help existing Section 317 grantees acquire and make recommended vaccines available by using \$200 million of these funds to purchase vaccines that will be made available to states and territories. CDC must meet a 75 percent vaccine and 25 percent operations breakdown nationally. Vaccines and Recovery Act resources will also be made available to special Section 317 programs in Chicago, Houston, New York City, Philadelphia and San Antonio. DSHS was awarded \$6.5 million for immunizations.

The remaining \$50 million will be used to provide program operation grants and vaccine distribution funding that states and territories will use to deliver the vaccines and

strengthen vaccination programs. This includes an additional \$18 million in grants to be used to provide support to Section 317 grantees that demonstrate innovative approaches to increase the number of Americans who receive the childhood vaccine series, zoster vaccine, and influenza vaccine, and for improving reimbursement practices. Applications to apply for these grants will be made available on [grants.gov](https://www.grants.gov).

Nearly \$32 million in Recovery Act funds will be used nationally to increase information, communication and education and strengthen the evidence base for immunization. This will include activities to increase national public awareness and knowledge about the benefits and risks of vaccines and vaccine-preventable diseases. Funds will also help provide tools and education for health care providers and to monitor and assess the impact and safety of licensed vaccines routinely recommended for use in the United States to ensure that national vaccine policy is appropriate and effective. DSHS was awarded \$493,255 for a rotavirus vaccine effectiveness project.

**Healthcare Associated Infections (HAI):** HHS released \$40 million for competitive supplemental grants to eligible states to create or expand state-based HAI prevention and surveillance efforts through existing epidemiology and laboratory capacity grants. Funds are intended to address the HHS Action Plan on HAIs. Funds will also be used to strengthen the public health workforce trained to prevent HAIs. HHS is also allocating \$10 million in grants to states to improve the process and increase the frequency of inspections for ambulatory surgical centers. DSHS was awarded \$1,233,977 for healthcare associated infections surveillance and prevention and \$531,232 to help increase the state's survey inspection capability at ambulatory surgical centers across the state.

## **VI. Other Current Federal Issues**

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### *Health Care Reform*

While reform of the health care system at the federal level has become one of this year's key Congressional agenda items, Texas continues its efforts for reform at the state level. Texas has pursued a Medicaid waiver since 2007 with submission of a concept paper and formal waiver submission in April 2008. The waiver, still pending at Centers for Medicare & Medicaid Services (CMS), seeks authority to create new health coverage options for the working poor. The proposal reflects the bipartisan direction of S.B. 10 (80th Legislature, Regular Session, 2007), and would provide premium subsidies for uninsured enrollees to access individual insurance or to buy into employer-sponsored coverage.

The 81<sup>st</sup> Legislature, Regular Session, 2009, further supported the availability of affordable employer sponsored insurance by creating the Healthy Texas program. This program, to be implemented by the Texas Department of Insurance in June 2010, uses general revenue funds to create more affordable small employer insurance options statewide. In addition, HHSC applied for and received a competitive federal Health Resources and Services Administration (HRSA) State Health Access Program (SHAP) grant worth up to \$50 million over five years, to increase employed Texans' access to affordable insurance. Under the grant, funding will be used to support the Healthy Texas project, and also to make cost-sharing accounts available for uninsured individuals to either help pay their premiums or to help pay cost-sharing such as deductibles, coinsurance and copayments.

At the federal level, if reform legislation passes, and depending on which components of the reform bills become law, the effects on Texas' health care system could be significant. Medicaid coverage is proposed up to 133 percent or 150 percent of poverty for all legal residents. In addition, there would be a federal mandate for all legal residents to have health insurance, and federally financed subsidies would help individuals from 100 to up to 400 percent of poverty buy insurance.

Compared to current Medicaid program coverage levels (e.g., no coverage of childless adults in Medicaid and coverage of parents up to about 14 percent of the poverty level), current County Indigent Health Care Program coverage levels (21 percent of poverty), some of the Safety Net Hospital charity programs levels (now providing some care up to 200 percent of poverty) and state funded indigent care programs, the anticipated levels of coverage under reform would significantly and fundamentally alter the current landscape of the indigent and low income health care system. Under reform, the Disproportionate Share Hospital (DSH) program is also likely to change, with reductions either triggered by reduced uninsured levels or reduced directly under law based on an assumed reduction in need for DSH funding under reform.

While seeking to provide access to affordable coverage for all legal residents under 400 percent of poverty, reform would require additional state funds to help pay for the

broader coverage. Currently, both bills would provide enhanced federal match for the expanded Medicaid population not currently covered, but under a mandate, the state anticipates additional costs at the regular match rate for increased enrollments of individuals who may currently be eligible for, but not enrolled in, Medicaid or CHIP. The House Bill also requires that Medicaid pay for primary care services at Medicare rates, creating a new precedent of Medicaid provider rates, or at least of portion of them, being set outside of the state-based Medicaid rate development prices. This approach makes states, including Texas, financially liable for Medicare rate decisions made by the federal government.

Reform is also anticipated to create additional pressure on the health care workforce as more individuals would have insurance funds and seek health care. Current health care workforce shortages would be exacerbated and accessing health care providers, or ensuring that they will be available under managed care, is likely to be more challenging. Texas would also likely need to re-assess its indigent care programs and funding, since the need for programs to provide health services to individuals who are uninsured and low-income will be mitigated under reform.

### ***CHIP Perinate***

Based on guidance from CMS, HHSC either will be required to restructure or terminate the CHIP Perinate program. The program currently serves approximately 70,000 women per month with incomes up to 200 percent of the federal poverty level who do not qualify for Medicaid coverage. Once born, the child receives CHIP benefits for the remainder of the 12 month coverage period. CMS has indicated that these children, if Medicaid eligible, must be covered by Medicaid instead of CHIP upon birth of the child. HHSC has asked for CMS clarification on this issue since April 2008, and received a response in September 2009 that HHSC must adjust its expenditures back to July 13, 2007, to claim federal Medicaid match instead of the higher CHIP match rate upon birth of the child. HHSC continues to work with CMS to resolve this issue, and has requested time to either restructure or terminate the program.

### ***CHIP Reauthorization***

The CHIP Reauthorization Act of 2009 (CHIPRA), which was signed into law on February 4, 2009, authorizes CHIP federal funding through federal fiscal year 2013. CHIPRA increases the amount of federal CHIP funding available to Texas. For fiscal year 2009, the federal CHIP allotment for Texas increased by 72 percent from \$549.6 million to \$945.6 million. Texas has two years to spend its CHIP allotment, instead of the three years allowed under prior federal law.

In addition to these funding changes, CHIPRA also includes significant policy changes that impact Texas. HHSC is working to implement the following 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 (effective October 1, 2009);
- Applying certain Medicaid managed care safeguards to CHIP;
- Citizenship verification for CHIP;
- Mental health parity in CHIP; (see additional information included below)
- Covering dental services in CHIP that are required by CHIPRA (see additional information included below); and
- Providing federally-matched CHIP and Medicaid coverage to qualified immigrant children (see additional information included below).

### ***Mental Health Parity***

CMS issued guidance on the implementation of mental health and substance use disorder parity requirements of the CHIPRA Section 502, including requirements for CHIP and preliminary guidance on requirements that apply to Medicaid. States will not have detailed information on the requirements of this law until Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) regulations are issued. The guidance letter does not provide a timeline for when the regulations will be issued. Federal Financial Participation (FFP) will not be denied if states make a good faith effort to comply with the MHPAEA requirements. If a state requires legislation to make these changes, the state has additional time to come into compliance.

MHPAEA applies to Medicaid Managed Care Organizations (MCOs) and all State CHIP programs; the provision does not apply to Medicaid Fee for Service (FFS). Specific issues for DSHS will be the extent to which provisions impact evidence-based treatment guidelines such as those for psychosocial rehabilitative services and prior authorization requirements.

### ***CHIP Dental***

Beginning October 1, 2009, the CHIP Reauthorization Act of 2009 (CHIPRA) requires 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.” Based on guidance from CMS, Texas will likely be required to expand CHIP dental benefits. The Texas CHIP dental benefit package currently consists of three tier levels that cover certain preventive and therapeutic services up to capped dollar amounts per 12-month coverage period. HHSC is exploring what additional funds may be required to meet the new requirements, which per CMS guidance include coverage of periodontic and prosthodontic services that Texas CHIP does not cover.

### ***Coverage of Qualified Immigrants***

Currently, Texas provides CHIP coverage using general revenue for children who are in the country legally but ineligible for Medicaid coverage due to their immigration status. The CHIP Reauthorization Act (CHIPRA) gives states the option of providing Medicaid or CHIP benefits for certain to qualified immigrant children and pregnant women. This

enables Texas to receive enhanced federal matching funds for the qualified immigrant children currently covered under CHIP with general revenue and for newly certified qualified immigrant children eligible for Medicaid or CHIP. HHSC plans to implement this change on May 1, 2010; however, HHSC appropriations assumed implementation on October 1, 2009. The later implementation date results in overall budget savings. The budget estimated that some newly qualified immigrants would enroll in Medicaid thus providing federal match to an increased population that was not previously covered, but the delay results in a shortfall in CHIP because the State must continue to cover the qualified immigrants using General Revenue until implementation.

### ***Permanency Care Assistance Program***

Passed by The 81<sup>st</sup> Legislature and signed by the Governor, H.B. 1151 authorized a Permanency Care Assistance (PCA) Program that would provide assistance to relatives and other designated caregivers who have served as verified foster parents for the subject child for six months and who have subsequently taken permanent managing conservatorship of the child.

H.B. 1151 requires DFPS to implement the optional provisions in the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 by September 1, 2010 (Medicaid eligibility begins October 1, 2010). DFPS and HHSC are coordinating to implement the financial assistance and related Medicaid coverage for these PCA children.

### ***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 any future bioterrorism or other man made disasters. Additional federal resources are needed for data collection demands during a disaster response. However, a reduction of approximately \$1.5 million is anticipated for FY 2010. Additionally, in FY 2009, the federal government added state-local matching funds requirement of 5 percent and 10 percent thereafter.

For fiscal year 2010, however, DSHS received over \$90 million in additional one time federal funding for emergency response efforts related to H1N1 and pandemic influenza preparedness.

### ***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.

### ***Ryan White Reauthorization***

The President signed the Ryan White HIV/AIDS Treatment Extension Act of 2009 on October 30th. The law keeps the 2006 reauthorization largely intact while making some minor changes to the program. Specifically, the law maintains the goal of ensuring the program allocations are based on name-based HIV reporting, but extends the deadline for those jurisdictions that are still transitioning to the new system.

Overall, the authorization level for the program is increased five percent annually. Congress maintained the funding allocation methodology for all programs, except the Minority AIDS Initiative (MAI) grants awarded competitively through Parts A and B and the supplemental Part A grants. The law requires the US Department of State Health Services (HHS) to develop a formula that ensures funding for the MAI grants is based on the distribution of population disproportionately impacted by HIV/AIDS.

While the law increases the authorization level, the actual funding level will be determined by the appropriations process. 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 previous reauthorization of Ryan White made substantial changes in funding methodology, program emphasis, and requirements. Two of these changes that affect programming in Texas are described below.

- Three of the former Ryan White Title I Eligible Metropolitan Areas (EMAs) lost this designation under the new law. These areas (San Antonio, Fort Worth, and Austin) became Transitional Grant Areas (TGAs) under the new Part A (formerly Title I) of the Act. The Dallas and Houston areas remain as EMAs. TGAs do not have the same hold harmless protections as EMAs and are thus subject to potentially large funding reductions. If these areas do lose significant funds, they will likely request financial assistance from the state. None of the TGAs in Texas show levels of reported HIV and AIDS cases that suggest that they would fall out of eligibility.

### ***Supplemental Nutrition Assistance Program (SNAP) (formerly known as Food Stamps) Timeliness***

On September 24, 2009, HHSC received notification from Food and Nutrition Service (FNS) that corrections must be made to bring HHSC's administration of SNAP into compliance with federal law related to application processing timeliness or be at risk for suspension or disallowance of federal funds. FNS requested a corrective action plan. Subsequently, HHSC submitted a SNAP timeliness corrective action plan to FNS on November 9, 2009. HHSC will provide quarterly reporting of progress.

***Title XX Social Services Block Grant Emergency Disaster Relief Funding***

***Hurricanes Katrina and Rita***

HHSC received approximately \$88 million of Title XX Social Services Block Grant (SSBG) Emergency Disaster Relief Funding in FY 2006 to provide a wide array of human services, including the provision of health care and rebuilding assistance to citizens of Texas and evacuees impacted by Hurricanes Katrina and/or Rita. Approximately \$84.4 million of the SSBG Emergency Disaster Relief Funding was allocated to 15 Regional Council of Governments (COGs), with the remaining \$3.5 million allocated to HHSC, DSHS, and DADS. All of the available SSBG Emergency Disaster Relief Funding was utilized for allowable services provided during the period August 2005 – September 2009, with approximately \$39.8 million of the SSBG Emergency Disaster Relief Funding expended in FY 2009.

***Hurricanes Ike and Dolly***

HHSC also received \$218.7 million of SSBG Emergency Disaster Relief Funding in FY 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 is allocated as follows:

Six Regional COGs:	\$ 125.9 million
U.T. Medical Branch at Galveston:	\$ 50.0 million
Uncompensated Care for Hospitals:	\$ 26.5 million
DADS, DSHS, and HHSC:	<u>\$ 16.5 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. The funding is available for allowable services provided between September 13, 2008 and September 30, 2010. HHSC projects all of this available SSBG Emergency Disaster Relief Funding will be utilized, with expenditures expected in FY 2010.

***Public Assistance Cost Allocation Plans (PACAPs)***

All HHS System agencies are now operating under federally approved cost allocation plans or indirect cost rate proposals.

***Pending State Plan Amendments (SPAs) and Federal Deferrals and Disallowances***

At this time, Texas has 34 pending SPAs. Ten of the SPAs address routine updates of rates due to a new directive from CMS that effective dates of the rates must be included into the actual SPA language. Seventeen of the SPAs address CMS requirements (removal of eligibility criteria per the CHIPRA, assurances of third party payors compliance per the Deficit Reduction Act, changes in federal regulations and changes in

CMS' interpretation of federal regulations (unbundling of service rates, ceasing monthly case rates, and services no longer allowable). The remaining pending SPAs address state-initiated changes to the Medicaid State Plan (adult wellness exams, change to the conditions of participation for urban hospitals, change in calculating cost of institutionalized care).

CMS may impose deferrals or disallowances following a federal audit or a change to the Medicaid State Plan, the state's contract with CMS. A deferral or disallowance may be imposed for the federal fiscal quarter(s) for which CMS asserts that the state is out of compliance with federal directives, and in the case of a disallowance, may retroactively encompass several years of claims. The Texas Medicaid program generally has some deferrals and disallowances at any given time that it is negotiating with CMS. At this time, there are four pending SPA deferrals totaling approximately \$7.8 million due to the state implementing changes in the Medicaid program prior to CMS approving the SPA. The majority of the \$7.8 million is deferrals for Day Activity and Health Services (DAHS) (See below for more detailed information).

When CMS imposes deferrals and disallowances, the availability of federal financial participation (FFP) for the Medicaid program is impacted. The difference between a deferral and a disallowance is explained below.

*Deferral:* CMS withholds funds until it determines the state is in compliance with reporting requirements or until the state provides additional information to support the allowability of the claim. Deferrals can become disallowances.

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

### ***Day Activity and Health Services (DAHS)***

Texas has offered DAHS as a State Plan service since the late 1970s. The DAHS facilities offer restorative nursing services; personal care services; nutrition/food services and related counseling; social, recreational, and educational activities; and transportation services, including transportation to medical appointments. The SFY 2009 budget (all funds) for DAHS is \$104.6 million, serving an average of 17,140 individuals per month. DAHS is currently offered in the Medicaid State Plan as a rehabilitative service; however, in 2005 CMS ceased approving DAHS related SPAs on the basis of a change in CMS' definition of "rehabilitative service" and concerns with rate structure and provider qualifications. CMS began deferring federal funds for DAHS services in FY 2007 due to HHSC implementing changes prior to CMS approval of the pended DAHS SPAs.

As of the third quarter of fiscal year 2009, DAHS deferrals total approximately \$4.7 million. Unless DAHS services are covered under a 1915(i) amendment to the Medicaid State Plan, they are at risk for disallowance of federal funds. The 1915(i) option, established by the Deficit Reduction Act of 2005, allows certain community services to be provided under the Medicaid State Plan to consumers with income of no more than 150 percent of the Federal Poverty Level (FPL). Texas awaits CMS approval of a

1915(i) amendment submitted in September 2009. As a result of more stringent eligibility requirements under 1915(i), Texas will also need to amend certain 1915(c) waivers to ensure that no existing DAHS clients lose services. Additionally, there will be some costs associated with completion of functional assessments under the 1915(i).

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

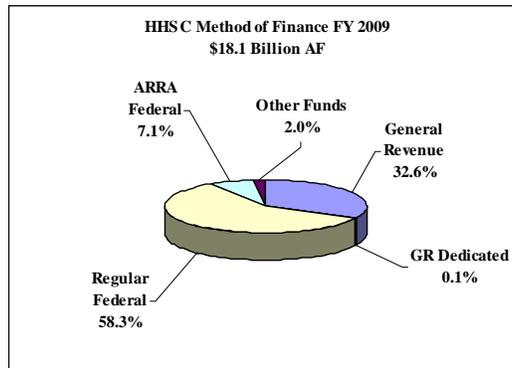
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This section includes a chart displaying each HHS agency's method of finance and a brief discussion of each agency's key federal funding sources in FY 2009.

### *Health and Human Services Commission*

HHSC's \$18.1 billion budget includes 58 percent Regular Federal Funds and 7 percent ARRA Federal Funds. Of the \$11.8 billion in federal funding HHSC receives, 97 percent comes from four sources: Medicaid, ARRA, CHIP, and SNAP (Food Stamps) Administrative Matching Grants. Medicaid comprises 79 percent of HHSC's federal funding, ARRA represents 11 percent, CHIP accounts for seven percent, and SNAP administration accounts for a little over 1 percent.

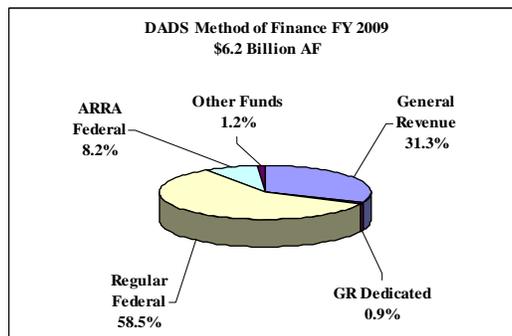
Figure VII.1



### *Department of Aging and Disability Service*

DADS' \$6.2 billion budget includes 59 percent Regular Federal Funds and 8 percent ARRA Federal Funds. Three sources, Medicaid, ARRA, and the Social Services Block Grant represent 97 percent of DADS' federal funding.

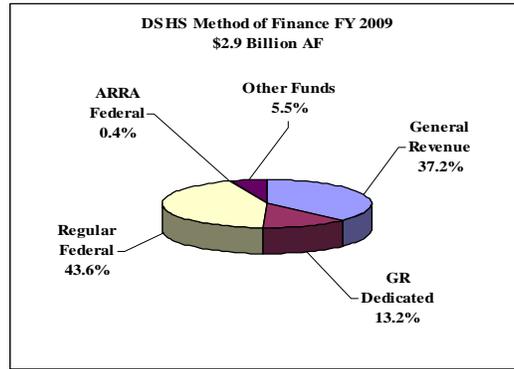
Figure VII.2



***Department of State Health Services***

The Method of Finance for DSHS includes 44 percent Regular Federal Funds and less than one percent ARRA Federal Funds. Of the approximately \$1.3 billion in Federal Funds received by DSHS, six sources account for approximately 79 percent: Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Substance Abuse Prevention and Treatment Block Grant, Medicaid, HIV Care Formula Grant, Public Health Emergency Preparedness, and Community Mental Health Services Block Grant. DSHS receives more types of federal grants than any other HHS agency, with over 70 federal funding sources used in FY 2009.

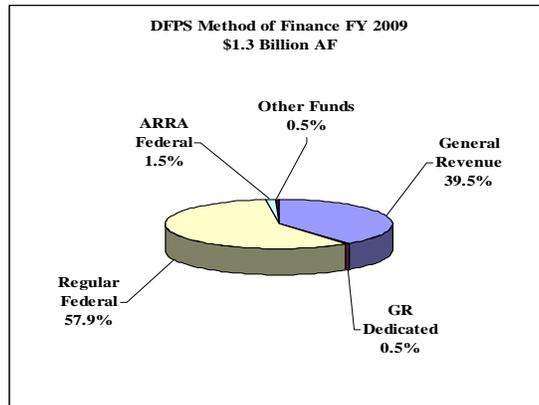
*Figure VII.3*



***Department of Family and Protective Services***

The DFPS budget includes 58 percent Regular Federal Funds and 2 percent ARRA Federal Funds. Three funding sources, TANF, Title IV-E Foster Care, and Title IV-E Adoption Assistance make up 78 percent of the agency's \$789 million in federal funds.

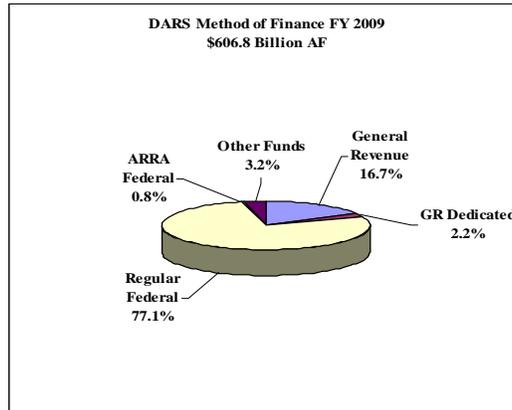
*Figure VII.4*



***Department of Assistive and Rehabilitative Services***

The DARS budget includes 77 percent Regular Federal Funds and one percent ARRA Federal Funds. Vocational Rehabilitation, Social Security Disability Insurance, and Special Education Grants represent 74 percent of the \$473 billion in federal funding at DARS.

*Figure VII.5*



## VIII. Federal Budget Outlook

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### *Fiscal Year 2010 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. The second CR passed by Congress funded fiscal year 2010 appropriations for discretionary spending at the fiscal year 2009 level through December 18, 2009.

As of December 1, Congress had enacted five of the twelve appropriations bills: Agriculture, Energy and Water, Homeland Security, Interior and Environment, and Legislative Branch. Congress had initially hoped that all FY 2010 spending bills would be enacted individually; however, they combined six of the remaining seven spending bills (Commerce/Justice, Financial Services, Labor/Health and Human Services/Education, Military Construction, Foreign Operations, and Transportation/Housing and Urban Development) into an omnibus bill that was cleared for the President’s signature on December 13. The defense spending bill will be considered separately and used as a vehicle for other legislative priorities.

The conference report on the omnibus H.R. 3288 provides for a total of \$447 billion in discretionary spending and approximately \$1.1 trillion when mandatory spending is included. The Labor-HHS-Education bill would provide a total of \$731 billion, which is 9 percent more than was enacted for fiscal 2009, excluding emergency spending. Of this amount, \$603.7 billion is for health and human services. Most of the appropriations are for mandatory programs, including \$221 billion for Medicaid grants and \$207.3 billion for Medicare.

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.

## **IX. Appendices**

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## Table A.1

### Title IV-E Stimulus FMAP by Month and SFY Average

#### State Fiscal Year 2009\*

Sep-08	60.53	Reg. FMAP
Oct-08	66.73	Stimulus FMAP
Nov-08	66.73	Stimulus FMAP
Dec-08	66.73	Stimulus FMAP
Jan-09	66.73	Stimulus FMAP
Feb-09	66.73	Stimulus FMAP
Mar-09	66.73	Stimulus FMAP
Apr-09	66.73	Stimulus FMAP
May-09	66.73	Stimulus FMAP
Jun-09	66.73	Stimulus FMAP
Jul-09	66.73	Stimulus FMAP
Aug-09	66.73	Stimulus FMAP
<b>SFY 2009</b>	<b>66.21</b>	

#### State Fiscal Year 2010\*

Sep-09	66.73	Stimulus FMAP
Oct-09	66.73	Stimulus FMAP
Nov-09	66.73	Stimulus FMAP
Dec-09	66.73	Stimulus FMAP
Jan-10	66.73	Stimulus FMAP
Feb-10	66.73	Stimulus FMAP
Mar-10	66.73	Stimulus FMAP
Apr-10	66.73	Stimulus FMAP
May-10	66.73	Stimulus FMAP
Jun-10	66.73	Stimulus FMAP
Jul-10	66.73	Stimulus FMAP
Aug-10	66.73	Stimulus FMAP
<b>SFY 2010</b>	<b>66.73</b>	

#### State Fiscal Year 2011\*\*

Sep-10	66.76	Stimulus FMAP
Oct-10	66.76	Stimulus FMAP
Nov-10	66.76	Stimulus FMAP
Dec-10	66.76	Stimulus FMAP
Jan-11	60.56	Reg. FMAP
Feb-11	60.56	Reg. FMAP
Mar-11	60.56	Reg. FMAP
Apr-11	60.56	Reg. FMAP
May-11	60.56	Reg. FMAP
Jun-11	60.56	Reg. FMAP
Jul-11	60.56	Reg. FMAP
Aug-11	60.56	Reg. FMAP
<b>SFY 2011</b>	<b>62.63</b>	

\*Title IV-E receives only the Hold Harmless (minus .03 in FY 2009 and FY 2010 due to Title IV-E ineligibility for the special FFY 2008 FMAP adjustment for Katrina) and the Across-the-Board increase; the FMAP Unemployment Bonus is not applied to the Title IV-rate.

\*\*In FY 2011, during the stimulus months (Sept.-Dec.) Title IV-E will receive an additional .03 on the Hold Harmless due to the change in the Regular FMAP rate.

**Table A.2****Medicaid Stimulus FMAP by Month and State Fiscal Year (SFY) Average****State Fiscal Year 2009****Tier I & TIER II**

Sep-08	60.56	Reg. FMAP
Oct-08	68.76	TIER I
Nov-08	68.76	TIER I
Dec-08	68.76	TIER I
Jan-09	68.76	TIER I
Feb-09	68.76	TIER I
Mar-09	68.76	TIER I
Apr-09	68.76	TIER I
May-09	68.76	TIER I
Jun-09	68.76	TIER I
Jul-09	69.85	TIER II
Aug-09	69.85	TIER II
<b>SFY 2009</b>	<b>68.26</b>	

**State Fiscal Year 2010\*****Tier II & TIER III**

Sep-09	69.85	TIER II
Oct-09	70.94	TIER III
Nov-09	70.94	TIER III
Dec-09	70.94	TIER III
Jan-10	70.94	TIER III
Feb-10	70.94	TIER III
Mar-10	70.94	TIER III
Apr-10	70.94	TIER III
May-10	70.94	TIER III
Jun-10	70.94	TIER III
Jul-10	69.85	TIER II
Aug-10	69.85	TIER II
<b>SFY 2010</b>	<b>70.67</b>	

**State Fiscal Year 2011\*****TIER II and  
Regular FMAP**

Sep-10	69.85	TIER II
Oct-10	69.85	TIER II
Nov-10	69.85	TIER II
Dec-10	69.85	TIER II
Jan-11	60.56	Reg. FMAP
Feb-11	60.56	Reg. FMAP
Mar-11	60.56	Reg. FMAP
Apr-11	60.56	Reg. FMAP
May-11	60.56	Reg. FMAP
Jun-11	60.56	Reg. FMAP
Jul-11	60.56	Reg. FMAP
Aug-11	60.56	Reg. FMAP
<b>SFY 2011</b>	<b>63.66</b>	

\* A special rule requires recalculation of TIERS for the last 2 calendar quarters of the recession adjustment period (July-December). The most recent previous 3 consecutive month period is the period beginning with December 2009, or if it results in a higher applicable percent for purposes of the unemployment increase, the 3 month period beginning with January 2010.