Appendix A

Key Medicaid and CHIP legislation
Texas Medicaid and Children’s Health Insurance Program (CHIP) change in response to legislative requirements at the state and federal levels. This appendix provides a brief legislative history of Medicaid and CHIP, including highlights of key federal and state legislation by topic.

Medicaid

Founding Legislation

In 1965, the Social Security Act (SSA) of 1935 was amended to add Title XIX, which created Medicaid as a state-administered health care program, jointly funded by the federal government. The SSA was further amended in 1967 to mandate inclusion of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for children in Medicaid, and again in 1972 to allow states to cover care for children and youth in inpatient psychiatric care. In 1977, the Centers for Medicare and Medicaid (CMS) was created to oversee and manage Medicare, Medicaid and CHIP programs.

The SSA dictated the principles that state Medicaid programs must fulfill, including:

- **Section 1902(a)(1):** required that state Medicaid programs be in effect “in all political subdivisions of the state.”
- **Section 1902(a)(10):** required that state Medicaid programs provide services to people that are comparable in amount, duration and scope.
- **Section 1902(a)(23):** required that state Medicaid programs ensure that clients have the freedom to choose any qualified provider to deliver a covered service.

Also included within the SSA are sections that allowed states to waive various Medicaid requirements and implement different service delivery models, eligibility criteria and benefits:

- **Section 1115(a):** allowed states to waive provisions of Medicaid law to test new concepts consistent with the goals of the Medicaid program. System-wide changes are possible under this provision. Waivers must be approved by CMS.
- **Section 1903(m):** allowed state Medicaid programs to develop risk contracts with managed care organizations (MCOs) or comparable entities.
- **Section 1915(b):** allowed states to waive freedom of choice. States may require that beneficiaries enroll in MCOs or other programs. Waivers must be approved by CMS.
- **Section 1915(c):** allowed states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an intermediate care facility for individuals with an intellectual disability.
or related condition (ICF/IID), nursing facility, institution for mental disease, or inpatient hospital. Waivers must be approved by CMS.

- **Section 1915(i):** allowed states to offer a variety of services under a state plan Home and Community-based Services (HCBS) benefit. Individuals must meet state-defined criteria based on need and typically get a combination of acute-care medical services and long-term services in home and community-based settings.

- **Section 1929:** allowed states to provide a broad range of home and community-based care to individuals with functional disabilities, as an optional state plan benefit. In all states but Texas, the option can serve only people age 65 and older. In Texas, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state’s functional disability test and financial eligibility criteria.

**Program Reforms and Expansions**

Federal and state laws also determine which populations are eligible for Medicaid and what Medicaid covers. Federal and state legislation have reformed and expanded the program over time—adjusting program eligibility criteria, as well as the type, amount, duration and scope of services provided through Medicaid.

**Federal Legislation**

Historically, all Medicaid clients either had Supplemental Security Income (SSI) or welfare. Beginning in the 1980s, several federal laws were passed that expanded Medicaid coverage to populations ineligible for SSI or Temporary Assistance for Needy Families (TANF) and, eventually, de-linked financial assistance from Medicaid eligibility. A few of these federal laws are highlighted below:

**The Omnibus Budget Reconciliation Act of 1986 (OBRA of 1986):**

- Mandated states cover emergency care services, including labor and delivery, for undocumented immigrants and required them to cover homeless people.
- Allowed states to cover infants and pregnant women under 100 percent of the federal poverty level (FPL); to create a phase-in for children age 4 and younger under 100 percent of the FPL; and to cover prenatal care while a Medicaid application is pending, along with guaranteed coverage for the full term of pregnancy and postpartum care. States may waive asset tests for this group.

**The Omnibus Budget Reconciliation Act of 1987 (OBRA of 1987):**

- Required states to extend coverage to children age 6 and younger born after September 30, 1983, whose families meet TANF financial standards—even if the family does not qualify for TANF. Extension through age 7 is at the state’s option.
• Allowed states to cover infants age 1 and younger and pregnant women under 185 percent of the FPL, with immediate coverage (no phase-in) for children age 4 and younger under 100 percent of the FPL.
• Mandated sweeping changes in nursing facility standards, including the creation of the Preadmission Screening and Resident Review process—a requirement that all current and prospective nursing facility clients be screened for mental illness, intellectual disability or related conditions.

**The Medicare Catastrophic Coverage Act of 1988:**
• Expanded Medicaid coverage for infants, young children and pregnant women.
• Provided phased-in coverage of infants through their first birthday and pregnant women under 100 percent of the FPL.
• Required more comprehensive coverage of hospital services for infants, and expanded payments for hospital services for infants in all hospitals and for children age 5 and younger in disproportionate share hospitals.
• Amended eligibility criteria and services provided to dually eligible Medicare clients—including providing phased-in coverage of out-of-pocket costs (premiums, deductibles and co-insurance) for Qualified Medicare Beneficiaries under 100 percent of the FPL and establishing minimum standards for income and asset protection for spouses of Medicaid clients in nursing homes.

**The Omnibus Budget Reconciliation Act of 1989 (OBRA of 1989):**
• Prohibited states from limiting the amount, duration, scope or availability of state plan services to children on Medicaid.

**The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996:**
• De-linked cash assistance and Medicaid eligibility. While Medicaid financial eligibility is determined by the FPL, the TANF monthly cap is based on a set dollar amount, and each state sets its income eligibility guidelines for TANF cash assistance. Prior to PRWORA, children age 18 and younger and their related caretakers, who qualified for TANF cash assistance, were also automatically qualified for Medicaid. Under PRWORA, if households need both TANF cash assistance and Medicaid, they must apply for both. Otherwise, they can only apply for TANF cash assistance or Medicaid.
• Required TANF clients to participate in work activities within two years of entering the program and prohibited them from receiving federally funded TANF benefits for more than 60 months over a lifetime. This requirement is thought to be partly responsible for the drop in Medicaid caseload in Texas in the mid-to-late 1990s.
• Gave states the option to decide whether to continue providing Medicaid to most legal immigrants. Most immigrants entering the U.S. after August 22, 1996, are
subject to a five-year wait period, during which no federal Medicaid funds can be accessed for their care. The Balanced Budget Act (BBA) of 1997 restored SSI benefits for legal immigrants who arrived in the U.S. prior to August 22, 1996, but limited the benefit until after the first seven years of a person’s residence in the U.S. (see below).

Various laws have been passed to extend PRWORA beyond its initial expiration in September 2002. The Deficit Reduction Act (DRA) of 2005 reauthorized TANF through 2010, and continuing resolutions have extended the program since then.

The DRA also reduced federal Medicaid and Medicare spending by $39 billion from 2006–2010, through changes to prescription drug regulations and long-term services and supports (LTSS) eligibility rules, among others.

**The Balanced Budget Act (BBA) of 1997:**
A landmark piece of federal legislation that:

- Created CHIP (see page 117) and changed Medicaid and Medicare rules and regulations.
- Added several new eligibility options including:
  - Guaranteed Eligibility: allowed states to choose to guarantee Medicaid coverage for up to 12 months for all children, even if they no longer meet Medicaid income eligibility tests.
  - Medicaid Buy-in: allowed states to offer individuals, with disabilities and income below 250 percent of the FPL, an opportunity to buy in to the Medicaid program.
  - Medicaid Buy-in for Children: allowed states to offer children age 18 and younger with disabilities an opportunity to buy in to the Medicaid program.
- Repealed the Boren Amendment from the Omnibus Budget Reconciliation Act of 1980 (OBRA of 1980), which linked Medicaid nursing home rates to federal and state quality-of-care standards.
- Allowed states to require most Medicaid-eligible individuals to enroll in managed care plans without a waiver, such as an 1115 or 1915(b)—but mandated all states with Medicaid managed care programs to ensure MCOs conduct Performance Improvement Projects (PIPs) (see Chapter 3, page 59).

The BBA was later amended by the Balanced Budget Refinement Act (BBRA) of 1999, which provided approximately $17 billion in “BBA relief” over five years. The BBRA also extended the phaseout of cost-based reimbursement for Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs), and changed Medicaid Disproportionate Share Hospital (DSH) payments and rules. It also prohibited states from using CHIP federal funds for DSH.
**The Affordable Care Act (ACA) of 2010:**
Made several important changes to the health care system in the U.S., including:
- Prohibiting coverage denials based on a pre-existing condition.
- Allowing children to remain on their parent’s health plan until age 26.
- Requiring persons to have health insurance or pay a penalty; however, the **Tax Cut and Jobs Act of 2017** eliminated this penalty starting in 2019.
- Requiring states to establish health insurance marketplaces or refer people to the federally facilitated marketplace to assist individuals and small employers in accessing health insurance. Texas currently utilizes the federally facilitated marketplace.
- Mandating states modify their Medicaid and CHIP programs, including their state plans and financial eligibility criteria.
- Giving states the option to expand Medicaid eligibility up through 133 percent of the FPL for individuals age 64 and younger, with federal funds paying 100 percent for the first three calendar years of the expansion. Effective in 2017, the federal matching rate decreased gradually each year. From 2020 onward, the matching rate will be 90 percent. Texas has not expanded Medicaid eligibility to this optional adult group.

Additionally, in anticipation that the uninsured population would decrease following Medicaid expansions and the implementation of the state health insurance marketplaces, the ACA intended to decrease DSH allotments. Since 2010, various pieces of legislation have delayed the implementation of DSH funding cuts under the ACA and changed the amounts of the reductions. Currently, the **Coronavirus Aid, Relief and Economic Security (CARES) Act of 2020** has delayed the reductions in DSH allotments until December 1, 2020, and has reduced the amount of the reduction scheduled for fiscal year 2021 (see Chapter 4, page 88).

The ACA also made changes to the federal drug rebate program created under OBRA of 1990—increasing the minimum federal rebate percentages that drug manufacturers are required to pay to participate in the Medicaid program, and also expanding the rebate program to cover claims paid by Medicaid MCOs (see page 109).

**State Legislation**

**Senate Bill (S.B.) 11, 85th Legislature, Regular Session, 2017:**
- Required the Department of Family and Protective Services (DFPS) to ensure that children who are taken into state conservatorship receive an initial medical exam within three business days, if they are removed from their home as the result of:
  - Sexual abuse, physical abuse or an obvious physical injury.
A chronic medical condition, a medically complex condition or a diagnosed mental illness.

- Prohibited a physician or other health care provider from administering a vaccination as part of the required exam—except for an emergency tetanus vaccination—without parental consent and until DFPS has been named managing conservator.
- Required DFPS to ensure that any child who enters state conservatorship receives any necessary emergency medical care as soon as possible.

**House Bill (H.B.) 2466, 85th Legislature, Regular Session, 2017:**
- Required Medicaid and CHIP to cover a maternal depression screening for mothers of children who are eligible for Medicaid. This screening occurs during the covered well-child visit, which takes place before the child’s first birthday.

## Prescription Drugs

### Federal Legislation

**The Omnibus Budget Reconciliation Act of 1990 (OBRA of 1990):**
- Established the Federal Rebate Program, which required drug manufacturers to pay rebates for drugs dispensed under state outpatient drug programs to be included in state Medicaid formularies.
- Required states to cover all drugs for which a manufacturer provides rebates under the terms of the law and to maintain an open formulary for all drugs of manufacturers that have signed a federal rebate agreement. Rebate amounts per unit are determined by the CMS.

OBRA of 1990 was later amended under the DRA of 2005, which extended the rebate program to outpatient drugs administered in a physician’s office or another outpatient facility.

The ACA also made changes by increasing the minimum federal rebate percentages that drug manufacturers are required to pay in order to participate in the Medicaid program, and by expanding the rebate program to cover claims paid by Medicaid MCOs. The federal government keeps 100 percent of the increased rebate amount.

The Vendor Drug Program (VDP) manages the federal manufacturer drug rebate program and collects rebates for medications—that are dispensed by pharmacies and administered by physicians—to people enrolled in fee-for-service (FFS) and managed care. Texas negotiates additional state rebates for preferred drugs. The Health and Human Services Commission (HHSC) also collects rebates for drugs provided to people enrolled in CHIP and three state health programs, including Healthy Texas Women (HTW).
The Medicare Prescription Drug Improvement and Modernization Act (MMA):
- Created a new Medicare prescription drug benefit (Part D) and made other program and payment changes. Medicare Part D is a voluntary Medicare prescription drug benefit, where people in traditional Medicare may choose a private, drug-only plan. Those who choose to enroll in an MCO may choose a plan offering a drug benefit. Medicare Part D is available to dual eligibles receiving Medicaid.
- Amended provider payments, some of which had been reduced or constrained by previous legislation. Major provisions affecting the Medicaid program include:
  - Recoupment of part of the federal cost of the drug benefit by requiring states to refund a portion of their savings that result from Medicare providing drug coverage to dual eligibles (referred to as the “clawback” provision).
  - Addition of preventive benefits to Medicare and the elimination of co-pays for home health services, some of which were previously covered by Medicaid.
  - Increased premiums for Medicare Part B, which covers physician services, lab services, etc. Medicaid pays these premiums on behalf of certain clients who are dually eligible for Medicare and Medicaid.

State Legislation

H.B. 2292, 78th Legislature, Regular Session, 2003:
- Directed HHSC on how to implement the Medicaid Preferred Drug List (PDL)—a tool used by many states to control growing Medicaid drug costs (see Chapter 3, page 56).
- Required HHSC to collect supplemental rebates. Rebates are collected from both FFS and MCO prescription drug claims. Supplemental rebate revenue is shared with CMS at the same federal medical assistance percentage used to pay claims.

H.B. 1917, 85th Legislature, Regular Session, 2017:
- Provided that the PDL will carve into managed care, allowing each MCO to determine the drugs that are on their preferred drug list on September 1, 2023.

S.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 115):
- Required HHSC to submit an annual report to the Legislature on rebate revenues and outstanding balances.
- Established rebate revenue as the first source of funding, before general revenue, for Medicaid and CHIP prescription drug services.

Economic and Public Health Crises
Since Medicaid primarily serves low-income individuals, a rise in unemployment can result in an increase in the number of people eligible for Medicaid. During the 2008 economic
recession, for example, the rise in unemployment—and subsequent federal legislation passed to meet the crisis—caused sudden growth in Medicaid enrollment.

Similarly, the recent public health crisis caused by the novel coronavirus (COVID-19) pandemic spurred federal legislation to address an economic recession and assist state and local governments, which included changes to the Medicaid and CHIP programs.

**The American Recovery and Reinvestment Act (ARRA) of 2009:**
- Temporarily increased the Federal Medical Assistance Percentage (FMAP) from October 2008 through December 2010.
- Temporarily prohibited states from making changes to any Medicaid eligibility standards, methodologies or procedures that were more restrictive than those in effect as of July 1, 2008.
- Extended the TANF Supplemental Funds, created a new TANF Emergency Fund and increased the DSH allotment.

ARRA also included reforms and financial incentives for health care technology under the Health Information Technology for Economic and Clinical Health (HITECH) Act (see page 115).

**The Families First Coronavirus Response Act (FFCRA) of 2020:**
- Required private and public health insurers—including Medicare, Medicaid and CHIP—to provide coverage for COVID-19 testing.
- Temporarily increased the Medicaid FMAP by 6.2 percentage points from January 1, 2020, throughout the duration of the emergency period. Because this period could be extended, the FY21 FMAP should not be considered final. As a condition of receiving the increased FMAP, states were required to maintain eligibility and services for any Medicaid recipients eligible as of March 18, 2020.
- Provided paid emergency sick leave and family medical leave for individuals and families impacted by the public health emergency.

The FFCRA has been extended through January 21, 2021.

**Rights and Entitlements for People With Disabilities**

**Federal Legislation and Policy**

**The Americans with Disabilities Act (ADA) of 1990:**
- Prohibited discrimination based on disability in the areas of employment; public services provided by state and local governments; and public services operated by private entities, transportation and telecommunications.
The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999:
- Expanded the eligibility options and funding for Medicaid Buy-in programs for individuals age 16 through age 64.
- Extended Medicare coverage for disabled individuals returning to work.
- Created the Ticket to Work Program, which enables SSI and Social Security Disability Insurance (SSDI) recipients to obtain employment services from both private and public providers.

State Legislation and Policy
Texas Government Code, Chapter 534 (established by S.B. 7, 83rd Legislature, Regular Session, 2013):
- Directed HHSC to implement an acute care and LTSS system for individuals with intellectual and developmental disabilities (IDD), a managed care delivery system, and the federal Community First Choice (CFC) option.
- Authorized HHSC to operate a pilot program by September 1, 2018, to test one or more managed care service delivery models to deliver Medicaid LTSS to individuals with IDD.

H.B. 3295, 85th Legislature, Regular Session, 2017:
- Extended completion of the managed care pilot program for individuals with IDD (under Chapter 534) from September 1, 2018, to September 1, 2019.
- Changed the transition of the Texas Home Living (TxHmL) waiver program from September 1, 2018, to September 1, 2020. The transition date of the TxHmL program into managed care was changed to September 1, 2027, by H.B. 4533, 86th Legislature, Regular Session, 2019. More information on H.B. 4533 is found on pages 120-122.

S.B. 547, 85th Legislature, Regular Session, 2017:
- Allowed state supported living centers (SSLCs) to provide certain non-residential Medicaid services to support individuals with IDD and directed HHSC to establish reimbursement rates for SSLCs for these services.
Home and Community-based Services and Promoting Independence

The 1999 Supreme Court decision, *Olmstead v. L.C.*, determined that individuals with intellectual disabilities or serious mental illnesses have the right to live in community-based settings rather than in institutions. The ruling mandated that publicly run programs provide the option for community-based services to individuals with disabilities, when such services are appropriate and can be reasonably accommodated. In response to the *Olmstead* decision and other federal policy priorities, Texas Medicaid has expanded coverage for a broad range of LTSS.

The General Appropriations Act, S.B. 1, 77th Legislature, Regular Session, 2001 (Article II, HHSC, Rider 37) established the Promoting Independence Initiative—also called Money Follows the Person—whereby the funding for individuals moving from nursing facilities to community-based services could be transferred from the nursing facility budget to the community-based services budget. Rider 37 was later codified by H.B. 1867, 79th Legislature, Regular Session, 2005.

The Promoting Independence Initiative received a demonstration award through the DRA of 2005. Federal authorization of the demonstration ended in September 2016, but states were given supplemental grants through September 30, 2020. The Medicaid Extenders Act of 2019 extended authorization of the demonstration through July 31, 2024. Even though the authorization extends to 2024, there may not be funds for each year. The available funds will depend on re-obligation and congressional appropriations.

In March 2014, CMS issued a rule for the delivery of Medicaid home and community-based services, ensuring individuals have the option to receive services in fully integrated settings. These settings must provide full access to the greater community, opportunities to work in integrated settings, and opportunities for individuals to control their schedules and activities. They must also ensure individual rights to privacy, dignity and respect, and freedom from coercion and restraint—and allow for choice regarding services and who provides them.

CMS initially gave states until March 2019 to comply with the regulation, but in June 2017, issued an extension until March 2022. In July 2020, CMS provided an additional one-year extension due to COVID-19, giving states until March 2023 to comply.
Mental Health and Behavioral Health

Federal Legislation

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008:
- Required group health plans, that offer behavioral health benefits, to provide those services at parity with medical and surgical benefits. This does not impact FFS, but does apply to Medicaid and CHIP managed care programs.

The Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018:
- Directed funding to federal agencies and states to increase access to addiction treatment and to take mitigating steps, such as preventing over-prescribing opioids.
- Required Medicaid to report on adult behavioral health outcome measures, expand drug utilization reviews, share data between Medicaid and the state’s prescription drug monitoring databases, expand the “qualified practitioners” who can prescribe buprenorphine for opioid treatment, and ensure health insurance coverage continuity for former foster youth to age 26 in any state they reside.

State Legislation

S.B. 1, 81st Legislature, Regular Session, 2009 (Article IX, Health-Related Provisions, Section 17.15):
- Authorized HHSC to add comprehensive substance use disorder (SUD) benefits for adults in Medicaid in order to reduce medical expenditures related to substance abuse.

S.B. 58, 83rd Legislature, Regular Session, 2013:
- Required HHSC to integrate behavioral health and physical health services into Medicaid managed care programs, by adding both mental health targeted case management and mental health rehabilitative services to the array of services provided by MCOs by September 1, 2014.

H.B. 10, 85th Legislature, Regular Session, 2017:
- Created a behavioral health ombudsman in the HHSC Office of the Ombudsman and established a mental health condition and SUD parity work group.
- Required HHSC and the Texas Department of Insurance to study and report on benefits provided by health benefit plans, both for medical or surgical expenses and for mental health conditions and SUDs.
S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 45):
- Required HHSC to develop performance metrics to increase accountability of MCOs for members with severe mental illness (SMI). These metrics must include integrated care, jail and emergency department diversion, post-release linkage to care, homelessness reduction, supportive housing, and medication adherence.
- Required HHSC to improve outcomes, care integration and enhanced cost control—against an established baseline for members with SMI—and report to the Legislative Budget Board (LBB) and the governor by November 1, 2018, detailing HHSC’s performance metrics on providing services to members with SMI. If cost effective, Rider 45 mandates the development and procurement of a managed care program, in at least one service delivery area, to serve members with SMI. After conducting extensive research and data analysis on the rider’s specific outcomes related to SMI, HHSC did not procure a managed care program for SMI population. Per the rider, a report was submitted outlining the results of the research and data analysis to the Legislature.

Technology, Patient Privacy and Fraud Prevention

Federal Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996:
- Mandated that all health plans, health care clearinghouses and health care providers must protect all individually identifiable health information that is held or transmitted by a covered entity or business associate. Protected health information includes digital, paper and oral information.
- Required standardized electronic exchange of administrative and financial health services information for all health plans, including Medicaid. All health care organizations must implement secure electronic access to health data and remain in compliance with privacy regulations set by the U.S. Department of Health and Human Services.
- Implemented the National Provider Identifier (NPI) system—in which each health care entity, including individuals, employers, health plans and health care providers—must have a unique 10-digit NPI number.

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009:
- Incentivized providers to adopt and meaningfully use electronic health records (EHRs) and advance health information exchange (HIE) systems. The EHR incentive program is set to end in 2021.
- Established health information exchange and data breach notification rules that build upon HIPAA privacy and security regulations.
**Appendix A — Key Medicaid and CHIP legislation**

**State Legislation**

**S.B. 1107, 85th Legislature, Regular Session, 2017:**
- Standardized requirements for telemedicine and telehealth services by specifying acceptable telemedicine and telehealth service delivery modalities; clarifying necessary physician-patient relationship requirements; and directing Texas Medical Board, Texas Board of Nursing, Texas Physician Assistant Board, and Texas State Board of Pharmacy to jointly develop administrative rules for valid prescriptions generated during a telemedicine visit.

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**Electronic Visit Verification**

Electronic visit verification (EVV) is a set of computer-based tracking systems to verify the occurrence of personal attendant service visits—either by using an individual’s home landline telephone or a small alternate device—in order to document the precise time a service delivery begins and ends.

The EVV program was first piloted following the direction of S.B. 7, 82nd Legislature, First Called Session, 2011. As of June 1, 2015, EVV has been required by state rule (15 TAC §354.1177) for attendant services in certain FFS and managed care home and community-based programs—including CFC and some waivers. HHSC requires EVV for 90 percent of attendant services.

The 21st Century Cures Act of 2016 mandated EVV for all Medicaid-funded programs delivering attendant services and made EVV mandatory for individuals using the Consumer Directed Services (CDS) option to receive those services. It reduced the federal payment under Medicaid for states that do not require the use of an EVV system. The effective date for attendant services is now January 1, 2021.
Children’s Health Insurance Program

Founding Legislation

Federal Legislation

The Balanced Budget Act (BBA) of 1997 created the State Children’s Health Insurance Program (SCHIP) under Title XXI of the Social Security Act (SSA) and appropriated nearly $40 billion for the program for federal fiscal years 1998–2007. SCHIP offered states three options when designing a program:

- Use SCHIP funds to expand Medicaid eligibility to children who were previously ineligible for the program.
- Design a separate state children’s health insurance program.
- Combine both the Medicaid and separate state program options.

States that choose to expand their Medicaid programs are required to provide all mandatory benefits and all optional services covered under their Medicaid state plan, and they must follow the Medicaid cost-sharing rules. States that choose to implement a separate program have more flexibility. Within federal guidelines, they may determine their own SCHIP benefit packages.

Texas originally opted to expand Medicaid eligibility using SCHIP funds. In July 1998, Texas implemented Phase I of SCHIP, providing Medicaid to children age 15 through age 17 whose family income was under 100 percent of the federal poverty level (FPL). Phase I of SCHIP operated from July 1998 through September 2002. The program was phased out as Medicaid expanded to cover those children.

State Legislation

Senate Bill (S.B.) 445, 76th Legislature, Regular Session, 1999, enacted Phase II of SCHIP, which created the Texas Children’s Health Insurance Program (CHIP). S.B. 445 specified that coverage under CHIP be available to children in families with incomes up to 200 percent of the FPL. Coverage under Phase II of the program began on May 1, 2000.

Texas CHIP was designed and operates as a separate child health program. Texas elected secretary-approved coverage for CHIP.
Program Reforms and Expansions

Federal Legislation

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000:
- Allowed states to retain unexpended federal fiscal year (FFY) 1998–99 federal allocations through FFY 2004.
- Granted states additional time to spend 50 percent of unused FFY 2000 and FFY 2001 federal allocations through FFY 2004 and FFY 2005, respectively.

The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009:
- Appropriated nearly $69 billion for FFY 2009–2013 and redesigned the allocation formula, so that it more closely reflected state spending.
- Required states to verify a CHIP applicant’s citizenship.
- Mandated states apply mental health parity standards established under the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.
- Allowed states to cover pregnant women above 185 percent of the FPL and up to the income eligibility level for children in CHIP.
- Allowed states to provide Medicaid and CHIP coverage to qualified immigrant children and pregnant women—without the previously required five-year delay.

Texas has implemented additional changes in accordance with CHIPRA guidance—including applying certain Medicaid managed care safeguards to CHIP, expanding dental services, and implementing mental health parity in CHIP.

Following CHIPRA, the Affordable Care Act (ACA) of 2010 extended federal funding for CHIP through FFY 2015 and increased the federal match rate for FFYs 2016–2019. Maintenance of effort (MOE) requirements prohibited states from restricting CHIP eligibility standards, methodologies or procedures through September 30, 2019. Medicaid payments are contingent upon meeting this CHIP MOE requirement. The ACA eliminated asset tests and most income disregards in CHIP financial eligibility determinations.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015:
- Extended federal funding for CHIP through FFY 2017, and fully funded state CHIP allotments through September 30, 2017, including funding the 23 percentage-point increase in federal matching funds authorized by the ACA.
- Extended CHIPRA outreach and enrollment grants and CHIPRA quality provisions, plus maintained MOE for children’s coverage in Medicaid and CHIP through 2019.
- Made permanent the authorization for Transitional Medical Assistance, which provides time-limited Medicaid to low-income parents transitioning to employment at higher wages that otherwise would make them ineligible for Medicaid.
Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2018:
- Reauthorized CHIP funding through FFY 2027. The reauthorization legislation also extended the MOE provision, but phased out the associated super-enhanced federal match rate. In FFY 2020, the 23 percent bump reduced to 11.5 percentage points, and in FFY 2021, the match will return to the standard CHIP enhanced rate.

Federal funding for CHIP lapsed from October 2017 through February 2018. While some states received additional grant funding from the Centers for Medicare and Medicaid (CMS), Texas continued to fund CHIP using fiscal year 2017 carry-over funds.

The Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018:
- Required mental health and substance use disorder (SUD) services to be included as a category for basic services in CHIP (Section 5022). These services include inpatient and outpatient services, psychosocial rehabilitation, and crisis stabilization.

State Legislation
The 2006–07 General Appropriations Act, S.B. 1, 79th Legislature, Regular Session, 2005 (Article II, Health and Human Services Commission [HHSC], Rider 70):
- Authorized HHSC to expend funds to provide unborn children with health benefit coverage under CHIP. The result was CHIP Perinatal, which began in January 2007.
- Determined that CHIP Perinatal services are for the unborn children of pregnant women, who are uninsured and do not qualify for Medicaid due income or immigration status.
# Recent Medicaid and CHIP State Legislation

## 86th Legislature, Regular Session, 2019

### Appeals and Fair Hearings

| Bill | Description |
| --- | --- |
| S.B. 1207 | Required Health and Human Services Commission (HHSC) and managed care organizations (MCOs) to issue notices to providers and members with clear and detailed information regarding either a denial, reduction or termination of coverage or a denial of a prior authorization (PA) request. Required that HHSC contract with an independent external medical reviewer (see Chapter 3, page 64). |

### Applied Behavior Analysis

| Bill | Description |
| --- | --- |
| H.B. 1 (Article II, HHSC, Rider 32) | Authorized HHSC to use existing Children’s Medicaid funds, if HHSC creates and implements a new Children’s Medicaid benefit for Intensive Behavioral Intervention (IBI) for children with Autism Spectrum Disorder. IBI is one frequency level of Applied Behavior Analysis (ABA) treatment. |

### Managed Care Operations and Oversight

| Bill | Description |
| --- | --- |
| H.B. 4533 | Required HHSC to standardize and implement consistent definitions surrounding MCO grievance processes, as well as reporting and data collection for Medicaid. |
| H.B. 1 (Article II, HHSC, Rider 43) | Required HHSC to create an incentive program that allows MCOs to increase the percentage of default enrollment clients they receive based on quality, efficiency and effectiveness, and performance metrics. |

### Managed Care Service and Population Carve-ins

| Bill | Description |
| --- | --- |
| H.B. 4533 | Required HHSC to implement a pilot program for individuals with intellectual and developmental disabilities (IDD), traumatic brain injury, and similar functional needs in STAR+PLUS. Established new timelines and processes for transitioning IDD long-term services and supports (LTSS) into managed care. |
| H.B. 1576 | Required HHSC to add non-emergency transportation services to managed care for coordination by the MCO. Nonmedical transportation services, which are a subset of demand response transportation services, will be provided for certain trips requested with less than 48-hour notice. |
| S.B. 750 | HHSC must assess the feasibility of providing services in the Healthy Texas Women (HTW) program though managed care (see Maternal Health, page 121, for additional legislation related to managed care). |
## Maternal Health

| Legislation | Description |
|-------------|-------------|
| **H.B. 253** | Required HHSC to develop a postpartum depression strategic plan. |
| **S.B. 750** | Required HHSC to develop a postpartum depression treatment network. |
| **S.B. 750** | Required HHSC to apply for federal funds to implement a model of care to improve the quality and accessibility of care for pregnant women with opioid use disorder. In December 2019, CMS awarded HHSC funding under the Maternal Opioid Misuse (MOM) Model. |
| **S.B. 750** | Required HHSC to develop a postpartum depression treatment network. |
| **S.B. 750** | Required HHSC to collaborate with MCOs to develop and implement cost-effective, evidence-based and enhanced prenatal services for high-risk pregnant women covered under Medicaid. |
| **S.B. 750** | HHSC must also assess the feasibility of providing services in the HTW program though managed care, and implement policies to improve the quality of maternal health in managed care. |
| **S.B. 750** | Required HHSC to develop an enhanced, cost-effective and limited postpartum care services package in HTW, and to implement strategies to ensure continuity of care for women transitioning from Medicaid to the HTW program. |
| **S.B. 748** | Established two separate pilot programs for pregnant women. One will provide services to pregnant women through a pregnancy medical home, while the other will provide prenatal and postpartum services through telemedicine and telehealth. |
| **S.B. 748** | Required a variety of program evaluations related to maternal health. |

## Pharmacy

| Legislation | Description |
|-------------|-------------|
| **S.B. 1096** | Required HHSC to make changes to pharmacy benefit requirements for the Medicaid STAR Kids population. Specifically, S.B. 1096 removes all Preferred Drug List (PDL) prior authorizations (PAs) and requires coverage of any drug without PA—including those produced by a manufacturer that has not entered into a federal rebate agreement with CMS. HHSC requires CMS approval prior to implementing changes (see STAR Kids, MDCP and STAR Health, page 122, for other drug-related PA legislation). |
| **S.B. 1780** | Allowed HHSC to enter into a value-based arrangement with a prescription drug manufacturer. |
### Prior Authorizations

| Legislation | Description |
|-------------|-------------|
| **S.B. 1207** | Required HHSC to establish time-frame guidelines for MCOs to issue decisions on PA requests, which must be published on MCO websites. Required HHSC to establish a uniform process and timeline for MCOs that receive an insufficient or inadequate PA request. Allowed a physician to discuss a PA request with another physician, who has a similar professional specialty, before a decision about the PA is determined. Required providers and members to receive a detailed notice when there is insufficient documentation for a PA request. |
| **H.B. 3041** | Required MCOs to publish information about submitting a PA and the process for communicating with the MCO about a PA request on their website. Required HHSC to allow, if practicable, renewal of a PA within 60 days of expiration for managed care and FFS. |

### Providers

| Legislation | Description |
|-------------|-------------|
| **H.B. 4533** | Required HHSC to phase out use of the Texas Provider Identifier (TPI) and switch to only using the National Provider Identifier (NPI) in order to identify providers. |
| **S.B. 1991** | Allowed service providers to utilize their own proprietary electronic visit verification (EVV) system and to be reimbursed by MCOs. Required HHSC to adopt rules that amend the MCO payment recovery and recoupment efforts process. |

### STAR Kids, MDCP and STAR Health

| Legislation | Description |
|-------------|-------------|
| **S.B. 1207** | Directed, for MDCP only, that the MCOs implement measures to ensure STAR Kids service coordinators provide results of the STAR Kids Screening Assessment Instrument (SK-SAI) to the child’s parent or legally authorized representative (LAR). The legislation also required MCOs to offer an opportunity for a peer-to-peer with a physician whom the member chooses. In addition, HHSC must: 1. Streamline the SK-SAI and reassessment process. 2. Create guidelines for providing wraparound services when a child has private insurance coverage. 3. Create a Medicaid escalation helpline for individuals in MDCP and with Deaf Blind with Multiple Disabilities (DBMD) waivers. 4. Allow a child denied MDCP the option to: (a) be placed at the top (first position) of the MDCP interest list in order to receive a new assessment from a different MCO, or (b) join another waiver interest list in a position based on the date the child was first placed on the MDCP interest list. |
### Appendix A — Key Medicaid and CHIP legislation

| Bill Number | Description |
|-------------|-------------|
| S.B. 1096   | Limited the ability of MCOs in the STAR Kids program to impose drug-related prior authorizations. |
| H.B. 4533   | Required HHSC to expand the availability of the Consumer Directed Services (CDS) option in the MDCP waiver program. |
| H.B. 72     | Directed HHSC to change managed care enrollment rules for children and young adults in the Adoption Assistance (AA) and Permanency Care Assistance (PCA) programs. Beginning September 1, 2020, as children transition from foster care to AA or PCA, they will remain in STAR Health for an additional two months to improve continuity of care. Certain AA and PCA children with disabilities have a choice between enrolling in STAR Kids or staying in STAR Health. |
| **Telehealth** | |
| H.B. 1063   | Expanded home telemonitoring to pediatric patients who have been diagnosed with end-stage solid organ disease; have received an organ transplant; or require mechanical ventilation. Directed HHSC to assess whether telemedicine, telehealth and home telemonitoring services are cost-effective for the Medicaid program in its biennial report on telemedicine, telehealth and home telemonitoring services. |
| S.B. 748    | Established a pilot program that provides prenatal and postpartum services through telemedicine and telehealth (see Maternal Health, page 121, for additional telehealth-related legislation). |
| S.B. 670    | Removed the requirement for a health professional to be present with a client during a school-based telemedicine service. Required HHSC to ensure MCOs meet specified requirements for reimbursing telemedicine and telehealth services and promoting patient-centered medical homes. Granted Medicaid MCOs greater flexibility in determining which covered services to reimburse as telemedicine or telehealth services, but prohibited MCOs from denying coverage solely because the service was delivered remotely. Authorized HHSC to allow Federally Qualified Health Centers (FQHCs) to be telemedicine distant and patient site providers, contingent on appropriations. |
Enrollment in Texas Medicaid and the Children’s Health Insurance Program (CHIP) can change in response to legislative requirements at the federal and state level. The figure below illustrates Texas Medicaid enrollment trends in response to legislative actions described throughout this appendix.

Medicaid eligibility was historically linked to receiving financial assistance. In the 1980s, several federal laws were passed that extended coverage to populations ineligible for financial assistance programs. This expansion—to include a greater number of people with disabilities, children, pregnant women and older individuals—fueled the growth of the Medicaid program.

Caseloads declined in the late 1990s after Medicaid eligibility was de-linked from cash assistance and stricter eligibility requirements for Temporary Assistance for Needy Families (TANF) were introduced by The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. In 2002, the number of children enrolled in Medicaid grew sharply due to the simplification of the Medicaid application process and six-month continuous eligibility. However, in 2003, Texas Medicaid’s TANF population declined because adults did not comply with the Personal Responsibility Agreement (PRA). The Affordable Care Act (ACA) of 2010 contributed to caseload growth throughout the subsequent decade because of required programmatic and financial eligibility changes.
Appendix A — Key Medicaid and CHIP legislation

Managed Care in Texas

State Legislation

Senate Bill (S.B.) 10, 74th Legislature, Regular Session, 1995:
- Directed the Health and Human Services Commission (HHSC) to enact a comprehensive statewide restructuring of Medicaid, incorporating a managed care delivery system. HHSC began expanding, and continues to expand, its Medicaid managed care program through 1915(b) waivers under the authority of S.B. 10.

S.B. 6, 79th Legislature, Regular Session, 2005:
- Directed HHSC and the Department of Family and Protective Services (DFPS) to develop a statewide health care delivery model for all Medicaid children in foster care. STAR Health was implemented on April 1, 2008.

House Bill (H.B.) 1, 82nd Legislature, Regular Session, 2011, and S.B. 7, 82nd Legislature, First Called Session, 2011:
- Instructed HHSC to expand its use of Medicaid managed care. The Legislature directed HHSC to preserve federal hospital funding historically received as supplemental payments under the upper payment level (UPL) program.

S.B. 7, 83rd Legislature, Regular Session, 2013:
- Directed HHSC to implement cost-effective options for delivering basic attendant care and a voluntary long-term services and supports (LTSS) managed care pilot program, expand STAR+PLUS to the Medicaid Rural Service Area, and integrate acute care and LTSS for individuals age 65 and older and those with disabilities. Most adults being served through one of the 1915(c) waivers for individuals with intellectual and developmental disabilities (IDD)—and living in community-based settings or in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID)—are now receiving acute care services through STAR+PLUS.
- Directed HHSC to develop the STAR Kids managed care program, tailored for children with disabilities—including children receiving Medically Dependent Children Program (MDCP) waiver benefits. STAR Kids was implemented statewide on November 1, 2016.
- Directed HHSC to develop quality-based outcome and process measures in quality-based payment systems by measuring potentially preventable events; rewarding use of evidence-based practices; and promoting health care coordination, collaboration and efficacy. HHSC initially implemented the medical and dental pay-for-quality (P4Q) programs in 2014. The programs were subsequently rede-
Appendix A — Key Medicaid and CHIP legislation

signed in 2016 and 2017. New medical P4Q programs were implemented in 2018 for STAR, STAR+PLUS and CHIP, as well as a new dental P4Q program. STAR Kids was added for 2020. However, due to COVID-19, HHSC is not currently implementing P4Q for calendar year 2020. Results for 2018 are on the Texas Healthcare Learning Collaborative Portal (THLCPortal.com).

S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, HHSC, Rider 51b[15]):
- Directed HHSC to transition remaining Medicaid fee-for-service (FFS) populations into managed care, as a cost containment measure. The rider stated that this reduction should be achieved through the implementation of a plan to improve care coordination through a capitated managed care program.

A.2: Development of Managed Care in Texas, 1994–2019

| State Fiscal Year | Service Areas (SA) and Implementation Dates | Total Medicaid Managed Care Enrollment | % of Medicaid Population in Managed Care |
|-------------------|---------------------------------------------|----------------------------------------|-----------------------------------------|
| 1994              | STAR implemented in Travis county and in the tri-county area | 58,243                                 | 2.86%                                   |
| 1995              | No change                                   | 65,388                                 | 3.16%                                   |
| 1996              | The tri-county area was expanded to include three additional counties (renamed to STAR) | 71,435                                 | 3.46%                                   |
| 1997              | STAR expanded to the Bexar, Lubbock and Tarrant SAs  
The Travis county area was expanded to include surrounding counties | 274,694                                 | 13.82%                                  |
| 1998              | STAR expanded to the Harris SA  
STAR+PLUS implemented in the Harris SA | 364,336                                 | 19.56%                                  |
| 1999              | STAR expanded to the Dallas SA               | 425,069                                 | 23.45%                                  |
| 2000              | STAR expanded to the El Paso SA              | 523,832                                 | 28.98%                                  |
| 2001              | No change                                   | 623,883                                 | 33.35%                                  |
| 2002              | No change                                   | 755,698                                 | 35.92%                                  |
| 2003              | No change                                   | 988,389                                 | 39.71%                                  |
| 2004              | No change                                   | 1,112,002                               | 41.43%                                  |
| 2005              | No change                                   | 1,191,139                               | 42.85%                                  |
| 2006              | Primary Care Case Management (PCCM) implemented in 197 counties | 1,835,390                               | 65.72%                                  |
| 2007              | STAR expanded to the Nueces SA               | 1,921,651                               | 67.83%                                  |
|                   | STAR+PLUS expanded to the Bexar, Travis, Nueces and Harris contiguous SAs |                                          |                                         |
|                   | STAR replaced PCCM in all urban areas        |                                          |                                         |
## A.2: Development of Managed Care in Texas, 1994–2019

| State Fiscal Year | Service Areas (SA) and Implementation Dates | Total Medicaid Managed Care Enrollment | % of Medicaid Population in Managed Care |
|------------------|---------------------------------------------|--------------------------------------|----------------------------------------|
| 2008             | Integrated Care Management (ICM) implemented in the Dallas and Tarrant SAs, STAR Health implemented statewide | 2,039,340                           | 70.86%                                 |
| 2009             | The ICM program was discontinued            | 2,127,382                           | 70.78%                                 |
| 2010             | No change                                   | 2,362,091                           | 71.62%                                 |
| 2011             | STAR+PLUS expanded to the Dallas and Tarrant SAs | 2,676,149                           | 75.53%                                 |
| 2012             | STAR expanded to Medicaid Rural Service Areas (MRSAs), replacing and discontinuing PCCM in all rural areas, Pharmacy benefits were carved into all managed care programs, and inpatient hospital benefits were carved into STAR+PLUS, The Children’s Medicaid Dental Services program implemented statewide | 2,893,965                           | 79.16%                                 |
| 2013             | No change                                   | 2,982,923                           | 81.53%                                 |
| 2014             | No change                                   | 3,012,262                           | 80.41%                                 |
| 2015             | STAR+PLUS expanded to all areas of the state, Non-dual eligible clients, IDD waivers and nursing facility benefits were carved into STAR+PLUS, Mental health targeted case management and mental health rehabilitative services were carved into all managed care programs, Dual Demonstration program implemented in Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant counties | 3,524,581                           | 86.88%                                 |
| 2016             | No change                                   | 3,570,411                           | 87.93%                                 |
| 2017             | STAR Kids implemented statewide, NorthSTAR was discontinued | 3,721,646                           | 91.50%                                 |
| 2018             | Adoption Assistance and Permanency Care Assistance were carved into STAR, and the Medicaid for Breast and Cervical Cancer program was carved into STAR+PLUS | 3,776,096                           | 93.89%                                 |
| 2019             | No change                                   | 3,676,441                           | 93.91%                                 |

Figures are Average Monthly Recipient Months and include STAR, STAR+PLUS, STAR Health, STAR Kids, PCCM, and ICM. In the Dallas Service Area, most Medicaid eligible individuals receive Medicaid acute care services through the STAR program. Until FY 2017, they received their behavioral health services through NorthSTAR.
Appendix B

Texas Medicaid and CHIP services
Medicaid State Plan

Mandatory and Optional Services

The Social Security Act specifies a set of benefits that state Medicaid programs must provide and a set of optional benefits that states may choose to provide. A state may choose to provide some, all or no optional services specified under federal law. Some optional services that Texas chooses to provide are available only to clients (a) age 20 and younger, or (b) age 20 and younger or age 65 and older and who are in an institution for mental disease. If the client is age 20 and younger, all federally allowable and medically necessary services must be provided.

Mandatory and optional state plan services provided by Texas Medicaid include:

| B.1: Acute Care Services | Mandatory |
|--------------------------|-----------|
|                         | Inpatient hospital services |
|                         | Outpatient hospital services |
|                         | Laboratory and x-ray services |
|                         | Physician services |
|                         | Medical and surgical services provided by a dentist |
|                         | Early and Periodic Screening, Diagnosis and Treatment services for individuals age 20 and younger |
|                         | Family planning services and supplies |
|                         | Federally Qualified Health Center services |
|                         | Rural health clinic services |
|                         | Nurse-midwife services |
|                         | Certified pediatric and family nurse practitioner services |
|                         | Home health services |
|                         | Freestanding birth center services (when licensed or otherwise recognized by the state) |
|                         | Transportation to medically necessary services |
|                         | Tobacco cessation counseling for pregnant women |
|                         | Extended services for pregnant women |
| Optional*                | Prescription drugs |
|                         | Medical or remedial care by other licensed practitioners: |
|                         | ◦ Nurse practitioners/certified nurse specialists |
|                         | ◦ Physician assistants |
|                         | ◦ Licensed midwife |
|                         | ◦ Certified registered nurse anesthetists |
|                         | ◦ Anesthesiologist assistants |
|                         | ◦ Psychologists |
|                         | ◦ Licensed clinical social workers** |
|                         | ◦ Licensed professional counselors |
|                         | ◦ Licensed marriage and family therapists |
|                         | Podiatry*** |
|                         | Limited chiropractic services |
|                         | Optometry (including eyeglasses and contacts) |
|                         | Telemedicine |
|                         | Home telemonitoring |
|                         | Hearing instruments and related audiology |
|                         | Home health supplies provided by a pharmacy |
|                         | Clinic services: |
|                         | ◦ Maternity clinic services |
|                         | ◦ Renal dialysis facility services |
|                         | ◦ Ambulatory surgical center services |
|                         | ◦ Tuberculosis clinic services |
|                         | ◦ Peer specialist services |
|                         | ◦ Rehabilitation and other therapies: |
|                         | ◦ Mental health rehabilitative services |
|                         | ◦ Rehabilitation and other therapy services |
### B.1: Acute Care Services, Con’t

| Mandatory | Optional* |
|-----------|-----------|
| • Substance use disorder treatment  |
| • Physical, occupational and speech therapy  |
| • Case management services for pregnant women with high-risk conditions  |
| • Pregnancy-related and postpartum services for 60 days after the pregnancy ends  |
| • Services for any other medical conditions that may complicate pregnancy  |
| • Respiratory care services  |
| • Ambulance services  |
| • Emergency hospital services  |
| • Private duty nursing  |

### B.2: Long-term Services and Supports

| Mandatory | Optional* |
|-----------|-----------|
| • Nursing facility services for clients age 21 and older  |
| • Intermediate care facility services for individuals with an intellectual disability or related condition  |
| • Inpatient services for clients who are in an institution for mental diseases and who are either age 21 and younger or age 65 and older  |
| • Services furnished under a Program of All-Inclusive Care for the Elderly  |
| • Day Activity and Health Services  |
| • 1915(i) Home and Community-based Services-Adult Mental Health Services  |
| • 1915(k) Community First Choice services:  |
| ▫ Attendant care (including habilitation)  |
| ▫ Emergency response services  |
| • Attendant services:  |
| ▫ Personal care/assistance services  |
| ▫ Community attendant services  |
| • Targeted case management for:  |
| ▫ Infants and toddlers with intellectual or developmental disabilities  |
| ▫ Adults with intellectual or developmental disabilities  |
| ▫ Individuals with chronic mental illness  |
| • Nursing facility services for individuals age 20 and younger  |
| • Prescribed Pediatric Extended Care Centers  |
| • Services provided in religious non-medical health care institutions  |

*Includes optional Medicaid services provided in Texas. Does not include all optional services allowed under federal policy.

**Except when delivered in a Federally Qualified Health Center setting.
CHIP State Plan

States can design their Children’s Health Insurance Program (CHIP) using one of three frameworks established by federal law. States can either include their CHIP program within their Medicaid program, create a separate CHIP program, or create a combination of these two options. Texas CHIP operates as a separate CHIP program, but many CHIP services are the same as Texas Medicaid services.

Services provided by Texas CHIP include:

| B.3: Services Covered by Texas CHIP |
|-----------------------------------|
| • Inpatient general acute and inpatient rehabilitation hospital services |
| • Surgical services |
| • Transplants |
| • Skilled nursing facilities (including rehabilitation hospitals) |
| • Outpatient hospital, comprehensive outpatient rehabilitation hospital, clinic (including health center), and ambulatory health care center services |
| • Physician/physician extender professional services (including well-child exams and preventive health services, such as immunizations) |
| • Laboratory and radiological services |
| • Durable medical equipment, prosthetic devices and disposable medical supplies |
| • Home and community-based health services |
| • Nursing care services |
| • Inpatient mental health services |
| • Outpatient mental health services |
| • Inpatient and residential substance abuse treatment services |
| • Outpatient substance abuse treatment services |
| • Rehabilitation and habilitation services (including developmental assessments and physical, occupational and speech therapy) |
| • Hospice care services |
| • Emergency services (including emergency hospitals, physicians and ambulance services) |
| • Emergency medical transportation (ground, air or water) |
| • Care coordination |
| • Case management |
| • Prescription drugs |
| • Dental services |
| • Vision |
| • Chiropractic services |
| • Tobacco cessation |
Home and Community-based Waiver Programs

Federal law allows states to apply to the Centers of Medicare and Medicaid Services (CMS) for permission to depart from certain Medicaid requirements. These waivers allow states to develop creative alternatives to the traditional Medicaid program. The table below provides a list of Texas Medicaid waiver programs.

| Waiver                                           | Description                                                                                                                                                                                                 | Services Covered                                                                                     |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| Community Living Assistance and Support Services (CLASS) | CLASS provides home and community-based services to individuals who have related conditions, as an alternative for placement in an intellectual disability or related condition (ICF/IID). A related condition is a disability other than an intellectual or development disability, which originates before age 22 and which substantially limits life activity. | • Adaptive aids and minor home modifications  
• Medical supplies  
• Dental services  
• Nursing  
• Respite  
• Professional therapies*  
• Employment assistance and supported employment  
• Case management  
• Prevocational services  
• Residential habilitation transportation  
• Prescriptions  
• Support family services  
• Transition assistance services |
### Appendix B — Texas Medicaid and CHIP services

#### B.4: Texas Medicaid Waivers

| Deaf Blind with Multiple Disabilities (DBMD) | DBMD provides home and community-based services as an alternative to residing in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) to people of all ages who are deaf, blind or have a condition that will result in deaf-blindness—and who also have an additional disability. The program focuses on increasing opportunities for individuals to communicate and interact with their environment. | • Adaptive aids and minor home modifications  
• Medical supplies  
• Dental services  
• Nursing  
• Respite  
• Professional therapies*  
• Employment assistance and supported employment  
• Case management  
• Day habilitation  
• Residential habilitation transportation  
• Assisted living  
• Prescriptions  
• Transition assistance services  
• Intervener  
• Orientation and mobility  
• Financial management services and support consultation** |
| --- | --- | --- |
| Home and Community-based Services (HCS) | HCS provides individualized services to individuals of all ages who qualify for ICF/IID level of care, yet live in their family’s home, their own home or other settings in the community. | • Adaptive aids and minor home modifications  
• Medical supplies  
• Dental services  
• Nursing  
• Respite  
• Professional therapies*  
• Employment assistance and supported employment  
• Day habilitation and residential services  
• Transportation  
• Transition assistance services  
• Financial management services and support consultation** |
### B.4: Texas Medicaid Waivers

| Medically Dependent Children Program (MDCP) | MDCP provides community-based services to children and youth age 20 and younger as an alternative to residing in a nursing facility. | • Adaptive aids and minor home modifications  
• Medical supplies  
• Respite  
• Employment assistance and supported employment  
• Flexible family support services  
• Transition and transition assistance services |
|---|---|---|
| STAR+PLUS Home and Community-based Services (STAR+PLUS HCBS) | STAR+PLUS HCBS provides community-based services to adults with disabilities and people age 65 and older, as an alternative to residing in a long-term care facility. These services are delivered through the STAR+PLUS managed care program. | • Adaptive aids and minor home modifications  
• Medical supplies  
• Respite  
• Employment assistance and supported employment  
• Dental services  
• Adult foster care  
• Assisted living services  
• Emergency response services  
• Home-delivered meals  
• Transition assistance services  
• Personal assistance services  
• Nursing services  
• Physical, occupational and speech therapies  
• Cognitive rehabilitation therapy  
• Financial management services and support consultation** |
## B.4: Texas Medicaid Waivers

| Texas Home Living (TxHmL) | TxHmL provides selected services and supports for people with intellectual disabilities who live in their own homes or their family’s home. | • Adaptive aids and minor home modifications  
• Medical supplies  
• Dental services  
• Nursing  
• Respite  
• Professional therapies*  
• Employment assistance and supported employment  
• Community support  
• Transportation  
• Day habilitation  
• Financial management services and support consultation** |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| Youth Empowerment Services (YES) | YES is a home and community-based waiver that allows for more flexibility in the funding of intensive community-based services for children and adolescents with severe emotional disturbances and their families. | • Adaptive aids and minor home modifications  
• Medical supplies  
• Dental services  
• Nursing  
• Respite  
• Professional therapies*  
• Employment assistance and supported employment  
• Community living support  
• Family supports and supportive family-based alternatives  
• Non-medical transportation  
• Paraprofessional services  
• Pre-engagement service (for non-Medicaid applicants)  
• Transition services |

*Professional therapies may include: physical therapy, occupational therapy, speech and language pathology, audiology, social work, behavioral support, dietary services, and cognitive rehabilitation therapy.  
**These services are only available to individuals using the Consumer Directed Service (CDS) delivery option.
Appendix C

Texas Medicaid and CHIP maps and figures
C.1: Texas Managed Care Services Delivery Map

Managed Care Service Areas

Texas Medicaid and CHIP maps and figures
Regional Healthcare Partnership
Regions by County

**RHP 1:** Anderson, Bowie, Camp, Cass, Cherokee, Delta, Fannin, Franklin, Freestone, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Trinity, Upshur, Van Zandt, and Wood.

**RHP 2:** Angelina, Brazoria, Galveston, Hardin, Jasper, Jefferson, Liberty, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, and Tyler.

**RHP 3:** Austin, Calhoun, Chambers, Colorado, Fort Bend, Harris, Matagorda, Waller, and Wharton.

**RHP 4:** Aransas, Bee, Brooks, DeWitt, Duval, Goliad, Gonzales, Jackson, Jim Wells, Karnes, Kenedy, Kleberg, Lavaca, Live Oak, Nueces, Refugio, San Patricio, and Victoria.

**RHP 5:** Cameron, Hidalgo, Starr, and Willacy.

**RHP 6:** Atascosa, Bandera, Bexar, Comal, Dimmit, Edwards, Frio, Gillespie, Guadalupe, Kendall, Kerr, Kinney, La Salle, McMullen, Medina, Real, Uvalde, Val Verde, Wilson, and Zavala.

**RHP 7:** Bastrop, Caldwell, Fayette, Hays, Lee, and Travis.

**RHP 8:** Bell, Blanco, Burnet, Lampasas, Llano, Milam, Mills, San Saba, and Williamson.

**RHP 9:** Dallas, Denton, and Kaufman.

**RHP 10:** Ellis, Erath, Hood, Johnson, Navarro, Parker, Somervell, Tarrant, and Wise.

**RHP 11:** Brown, Callahan, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Palo Pinto, Shackelford, Stephens, Stonewall, and Taylor.

**RHP 12:** Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Swisher, Terry, Wheeler, and Yoakum.
RHP 13: Coke, Coleman, Concho, Crockett, Irion, Kimble, Mason, McCulloch, Menard, Pecos, Reagan, Runnels, Schleicher, Sterling, Sutton, Terrell, and Tom Green.

RHP 14: Andrews, Brewster, Crane, Culberson, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Presidio, Reeves, Upton, Ward, and Winkler.

RHP 15: El Paso and Hudspeth.

RHP 16: Bosque, Coryell, Falls, Hamilton, Hill, Limestone, and McLennan.

RHP 17: Brazos, Burleson, Grimes, Leon, Madison, Montgomery, Robertson, Walker, and Washington.

RHP 18: Collin, Grayson, and Rockwall.

RHP 19: Archer, Baylor, Clay, Cooke, Foard, Hardeman, Jack, Montague, Throckmorton, Wichita, Wilbarger, and Young.

RHP 20: Jim Hogg, Maverick, Webb, and Zapata.
Demographics

The number of Texas Medicaid and Children’s Health Insurance Program (CHIP) clients can be expressed as a monthly average count or an annual unduplicated count. The monthly average count is the average number of clients on Medicaid or CHIP per month. The unduplicated count is the total number of individual Texans who received Medicaid or CHIP services over a period of time. In 2019, the monthly average count for Medicaid was 3,915,000 clients, and the monthly average count for CHIP was 408,000 clients.

In 2019, about 25 percent of Texas Medicaid clients were recipients due to age and disability-related reasons, 7 percent of clients were non-disabled adults, and 68 percent were non-disabled children. CHIP covers children, birth through age 18, who are not eligible for Medicaid due to income, but cannot afford private health insurance.

The following figures breakdown the total statistics for unduplicated clients, who received Medicaid or CHIP in 2019, by age group and ethnicity. As previously indicated, most Medicaid clients in any given year are children. In addition, Hispanics accounted for the largest portion of Medicaid clients, comprising 49 percent of the population. Meanwhile, 24 percent of CHIP clients were age 5 and younger, 56 percent were age 6 through age 14, and 20 percent were age 15 through age 18.
Medicaid covers low-income women for pregnancy-related services and newborns in low-income families. Pregnant women make up 4.3 percent of the Texas Medicaid and CHIP caseload. The following figures illustrate the distribution of pregnant women on Medicaid by age group and ethnicity. Almost 70 percent of the pregnant women in the Texas Medicaid program are between age 19 and age 29, while only 5 percent are age 18 and younger. Reflective of the Medicaid population as a whole, just over half, or 52 percent, of pregnant women receiving Medicaid are Hispanic.

Eighty-one percent of pregnant women receive services from Medicaid. The remaining 18 percent receive services from CHIP Perinatal.

CHIP Perinatal covers the unborn children of pregnant women who do not qualify for Medicaid due to income, but cannot afford private health insurance. In 2019, the monthly average caseload for CHIP Perinatal was 34,458.

Beginning in 2010, newborns under 185 percent of the federal poverty level (FPL) began moving out of CHIP Perinatal into Medicaid due to changes in eligibility. The Affordable Care Act (ACA) changed this income limit to 198 percent of the FPL effective January 2014 (see Appendix A, page 108).

The following table shows the total average monthly caseload for the CHIP Perinatal population from 2010 to 2019—including the number of perinates and newborns below 185 percent of the FPL prior to the 2014 change, and the number of perinates and newborns below 198 percent of the FPL after the 2014 change.
### C.5: CHIP Perinatal Caseload Summary, 2010–2019

| State Fiscal Year | Total Caseload | Perinates 0%–184% FPL | Perinates 185%–200% FPL | Newborns 0%–184% FPL | Newborns 185%–200% FPL |
|-------------------|----------------|------------------------|--------------------------|-----------------------|------------------------|
| 2010              | 67,148         | 36,158                 | 433                      | 30,215                | 342                    |
| 2011              | 44,214         | 36,775                 | 546                      | 6,582                 | 310                    |
| 2012              | 37,190         | 36,238                 | 652                      | 0                     | 300                    |
| 2013              | 37,027         | 36,068                 | 640                      | 0                     | 319                    |

| State Fiscal Year | Total Caseload | Perinates 0%–197% FPL | Perinates 198%–202% FPL | Newborns 0%–197% FPL | Newborns 198%–202% FPL |
|-------------------|----------------|------------------------|--------------------------|-----------------------|------------------------|
| 2014*             | 36,800         | 36,203                 | 509                      | 0                     | 88                     |
| 2015              | 36,535         | 35,703                 | 742                      | 0                     | 90                     |
| 2016              | 35,071         | 34,638                 | 329                      | 0                     | 104                    |
| 2017              | 34,458         | 33,969                 | 389                      | 0                     | 100                    |
| 2018              | 32,696         | 32,158                 | 417                      | 0                     | 121                    |
| 2019              | 30,856         | 30,272                 | 445                      | 0                     | 139                    |

*ACA income limit changes effective January 1, 2014.
Income limits do not include a five percentage point income disregard.
Appendix C — Texas Medicaid and CHIP maps and figures

Budget and Enrollment

C.6: Annual Expenditures for Medicaid and CHIP, 2010-2019*

*Dollars in Millions

| Year | Total Medicaid/CHIP | Medicaid | CHIP |
|------|---------------------|---------|------|
| 2010 | $28,760             | $27,651 | $1,109 |
| 2011 | $30,548             | $29,433 | $1,115 |
| 2012 | $30,582             | $29,348 | $1,234 |
| 2013 | $30,721             | $29,533 | $1,188 |
| 2014 | $34,503             | $33,394 | $1,109 |
| 2015 | $37,784             | $36,970 | $814  |
| 2016 | $42,811             | $41,954 | $857  |
| 2017 | $41,013             | $39,417 | $965  |
| 2018 | $43,505             | $40,038 | $975  |
| 2019 | $42,577             | $42,811 | $928  |

*Medicaid data is for FFYs 2010–2019 and CHIP data is for SFYs 2010–2019.

C.7: Average Monthly Medicaid and CHIP Enrollment, SFYs 2010-2019

*Enrollment in Thousands

| Year | Total Medicaid/CHIP | Medicaid | CHIP |
|------|---------------------|---------|------|
| 2010 | 3,868               | 3,298   | 570  |
| 2011 | 4,120               | 3,543   | 577  |
| 2012 | 4,263               | 3,656   | 607  |
| 2013 | 4,289               | 3,659   | 631  |
| 2014 | 4,308               | 3,746   | 561  |
| 2015 | 4,433               | 4,057   | 376  |
| 2016 | 4,456               | 4,061   | 396  |
| 2017 | 4,492               | 4,067   | 425  |
| 2018 | 4,465               | 4,022   | 443  |
| 2019 | 4,323               | 3,915   | 408  |
### C.8: Average Monthly Enrollment and Annual Expenditures for Long-term Services and Supports Programs and Services, 2019

| Program/Service Name | Average Number of Clients Served per Month | Annual Expenditures, All Funds |
|----------------------|------------------------------------------|--------------------------------|
| **Facilities**       |                                          |                                |
| Nursing Facilities   | 60,190                                   | $2,920,415,859                 |
| ICFs/IID             | 4,733                                    | $253,304,014                   |
| SSLC                 | 2,852                                    | $644,808,589                   |
| **Home and Community-based Services** |                                |                                |
| CAS                  | 74,408                                   | $821,007,059                   |
| CFC PAS/HAB Adult (STAR+PLUS; non-waiver) | 1,406                                   | $11,640,243                    |
| CFC PAS/HAB Adult (STAR+PLUS HCBS) | 9,078                                   | $98,236,861                    |
| CFC PAS/HAB Child (STAR Kids, STAR Health, FFS) | 2,797                                   | $16,408,726                    |
| CLASS                | 5,963                                    | $290,751,949                   |
| DAHS                 | 1,292                                    | $8,328,462                     |
| DBMD                 | 338                                      | $15,629,970                    |
| HCS                  | 28,669                                   | $1,149,186,554                 |
| MDCP                 | 5,381                                    | $73,979,895                    |
| PAS (STAR+PLUS HCBS) | 42,127                                   | $364,454,338                   |
| PAS (STAR+PLUS; non-waiver) | 101,001                                 | $612,459,440                   |
| PCS (STAR Kids, STAR Health, FFS) | 9,118                                   | $21,633,237                    |
| STAR+PLUS HCBS with Dual Demonstration | 61,446                                   | $1,480,558,159                 |
| STAR+PLUS HCBS without Dual Demonstration | 57,314                                   | $1,382,161,936                 |
| TxHmL                | 4,548                                    | $121,512,550                   |
| YES                  | 1,646                                    | $10,190,040                    |
| **Other**            |                                          |                                |
| Hospice              | 8,857                                    | $282,498,770                   |
| PACE                 | 1,253                                    | $42,104,582                    |
| Skilled Nursing Facility Medicare Co-insurance | 1,647                                   | $47,847,447                    |

Because some programs may take up to three years to complete, the provided figures are not final. Nursing facility expenditures include costs outside the daily rate. SSLC expenditures may include some non-Medicaid costs. MDCP and CLASS include Promoting Independence (rider). MDCP expenditures are waiver services only, including STAR Kids and STAR Health MDCP.
### C.9: Medicaid Expenditure History, FFYs 2015–2019

| Fiscal Year | Payer | Grant Benefits | Disproportionate Share Hospital | Uncompensated Care | Upper Payment Level | DSRIP | Clawback | CHIP Phase I | Administration | Survey and Certification | Total Medicaid |
|-------------|-------|----------------|-------------------------------|--------------------|---------------------|-------|----------|-------------|----------------|------------------------|---------------|
| 2019        | FED   | 18,648,468,575 | 1,135,454,021                 | 2,087,928,703      | 0                   | 1,489,493,368 | 0        | 527,505,019 | 880,280,799   | 34,740,956 | 24,803,871,441 |
| 2019        | FED-ARRA | 0            | 0                             | 0                  | 0                   | 0        | 0        | 0           | 0             | 0         | 12,697,190          |
| 2019        | NONFED | 13,261,596,951 | 815,280,033                   | 1,517,288,370      | 0                   | 1,070,166,468 | 481,830,280 | 35,391,653 | 567,268,631   | 11,585,207 | 17,760,407,593 |
| 2019        | TOTAL  | 31,910,065,526 | 1,950,734,054                 | 3,605,217,073      | 0                   | 2,559,659,836 | 481,830,280 | 562,896,672 | 1,460,246,620 | 46,326,163 | 42,576,976,224 |
| 2018        | FED    | 17,106,627,997 | 1,081,579,027                 | 1,540,814,930      | 0                   | 1,754,634,974 | 0        | 507,257,806 | 822,708,662   | 29,036,137 | 22,842,659,533 |
| 2018        | NONFED | 12,777,021,171 | 819,932,090                   | 1,174,000,086      | 0                   | 1,330,166,318 | 489,795,321 | 40,162,197 | 532,639,351   | 9,976,953 | 17,173,693,487 |
| 2018        | TOTAL  | 29,883,649,168 | 1,901,511,117                 | 2,714,815,016      | 0                   | 3,084,801,292 | 489,795,321 | 547,420,003 | 1,377,351,413 | 39,013,090 | 40,038,356,420 |
| 2017        | FED    | 15,949,253,442 | 1,017,299,170                 | 1,540,241,906      | 0                   | 1,604,753,947 | 0        | 733,099,118 | 915,164,055   | 31,011,499 | 21,790,823,137 |
| 2017        | NONFED | 12,290,313,332 | 793,261,567                   | 1,196,100,572      | 0                   | 1,251,691,974 | 462,902,271 | 60,944,177 | 540,679,435   | 11,292,410 | 16,609,185,738 |
| 2017        | TOTAL  | 28,239,525,213 | 1,810,560,737                 | 2,738,342,478      | 0                   | 2,856,445,921 | 462,902,271 | 794,043,295 | 1,507,683,658 | 42,303,909 | 38,451,807,482 |
| 2016        | FED    | 16,030,379,491 | 1,680,300,179                 | 3,513,327,443      | 0                   | 1,510,079,934 | 0        | 406,135,213 | 910,544,054   | 31,487,209 | 24,082,253,523 |
| 2016        | NONFED | 11,879,923,210 | 1,239,498,723                 | 2,582,312,821      | 0                   | 1,133,154,677 | 406,131,303 | 31,185,078 | 536,844,295   | 11,224,325 | 17,820,274,432 |
| 2016        | TOTAL  | 27,904,473,377 | 2,919,798,902                 | 6,095,640,264      | 0                   | 2,643,234,611 | 406,131,303 | 437,320,291 | 1,505,039,988 | 42,711,534 | 41,954,350,270 |
| 2015        | FED    | 15,442,364,936 | 1,367,834,218                 | 2,080,629,579      | 0                   | 1,432,632,157 | 0        | 297,843,117 | 886,094,144   | 22,605,040 | 21,530,003,191 |
| 2015        | NONFED | 10,789,116,883 | 970,120,562                   | 1,466,393,531      | 0                   | 1,035,305,295 | 370,092,170 | 123,939,980 | 484,172,478   | 7,535,012 | 15,246,675,911 |
| 2015        | TOTAL  | 26,338,337,674 | 2,337,954,780                 | 3,547,023,110      | 0                   | 2,467,937,452 | 370,092,170 | 421,783,097 | 1,456,423,687 | 30,140,052 | 36,969,692,022 |
### Appendix C — Texas Medicaid and CHIP maps and figures

#### C.10: Medicaid Expenditure History, FFYs 2010–2014

| Federal Fiscal Year | Payer     | Grant Benefits | Disproportionate Share Hospital | Uncompensated Care | Upper Payment Level | DSRIP | Clawback | CHIP Phase I | Administration | Survey and Certification | Total Medicaid |
|---------------------|-----------|----------------|---------------------------------|--------------------|---------------------|-------|----------|--------------|----------------|-------------------------|----------------|
| 2014                | FED       | 14,982,927,389 | 905,058,004                    | 1,451,339,911      | 0                   | 1,348,925,140 | 0       | 117,437,708 | 737,229,930   | 19,236,614               | 19,562,154,776 |
| 2014                | FED-ARRA  | 0              | 0                               | 0                  | 0                   | 0     | 0        | 0            | 0              | 0                       | 0               |
| 2014                | NONFED    | 10,027,061,825 | 621,178,089                    | 997,553,985        | 0                   | 949,464,943 | 0       | 47,794,336 | 562,215,287   | 6,412,204                | 13,583,967,274 |
| 2014                | TOTAL     | 25,111,827,814 | 1,526,236,093                  | 2,448,893,976      | 0                   | 2,298,390,083 | 0       | 165,232,044 | 1,445,978,048 | 25,648,818               | 33,394,493,481 |
| 2013                | FED       | 14,209,243,885 | 133,812,750                    | 1,885,406,398      | 0                   | 287,667,948  | 0       | 28,657,109  | 646,050,231   | 22,731,210               | 17,213,569,531 |
| 2013                | FED-ARRA  | (2,722,794)    | 0                               | 0                  | 0                   | 0     | 0        | 0            | 0              | 0                       | 0               |
| 2013                | FED-ACA   | 82,774,190     | 0                               | 0                  | 0                   | 0     | 0        | 0            | 0              | 0                       | 82,774,190     |
| 2013                | NONFED    | 9,540,324,425  | 92,935,191                     | 1,325,138,105      | 0                   | 197,438,203 | 376,596,140 | 11,728,774   | 502,399,429   | 7,577,070                | 12,054,137,337 |
| 2013                | TOTAL     | 23,829,619,706 | 226,747,941                    | 3,210,544,503      | 0                   | 485,106,151 | 376,596,140 | 40,385,883   | 1,334,144,546 | 30,308,280               | 29,533,453,150 |
| 2012                | FED       | 13,773,119,669 | 882,595,210                    | 0                  | 1,400,669,919       | 0     | 0        | 28,108,056  | 651,723,257   | 22,796,293               | 16,759,012,404 |
| 2012                | FED-ARRA  | 6,301,635      | 0                               | 0                  | 12,501,171          | 0     | 0        | 0            | 209,039,020   | 0                       | 227,841,826    |
| 2012                | NONFED    | 9,833,604,615  | 633,370,455                    | 0                  | 981,318,763         | 0     | 0        | 344,689,503 | 11,194,337   | 549,535,172              | 7,598,764      |
| 2012                | TOTAL     | 23,613,025,919 | 1,515,965,665                  | 0                  | 2,394,489,853       | 0     | 0        | 344,689,503 | 39,302,393   | 1,410,297,449            | 30,395,057     |
| 2011                | FED       | 14,093,145,087 | 956,328,092                    | 0                  | 1,829,711,562       | 0     | 0        | 20,859,639  | 589,699,290   | 23,918,822               | 17,513,662,492 |
| 2011                | FED-ARRA  | 1,395,373,748  | 0                               | 0                  | 231,747,606         | 0     | 0        | 0            | 167,790,509   | 0                       | 1,794,911,863 |
| 2011                | NONFED    | 7,741,106,553  | 622,813,407                    | 0                  | 977,218,223         | 0     | 0        | 277,468,044 | 7,982,215    | 490,315,493              | 7,912,940      |
| 2011                | TOTAL     | 23,229,625,388 | 1,579,141,499                  | 0                  | 3,038,677,391       | 0     | 0        | 277,468,044 | 28,841,854   | 1,247,805,292            | 31,831,762     |
| 2010                | FED       | 12,670,015,218 | 991,515,974                    | 0                  | 1,849,499,135       | 0     | 0        | 0            | 585,452,634   | 23,347,881              | 16,119,830,842 |
| 2010                | FED-ARRA  | 2,599,216,338  | 0                               | 0                  | 366,322,520         | 0     | 0        | 0            | 1,366,805     | 0                       | 2,966,907,663 |
| 2010                | NONFED    | 6,231,480,571  | 696,673,993                    | 0                  | 925,963,561         | 0     | 0        | 188,351,774 | 513,545,911   | 7,782,627               | 8,563,798,437 |
| 2010                | TOTAL     | 21,500,712,127 | 1,688,189,967                  | 0                  | 3,141,785,216       | 0     | 0        | 188,351,774 | 1,100,367,350 | 31,130,508              | 27,650,536,942 |