MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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Director
AMY CARLSON

DATE: June 1, 2010

TO: Legislative Finance Committee

FROM: Lois Steinbeck
Senior Analyst

RE: Update - Patient Protection and Affordable Care Act, 2010

PURPOSE

Congress passed several bills[1] to implement changes to several components of the U.S. health care system. This memo and attachments:

- Summarize some of the major provisions of those bills and the Department of Public Health and Human Services (DPHHS) cost estimate for Montana
- Provide information on some of the newly enacted changes that are effective within six months of passage, some of which could limit legislative cost reduction options
- Identify legislation that may come before the 2011 Legislature as a result of the bills

SUMMARY OF MAJOR PROVISIONS

Attachment 1, "SJR 35: Health Care Selected Elements of the Final Federal Health Care Legislation" was written by Sue O'Connell, Research Analyst, Legislative Services Division and presented to the Children, Families, Health, and Human Services Interim Committee (Interim Children and Families Committee) at its April meeting. The attachment lists the major provisions of the federal bills with the effective dates. Major provisions include:

- Insurance market changes effective January 1, 2014:
    - Individuals (with certain exceptions) must purchase health insurance or pay a penalty
    - Tax credits will be provided to help individuals with incomes below 400 percent of the federal poverty level purchase health insurance
    - States must establish insurance exchanges[2] to allow persons to compare options and purchase health insurance
    - The exchanges must determine a person's financial eligibility for Medicaid and low-income tax subsidies
    - Tax credits will be paid to the exchanges, effectively lowering the purchase price of insurance for low-income persons

[1] The Patient Protection and Affordable Care Act was enacted March 23, 2010. The Health Care and Education Reconciliation Act of 2010, which included changes to the new law, was enacted March 30, 2010.

[2] Internet applications that allow comparison shopping among certain bench marked insurance plans. Exchanges can include more than one state.

    - Small employers may participate in the exchanges and depending on the number of employees and average wages paid, small employers may also receive tax credits
- Medicaid changes effective January 1, 2014:
    - States must expand Medicaid services to all individuals under 65 with incomes below 138 percent of the federal poverty level[3]
    - Medicaid eligibility will be determined using a modified gross adjusted income method and there will be no assets test
    - The expansion population must receive a benchmark benefit package to be determined by the Secretary of the Department of Health and Human Services (HHS)
    - The states will not be required to participate in the services cost for the expansion population until 2017 when there will be a 5 percent match rising to 10 percent in 2020 and beyond

ESTIMATED MEDICAID EXPANSION COST

Attachment 2 shows the estimated impact of the Medicaid expansion to the state of Montana. Attachment 2 was prepared by DPHHS for the April meeting of the Interim Children and Families Committee.

DPHHS estimates that by FY 2019 there will be 84,088 additional persons eligible for Medicaid due to federal changes. There were 90,562 persons eligible in January 2010.

The state share of costs is estimated to be $15 to $16 million each year in FY 2014 and FY 2015. In FY 2016, DPHHS estimates that the state will experience a small savings (about $2.5 million) due to a higher match rate for the federal Children's Health Insurance Program (CHIP) grant. Those savings will be erased in the following three years and the state share of costs is expected to rise to about $71 million in FY 2019 as more persons enroll, the state share for the eligibility expansion rises to 10 percent, and service utilization and some costs grow.

This cost increase is net of $8 to $9 million in savings from the Mental Health Services Plan, which is 100 percent state funded and provides prescription drug services and other mental health services to low-income adults with a serious and disabling mental illness. Many persons receiving services through MHSP would be eligible for Medicaid with the expansion in financial eligibility.

This cost estimate assumes that the state will be able to continue the basic Medicaid service package for low-income nondisabled adults, which is a scaled back version of regular Medicaid benefits. The state received a waiver to offer a Medicaid service package more comparable to private insurance as part of state welfare reform in the early 1990s. If the state is required to augment that service package under the federal health care legislation, the costs could be higher than estimated by DPHHS.

[3] The federal legislation establishes Medicaid eligibility for persons under 65 at 133 percent of the federal poverty level, but also requires a 5 percent disregard, raising effective eligibility to 138 percent of the federal poverty level.

OTHER NEAR TERM IMPACTS

There are several other changes that will be implemented prior to the 2011 legislative session or that became effective on passage of the federal legislation. Some of these changes will limit legislative options to reduce Medicaid costs.

Medicaid and CHIP

The federal health care legislation established a maintenance of effort (MOE) for Medicaid and CHIP eligibility. If a state reduces or restricts eligibility from levels in June 2009, it could be penalized by the withdrawal of all federal Medicaid matching funds. In some instances, changes in service levels, such as reducing the number of home and community based waiver slots, could also be construed as limiting or restricting eligibility for services.

Federal High Risk Pools

The State Auditor's Office submitted an application on June 1 to implement a second high risk insurance pool for individuals with pre-existing conditions who have been uninsured in the previous six months effective July 1. The federal pool will be managed separately from the Montana Comprehensive Health Association (MCHA) Plan, which is the state high risk pool and currently insures about 3,000 people. The state must maintain the level of expenditures for MCHA in order to receive federal funds. 1% of book of business in Montana and premiums

The state received $16 million in federal grant funds to run the federal high risk pool until health insurance exchanges are implemented in January 2014. The actuary working with the MCHA estimates the funds may provide insurance for about 400 more individuals per year.

Retiree Reinsurance Program

The federal legislation included $5 billion to fund a reinsurance program for employers who insure retirees older than 55 but not yet eligible for Medicare, or who allow retirees to participate in the employer program. The State of Montana would be eligible to receive a grant under this program. Actuaries for the state employee group plan estimate that the plan could submit a reinsurance claim between $3 and $4 million.

The program will fund 80 percent of the cost of claims over $15,000 and up to $90,000 for early retirees. The funds are available to grantees on a first come, first serve basis and grantees must meet certain conditions.

It appears that the state group plan would be eligible to participate in the program. Legislative Fiscal Division staff has asked whether the state group plan will submit an application and if so when.

Small Business Federal Tax Credits

Small businesses will be eligible for federal tax credits to help fund or continue providing insurance to employees. Small businesses can claim the credit as part of the general business credit starting with the 2010 income tax return they file in 2011. The federal tax credits will be in addition to the state tax credits authorized as part of the Insure Montana Program. At this

point, it is not known whether there could be an impact to state revenues due to the federal tax credit.

Other Grants Related to Federal Health Reform

Attachment 3 lists grants that are funded in the federal health care legislation. The attachment was prepared by the National Conference of State Legislatures. Some of the grants will be awarded competitively and some will be awarded based on a formula and each state will receive a certain amount. All grants have requirements that will be established by the Secretary of HHS.

LEGISLATION IN THE 2011 SESSION

At this point, only a few of the potential issues related to federal health reform that could come before the 2011 Legislature are known. The most significant issue is the authority for the State Auditor to establish a health insurance exchange and the Auditor has indicated such a bill will be requested. Although the exchanges are required to be operational by January 2014, the Auditor must submit the Montana insurance exchange proposal to HHS in January 2013.

There also may be proposals related to state authority to review and regulate insurance rates. The federal legislation includes more review and regulatory requirements than current state statute and the legislature may be asked to determine whether to assume such responsibility at the state level.

The legislature may consider several issues related to health reform prior to receiving much federal guidance on what is expected. It may need to enact broad, delegated authority unless it would wish to convene again after the regular session concludes.

NEXT STEPS

Legislative Services Division (LSD) and LFD have formed a staff team for the federal health legislation. Sue O'Connell is the LSD representative and Lois Steinbeck is the LFD representative. Together the team is developing materials to explain major components of the legislation, a timeline for major developments, and identifying what types of legislative action may be necessary to implement the state's response. The team will keep both the Interim Children and Families Committee and LFC apprised as issues arise.

Attachement 1

SJR 35: HEALTH CARE

Selected Elements of the Final Federal Health Care Legislation

Prepared by Sue O'Connell
for the Children, Families, Health, and Human Services Interim Committee
April 2010

The following table highlights selected provisions of the final health care reform legislation approved by Congress in March 2010. The elements are contained in H.R. 3590, passed by the Senate in December 2009 and the House in March 2010; H.R. 4872, the reconciliation bill approved by both chambers in March 2010; and the manager's amendment to H.R. 4872.

	Final Federal Health Care Legislation
Individual Insurance Mandate	• **Effective in 2014**: All eligible individuals must have health insurance that meets minimum coverage requirements • Exemptions: Financial hardship, Native Americans, religious objections, and individuals who are either incarcerated, without coverage for less than three months, for whom the lowest cost plan exceeds 8% of their income, or who have incomes below the tax filing threshold. In 2009, the threshold was $9,350 for single filers and $18,700 for couples.
Penalties for Individuals	• **Effective in 2014**: Penalties for failure to obtain insurance coverage • Penalty is the greater of $695 per year (up to a maximum of three times that amount, or $2,085, per family) or 2.5% of household income • Penalty is phased in as follows: a flat fee of $95 per person in 2014, $325 in 2015, and $695 in 2016 or 1% of taxable income in 2014, 2% in 2015, and 2.5% in 2016. After 2016, penalty increases by the cost-of-living adjustment.
Subsidies for Individuals	• **Effective in 2014**: To offset the costs of buying insurance, refundable and advanceable premium credits will be available for individuals and families who buy insurance through a state health insurance exchange if they have incomes between 133% and 400% of the federal poverty level • Amount that qualifying individuals must contribute to their premiums ranges from 2% of income for people at or below 133% of poverty to 9.5% of income for those between 300% and 400% of poverty • Cost-sharing subsidies available to reduce the amount of annual out-of-pocket costs for people who are between 100% and 400% of poverty • Employees offered coverage through their jobs are ineligible for tax credits if they purchase a policy through the exchange unless the actuarial value of the employer's plan is less than 60% or the employee share of the premium exceeds 9.5% of income • Legal immigrants who are barred from enrolling in Medicaid during their first five years in the United States are eligible for premium credits • Verification of income and citizenship status required for determining eligibility for premium credits

Topic	Final Federal Health Care Legislation
Employer Insurance Provisions	• **In general**: Employers not required to offer insurance • **Effective in 2014**: Firms employing 50 or more workers must pay a fee if at least one full-time employee receives a premium tax credit for obtaining insurance in the state insurance exchange • The fee varies depending on whether the firm offers insurance coverage. Firms that don't offer coverage must pay $2,000 per full-time employee, but the first 30 employees are exempt from the calculation. Firms that offer coverage must pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee. • Employers that offer coverage must provide employees with a voucher if the employee has an income that is less than 400% of poverty, the employee's share of the premium for the employer plan is more than 8% but less than 9.8% of the employee's income, and the employee opts to buy insurance through the exchange. The voucher must equal the amount the employer would have paid for the employee's coverage and must be used to offset the premium costs for the exchange-purchased plan. • Employers with 200 or more employees must enroll employees into plans they offer; employees may opt out
Tax Credits for Employers	• **Effective immediately**: Employers with 25 or fewer employees and average wages below $50,000 qualify for tax credits if they offer insurance coverage and pay a portion of the employee's premium • **Effective in tax years 2010-2013**: Credits of up to 35% of the employer's contribution are available if the employer contributes at least 50% of the premium cost or 50% of a benchmark premium • Tax-exempt businesses may receive up to 35% of their contribution toward employees' premiums until 2013 • **Effective in 2014 and late**r: Credits of up to 50% of the employer's premium costs are available for two years for eligible small businesses that buy insurance through the state exchange and pay at least 50% of the employee's total premium costs • The full tax credit is available to employers with 10 or fewer employees and average annual wages of less than $25,000; credit phases out as firm size and average wage increases • Tax-exempt businesses may receive up to 25% of their contribution toward employees' premiums in 2014 and later • **Effective in 2010**: A $5 billion reinsurance program will reimburse employers who provide insurance coverage to retirees over age 55 but under age 65. The program will reimburse 80% of claims of $15,000 to $90,000 and will terminate Jan. 1, 2014.
Medicaid Expansion	• **Effective immediately**: States must maintain current Medicaid eligibility guidelines until 2014 or lose federal matching funds • **Effective in 2014**: Medicaid coverage expanded to childless, nondisabled adults; eligibility limit for all Medicaid-covered individuals set at 133% of poverty • Income disregards eliminated; income eligibility measured by modified adjusted gross income • Newly eligible adults will receive a benchmark benefit package that covers essential health benefits, as defined by the federal government • Federal government pays the full costs of the expansion for the first three years • **Effective in 2017**: States begin sharing in the costs of the expansion as follows: 5% in 2107, 6% in 2018, 7% in 2019, and 10% in 2020 and beyond

	Final Federal Health Care Legislation
CHIP	• **Effective immediately**: States must maintain current Children's Health Insurance Program (CHIP) eligibility levels through 2019 or lose federal funds • CHIP benefit packages and cost-sharing rules will continue as under current law • **Effective in 2014**: CHIP-eligible children who cannot enroll in the program because of enrollment caps will be eligible for tax credits for buying insurance through the exchanges • **Effective in 2015**: States will receive an increase of 23 percentage points in the CHIP matching rate, up to a cap of 100%
Health Insurance Exchanges	• **By 2014**: States must establish a health insurance exchange through which individuals and small businesses (up to 100 employees) may buy insurance coverage • Each exchange must offer at least two multi-state plans that meet the federally established coverage requirements and that have separate risk pools • Exchanges must maintain a customer service call center and establish procedures for enrollment and for determining eligibility for tax credits • American Indians with incomes at or below 300% of poverty are exempt from any cost-sharing requirements of policies sold through the exchange • **Effective in 2016**: States may form compacts to allow for purchase of individual policies across state lines; insurers in the compact would be subject only to the coverage laws of the state where the policy is written or issued • **Effective in 2017**: States may allow businesses with more than 100 employees to buy coverage through the exchange
Insurance Market Reforms	• **Effective in 2010**: No denial of coverage for children with pre-existing conditions; no lifetime limits on coverage for individual or group health plans; no restrictive annual limits on coverage; no rescission of coverage except in cases of fraud; children may remain on a parent's policy up to age 26 regardless of marital status; process established to review insurer premium increases • **Effective in 2011**: Insurers must provide rebates to consumers if they fail to spend a certain percentage of premium dollars on health care costs. The percentage is set at 85% for plans in the large group market and 80% for plans in the individual and small group markets. • **Effective in 2014**: Guaranteed issue and renewability; no exclusions for pre-existing conditions for any individuals; no annual limits on benefits; premiums may vary based on age (3:1 ratio), tobacco use (1.5:1 ratio), family composition, and geographic location; waiting period for coverage limited to 90 days; deductibles in the small group market limited to $2,000 for individuals and $4,000 for families, with some exceptions • **Exceptions**: Existing individual and group plans will not need to meet many of the benefit and insurance reform requirements until 2014 but must, in 2010, extend dependent coverage to adult children up to age 26, prohibit rescission of coverage, and eliminate waiting periods in excess of 90 days for coverage

	Final Federal Health Care Legislation
Benefit Plans	• **Effective in 2010:** New plans in the private market must cover preventive care with no deductibles or cost-sharing requirements; requirement will apply to all plans in 2018 • **Effective in 2014**: All plans offered in the exchange and in the individual and small group markets outside of the exchange must offer at least the essential health benefit package developed by the federal government. The plan must offer a comprehensive set of services, have an actuarial value of at least 60%, and limit annual cost-sharing to the current Health Savings Account limits of $5,950 for individuals and $11,900 for families. • Plans offered in the exchange and in the individual and small group markets must offer four benefit options with actuarial values ranging from 60% to 90% • Grandfathered individual and employer-sponsored plans would be exempt from offering the essential health benefits package • "Catastrophic" policy available, in the individual market only, to young adults under the age of 30 who want a less expensive policy that covers only major medical costs; policy must cover preventive services and three primary care visits
State Role	• **Effective in 2010**: States must establish an ombudsman office to act as a consumer advocate and may establish a high-risk pool meeting federal guidelines. State high-risk pools will share in federal funds available for covering individuals with pre-existing conditions. If a state high-risk pool is not created by July 1, residents are covered by a federal plan. • **By 2104**: States must establish health insurance exchanges • **Effective in 2017 and beyond**: States must pay a portion of the costs of expanding Medicaid coverage, starting at 5% of the additional costs in 2017 and increasing gradually to 10% in 2020 and beyond
Alternative to Private Insurance	• **Effective July 1, 2013**: A nonprofit, member-run insurance company (co-op) may be created and may receive federal loans for startup costs and federal grants to meet state solvency requirements • The cooperative may not be an existing organization that was providing insurance on July 16, 2009, or affiliated with such an organization and may not be sponsored by a governmental entity of any type
Workforce Issues	• **Effective in 2010:** More flexibility for the types of locations where medical residents can train; additional federal incentives — including scholarships, loans, and loan repayments — available to increase the workforce supply and support primary care training; appointment of a Workforce Advisory Committee to develop a national workforce strategy • **Effective in 2011**: Primary care providers and general surgeons in shortage areas will receive 10% Medicare bonus payments for 5 years; residency slots for primary care training will be created by redistributing unused slots, with priority given to states with the lowest resident physician-to-population ratios • **Effective in 2013 and 2014**: Increase in Medicaid reimbursement rates to 100% of the Medicare rate for primary care physicians. The federal government will fund the cost of the increase.

	Final Federal Health Care Legislation
Revenue Sources	• **Effective July 1, 2010**: Imposes a tax of 10% on indoor tanning services • **Effective 2011**: Increases to 20% the tax on withdrawals from Health Savings Accounts (HSAs) or Archer Medical Savings Accounts (MSAs) for non-medical expenses, from 10% and 15%, respectively; excludes costs of over-the-counter, non-prescribed drugs from being reimbursed through a health Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRAs) or on a tax-free basis through an HSA or Archer MSA; imposes an annual fee of $2.5 billion on pharmaceutical manufacturers, increasing annually to $4.1 billion in 2018 and reverting to $2.8 billion in 2019 and beyond • **Effective 2013**: Imposes a tax of 2.3% on the sale of taxable medical devices; limits contributions to medical FSAs to $2,500 a year, increased annually by the cost of living; increases the threshold for itemized deduction of unreimbursed medical expenses from 7.5% of adjusted gross income to 10%; increases the Medicare Part A tax rate on wages from 1.45% to 2.35% on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% tax on unearned income for higher-income taxpayers • **Effective 2014**: Imposes a tax on individuals who don't have insurance coverage; imposes an annual fee of $8 billion on the health insurance sector, increasing annually until it reaches $14.3 billion in 2018 and then increasing in subsequent years by the rate of premium growth • **Effective 2018**: Imposes a tax of 40% on insurance companies that offer employer-sponsored plans with an aggregate value higher than $10,200 for individual coverage and $27,500 for family coverage; the tax is imposed on the value of the plan that exceeds the threshold amount. The aggregate value includes reimbursements under a medical FSA or HRA, employer contributions to an HSA, and coverage for supplementary health insurance coverage, excluding dental and vision coverage.

Sources: Compiled from Kaiser Family Foundation and National Conference of State Legislatures materials.

Implications of Selected Provisions for Montana

While the federal legislation affects all states, some provisions apply only to Montana or a selected group of rural states, including:

- designated funding to assist Libby residents with diseases stemming from their exposure to asbestos at the W.R. Grace and Co. vermiculite operation. The bill provides $25 million through 2014 and $20 million for every five-year period after that to screen people for asbestos-related diseases. It also will expand Medicare coverage regardless of age to those who test positive if they meet the residency requirements, and it establishes a pilot project to pay for asbestos-related disease care that's not covered by Medicare.

- an increase in the Medicare minimum "area wage index" for hospitals located in a frontier state. The bill defines a frontier state as one in which at least 50% of the counties have fewer than 6 people per square mile. Montana, North Dakota, South Dakota, Utah, and Wyoming qualify for this provision, which will increase Medicare reimbursements to the state's largest hospitals.

In addition, Northern Montana Hospital in Havre will benefit from a one-year extension of the Rural Community Hospital Demonstration Program, which reimburses small rural hospitals at cost for their services. About a dozen hospitals in eight states are currently involved in the demonstration project.

Attachement 1

2009 FEDERAL POVERTY LEVEL GUIDELINES

	Gross Yearly Income							
Family Size	**approx 33%**	**100%**	**133%**	**150%**	**175%**	**250%**	**300%**	**400%**
1	$3,576	$10,830	$14,404	$16,245	$18,953	$27,075	$32,490	$43,320
2	$4,704	$14,570	$19,378	$21,855	$25,498	$36,425	$43,710	$58,280
3	$5,892	$18,310	$24,352	$27,465	$32,043	$45,775	$54,930	$73,240
4	$7,092	$22,050	$29,327	$33,075	$38,588	$55,125	$66,150	$88,200
5	$8,280	$25,790	$34,301	$38,685	$45,133	$64,475	$77,370	$103,160
6	$9,468	$29,530	$39,275	$44,295	$51,678	$73,825	$88,590	$118,120
7	$10,668	$33,270	$44,249	$44,905	$58,223	$83,175	$99,810	$133,080
8	$11,844	$37,010	$49,223	$55,515	$64,768	$92,525	$111,030	$148,040

ELIGIBILITY LEVELS: STATE PROGRAMS AND FEDERAL REFORM PROPOSALS

Montana Programs	**% of FPL**
Medicaid	
Adults with children	~33%
Children through age 18	133%
Pregnant women	150%
Healthy Montana Kids	250%
MCHA premium assistance	150%

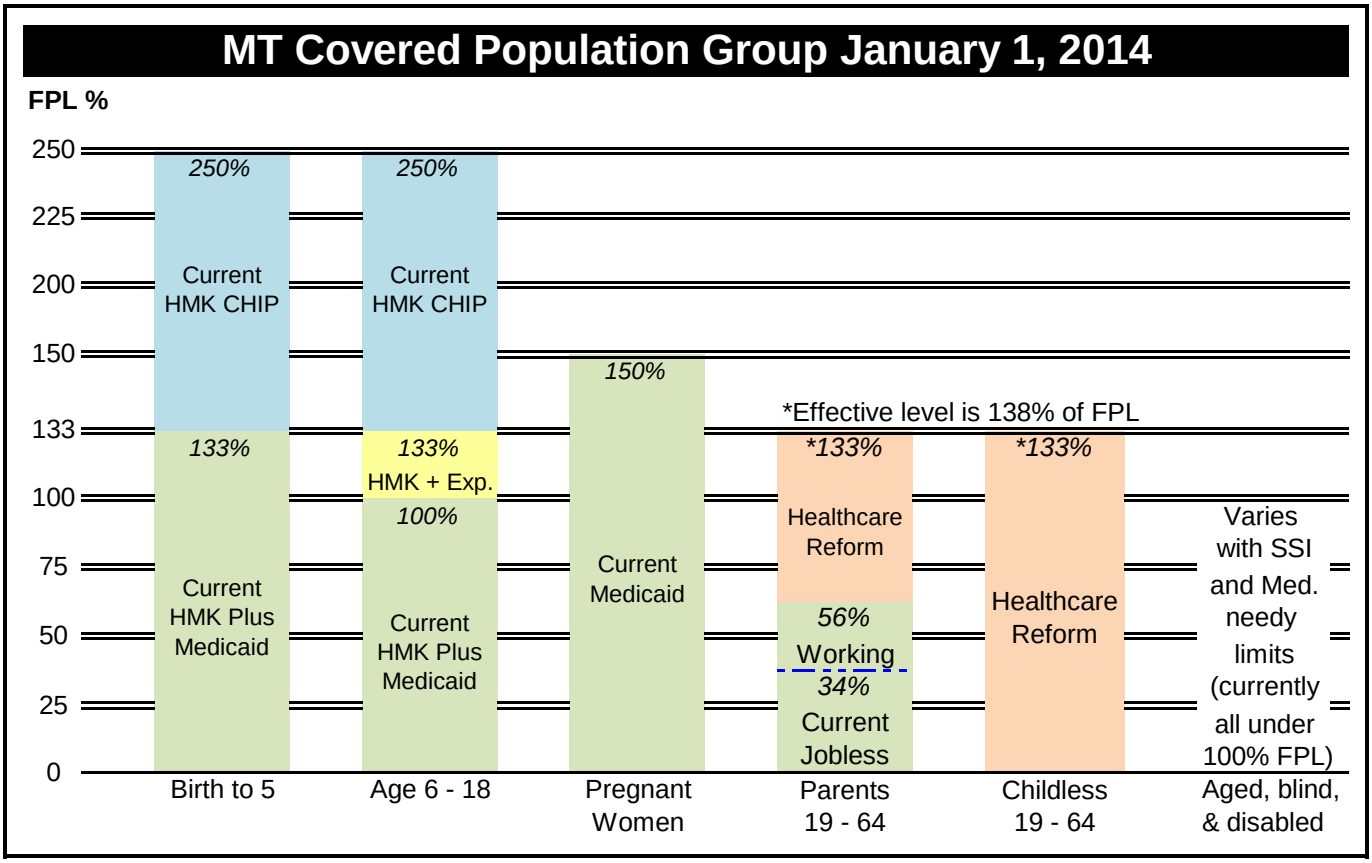
Federal Health Care Legislation	**% of FPL**
Medicaid Expansion	133%
Low-Income Subsidies	400%

Attachment 2

Montana and Major Components of Federal Healthcare Reform

(DPHHS Analysis of Major components as of 4-19-2010. Since this is a dynamic analysis, it is anticipated that there will be multiple changes moving forward)

1. **Expands Medicaid eligibility to individuals under age 65 with incomes up to 133% FPL**
   (*Income deduction allowance of five percentage points creates effective eligibility level of 138%)
   - On or after April 1, 2010 –December 2013: Eligibility expansion optional for states.
   - January 1, 2014: States required to begin expansion.



2. **Requires benchmark or benchmark-equivalent coverage for Medicaid expansion populations.**
   - Benchmarks include the Federal employees Blue Cross preferred provider plan, plans offered or available to state employees, the plan of the HMO in the state with the largest non-Medicaid enrollment, or any other plan approved by the Secretary.

3. **Changes Medicaid income eligibility requirements.**
   - Requires use of modified gross income and prohibits assets test and most income deductions.

4. **Requires Montana to maintain existing Medicaid eligibility until the state's exchange is fully operational on January 1, 2014.**

5. **For the first three calendar years (Jan. 1, 2014 to Dec. 31, 2016) of the mandated expansion, the Federal government bears the full cost of coverage for new eligibles in Montana.**

   – Table displays the blended State Fiscal Year percentages for both expansion and current eligible. Note that the population currently eligible will continue to be matched at the current FMAP rate (left-hand side of table)

Federal Medical Assistance Percentages (FMAP)
Montana State Share Percentage

State Fiscal Year	Clients Currently Medicaid Eligible	New Adults Under Reform
FY 2010	22.7%	Not Eligible
FY 2011	26.6%	Not Eligible
FY 2012	33.1%	Not Eligible
FY 2013	33.9%	Not Eligible
FY 2014	33.5%	0.0%
FY 2015	33.5%	0.0%
FY 2016	33.5%	0.0%
FY 2017	33.5%	2.5%
FY 2018	33.5%	5.5%
FY 2019	33.5%	6.5%
FY 2020	33.5%	8.5%
FY 2021	33.5%	10.0%

6. **The bill makes several changes to Medicaid drug rebate policy that apply upon enactment, including increasing the minimum manufacturer rebate on brand name products from 15.1% to 23.1%.**

   – The Federal government is utilizing this difference in percent and therefore states will not see the increased revenue. Some risk that Montana could lose some supplemental collections that are currently received, awaiting interpretation and guidance from CMS.

7. **States are required to increase Medicaid rates to 100% of Medicare rates in 2013 and 2014 for certain services provided by primary care physicians.**

   – Montana's primary care physician rates are mostly at or above 100% of Medicare rates.

8. **Reduces aggregate Medicaid disproportionate share hospital (DSH) allotments and requires a methodology to reduce state DSH allotments.**

   – Montana State Government allocates DSH allotments 100% to hospitals: net impact to State Government is zero, but hospitals in total could be impacted.

9. **National high risk pool must be in place in 90 days and last till January 1, 2014.**

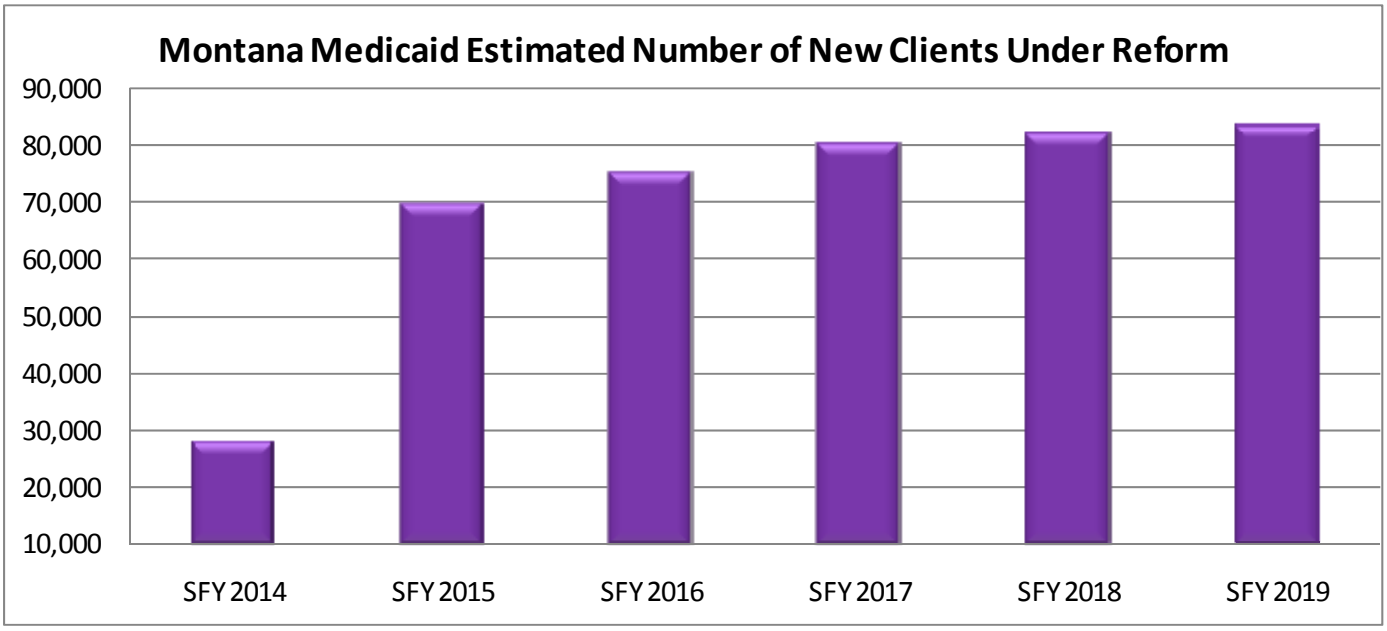
10. Requires states to maintain existing CHIP eligibility through September 2019.

11. Extends Federal CHIP funding through 2015.

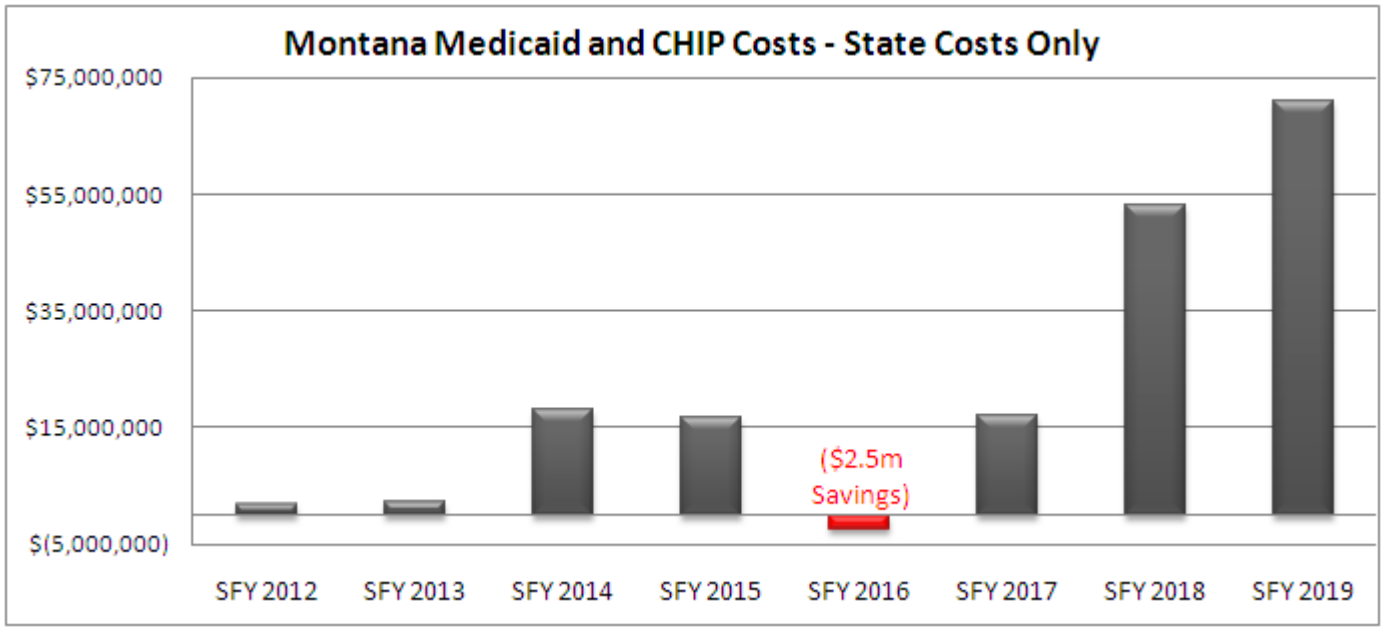
12. From October 1, 2015 to September 30, 2019 increases the Federal CHIP match rate by 23 percentage points (not to exceed 100 percent).

– Montana anticipates Federal participation to be 100% with additional 23% October 1 2015.

13. Expected number of new Medicaid clients by State Fiscal Year:



14. Preliminary State Fiscal Impacts by State Fiscal Year:



Financial Impacts for HealthCare Reform - DPHHS Assumptions

1. In 2008 - 2009 there were 199,145 people in Montana under 138% of poverty (effective level includes 5% income deduction), or 20% of the total Montana population of 972,972.

2. Of the 199,145 under 138% of poverty 54,275 or 27% were uninsured: with 45,970 of these uninsured being adults 19 to 64.

3. Of the 199,145 under 138% of poverty 61,539 or 31% had private insurance: with 25,964 of these people being adults 19 to 64.

4. Assume the following take-up rates for Medicaid under Healthcare reform:
   - ✓ 95% for uninsured adults
   - ✓ 80% for privately insured adults
   - ✓ 15% for uninsured and privately insured children

5. Assume in current 2008 – 2009 population numbers that Healthcare reform (138% FPL) would have added 64,442 adults and 4,539 kids onto Medicaid; for a total of 68,981 clients (this is the baseline figure).

6. Assuming an annual enrollment growth for this group of 2%, and assume that we won't reach the full take-up rate percentages for a few years (until 2017, which is about 3 years after bill implementation in Jan 1, 2014). Assume the following phase-up of clients into Medicaid: 2014 = 75% (6 months); 2015 = 90%; 2016 = 95%; 2017 & beyond = 100%.

7. Per the above assumptions, the following schedule of additional **clients** is estimated:

SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
28,560	69,916	75,276	80,823	82,439	84,088

8. Medicaid non-disabled adults on average cost about $600 per month, while Medicaid kids cost about $265 per month. (Amounts include hospital tax and DSH allocations.)

9. Overall costs in Medicaid for adults increases by approximately 9% annually, while costs for children increases by approximately 4% annually. (Annual costs include enrollment growth of 2% annually from above; excludes growth from hospital tax and DSH payments.)

10. The State share (Federal Medical Assistance Percentages (FMAP)) for newly eligible adult clients under the reform bill is as follows (blended for state fiscal years): 2014 = 0% (6 months); 2015 = 0%; 2016 = 0%; 2017 = 2.5%; 2018 = 5.5%; 2019 = 6.5%; 2020 = 8.5%; 2021 = 10.0%. Note that clients currently eligible will still have the current FMAP rates that are not enhanced by the reform bill.

11. Per the above assumptions, the following schedule of **State share of benefit related costs** are estimated for adults and children: 2014 = $2.2m; 2015 = $5.6m; 2016 = $6.2; 2017 = $32.0m; 2018 = $67.5m; 2019 = $85.2m; Note that the expenditures from 2014 to 2016 are all attributable to currently eligible kids.

12. **Medically Needy:** (There is possible savings for the Medically needy population, but the Department will need CMS interpretation before an impact (savings or cost) can be identified.

13. Assumption is that **administrative costs** will be matched at current rates and current split which is 42% State / 58% Federal.

14. Administrative costs currently total 6.2% of total benefits with the state share equal to 2.6% of total benefit costs. Estimate assumes that administrative costs ratio(s) would continue to equal 6.2% of new expenditures overall and 2.6% for the state share. For example under this assumption, if benefit expenditures double, administrative costs overall and to the state would also double.

15. Administrative costs in 2014 are estimated at a full year amount as start-up costs will be higher than a half year amount. ** Montana is analyzing potential costs of IT system changes for health care reform; the preliminary estimate is $1.9 million state costs overall. Changes include eligibility determination, health insurance exchange, Medicaid claims processing, and federal reporting requirements. The bill would require the changes to occur prior to January 1, 2014. It is estimated that a majority of the system update costs would be born in SFY 2013. Assume costs of $750,000 in 2012 and $1,150,000 in 2013.

16. State share of **administrative costs** estimated at 2.6% of new benefits would equal: 2012 = $750,000; 2013 = $1.15m; 2014 = $20.3m; 2015 = $20.3m; 2016 = $23.3; 2017 = $26.7m; 2018 = $29.1m; 2019 = $31.7m.

17. **Savings.** Under the reform bill, the FMAP for **CHIP** is expected to be 100% federal from October 1, 2015 through September 30, 2019. Using current proposed CHIP budget amounts and an estimated growth rate of 6%: The change in CHIP FMAP is expected to save the State of Montana: 2016 = $23.0; 2017 = $32.9m; 2018 = $35.2m; 2019 = $37.7m.

18. **Savings**. The Mental Health Services Plan (MHSP) program is currently funded with 100% State funds, but under the reform bill most clients will be eligible to receive (Medicaid) Federal funding. If the HIFA waiver is not moved then most of this population would qualify under reform. MHSP program currently expends $10 million per year on mental health services; with the bill now allowing this client group to receive Medicaid it is expected to save the State approximately $9 million per year through SFY 2016, then phasing down to $8.4 million in 2019.

19. **Total change.** Combining the expenditures and savings together for each fiscal year, yields estimated expenditure changes to the State of Montana as follows:
    2012 = add $750,000; 2013 = add $1.15m; 2014 = add $18.0m; 2015 = add $16.9; 2016 = save ($2.5); 2017 = add $17.1m; 2018 = add $53.0m; 2019 = add $70.8m.

SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019
$ 750,000	$ 1,150,000	$17,995,160	$16,854,674	$(2,508,145)	$17,106,834	$52,926,267	$70,819,282

Note: Analysis does not include all financial impacts. Only those listed in this summary.

The following financial impact analysis does not include all aspects of the reform bill. The analysis covers the following six major components of the bill:

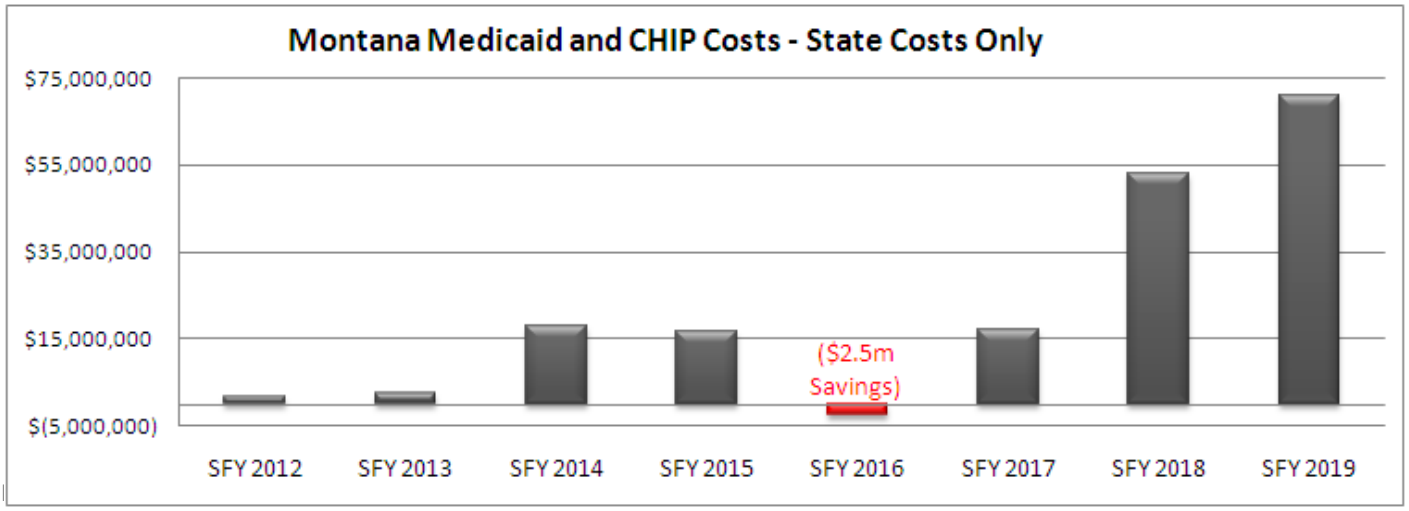
1. Estimated number of newly eligible adults along with estimated number of currently eligible children that are anticipated to enroll in Medicaid due to healthcare reform.
2. Estimated state share costs for newly eligible adults (this group will receive enhanced FMAP).
3. Estimated state share costs for new children enrollees that are currently eligible (this group will not receive enhanced FMAP).
4. Approximate administrative costs. (Note not shown in the table immediate below are system update costs for 2012 and 2013 that total $1.9 million. Bar Chart includes them.)
5. Estimate CHIP savings as Federal participation is moved to 100% from October 1, 2015 through September 30, 2019.
6. Estimate savings to Mental Health Services Plan (MHSP) assuming HIFA waiver is not moved. (Currently funded with 100% State funds, now will receive Federal funding)

As of April 19, 2010

Medicaid Expansion Under National Healthcare Reform (March 2010)
Jan. 1, 2014 Effective Date. State Match Begins Jan. 1 2017. CHIP 100% Federal Oct. 1, 2013 through Sept. 30, 2019
Cover All Population Under 133% of Poverty (Effective FPL is 138% FPL with 5% income deduction)

First Year of Proposal = FY2014	Proposal 1/2 Year	State Share % new 0%	State Share % new 0%	State Share % new 2.5%	State Share % new 5.5%	State Share % new 6.5%
MT Medicaid Additional Costs Under Proposal	**SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**SFY 2019**
Estimated number of new clients under proposal	28,560	69,916	75,276	80,823	82,439	84,088
State share with new FMAP medical benefit costs for new clients	$ -	$ -	$ -	$ 25,193,094	$ 60,413,040	$ 77,822,980
State share medical benefit costs for added children already eligibl	$ 2,218,047	$ 5,577,561	$ 6,168,278	$ 6,851,944	$ 7,126,022	$ 7,411,063
State share of costs for "other" changes	$ -	$ -	$ -	$ -	$ -	$ -
State share of admin. costs (@ current FMAP for admin. costs)	$ 20,277,113	$ 20,277,113	$ 23,307,267	$ 26,717,197	$ 29,095,925	$ 31,687,707
State share of costs / savings for Medically needy	$ -	$ -	$ -	$ -	$ -	$ -
Savings - MHSP program (*If HIFA not moved)	$ (4,500,000)	$ (9,000,000)	$ (9,000,000)	$ (8,775,000)	$ (8,505,000)	$ (8,415,000)
State share of savings for "other" changes	$ -	$ -	$ -	$ -	$ -	$ -
Montana costs under proposal (State only)	$ 17,995,160	$ 16,854,674	$ 20,475,545	$ 49,987,235	$ 88,129,988	$ 108,506,750
MT CHIP Additional Savings Under Proposal	**SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**SFY 2019**
Savings - CHIP FMAP to 100%	$ -	$ -	$ (22,983,689)	$ (32,880,401)	$ (35,203,720)	$ (37,687,468)
Montana Total Medicaid and CHIP costs under proposal (State only	$ 17,995,160	$ 16,854,674	$ (2,508,145)	$ 17,106,834	$ 52,926,267	$ 70,819,282

**Note that CHIP additional FMAP (23%) could be expanded into future years, but is only carried to September 2019 in the reform bill.



Attachment 2

CY 2008 Baseline Figures for Healthcare Reform

Montana Population & Demographics Under 138% of Poverty (Effective Rate)

(Effective rate is 133% of poverty + 5% income deduction specified in bill)

	Population	Age			
Description	**Total**	**0-5**	**6-18**	**19-64**	**65+**
Total Montana Population Estimate 2008	972,972	74,128	152,617	600,024	146,203
Under 138% of Poverty 2008 (approx)	199,145	26,218	39,357	106,640	26,931
Uninsured under 100% Poverty (approx)	36,023	407	6,028	29,588	-
Uninsured 100% - 138% Poverty (approx)	18,252	1,136	735	16,382	-
Total uninsured under 138% of Poverty	54,275	1,543	6,763	45,970	-
Privately insured under 100% FPL (approx)	33,612	4,723	11,004	15,765	2,120
Privately insured 100% - 138% Poverty (approx)	27,927	3,401	2,828	10,199	11,500
Total Privately Insured under 138% of Poverty	61,539	8,124	13,832	25,964	13,620
Take-up: Only those individuals up to 138% FPL / Healthcare Reform					
Uninsured with take-up of 95% (15% age 0-18)	44,917	231	1,014	43,671	-
Insured with take-up of 80% (15% age 0-18)	24,064	1,219	2,075	20,771	-
Total Take-up Population (As of 2008-2009)	**68,981**	**1,450**	**3,089**	**64,442**	**-**

The following financial impact analysis does not include all aspects of the reform bill. The analysis covers the following six major components of the bill:

1) Estimated number of newly eligible adults along with estimated number of currently eligible children that are anticipated to enroll in Medicaid due to healthcare reform.
2) Estimated state share costs for newly eligible adults (this group will receive enhanced FMAP).
3) Estimated state share costs for new children enrollees that are currently eligible (this group will not receive enhanced FMAP).
4) Approximate administrative costs (Note not shown in the chart are system update costs for 2012 and 2013 that total $1.9 million).
5) Estimate CHIP savings as Federal participation is moved to 100% from October 1, 2015 through September 30, 2019.
6) Estimate savings to Mental Health Services Plan (MHSP) assuming HIFA waiver is not moved. (Currently funded with 100% State funds, now will receive Federal funding)

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**Note that CHIP additional FMAP (23%) could be expanded into future years, but is only carried to September 2019 in the reform bill.

Attachment 2

Fiscal Impact Assumptions Detail

1) Population Figures sourced from 2009 Census Bureau Current Population Survey (CPS).

2) There is a 5% income deduction specified in the bill for eligibility creating an effective level of 138%. The analysis considers this in the population take-up estimate.

3) Take-up rate for children under 133% (effective rate 138%) of poverty. Assumed that the national attention and additional access under the proposal would bring more recipients into the system then Healthy Montana Kids (HMK). Even though these recipients would be eligible for Medicaid or CHIP under HMK, assume that 15% of children listed in 2008 as uninsured or privately insured under 133% FPL (effective rate 138%) would move to Medicaid under reform.

4) Adults under 133% FPL (effective rate 138%) and currently uninsured take-up rate estimated at 95%.

5) Adults under 133% FPL (effective rate 138%) currently with private insurance take-up rate estimated at 80%.

6) Assume that we won't reach the full take-up rate percentages for a few years (until 2017, which is about 3 years after bill implementation in Jan 1, 2014). Assume the following phase-up of clients into Medicaid:
2014 = 75% (6 months); 2015 = 90%; 2016 = 95%; 2017 = 100%.

7) Assume that enhanced 100% to 90% FMAP will only apply to newly eligible adult FPL populations…meaning that any new children would not be eligible for 100% to 90% match rate since they would be eligible for current programs on the basis of FPL alone.

8) Assume annual population growth of 2% on the number of enrolled recipients.

9) FMAP for new children under current Medicaid FPL limits (children 0-5 and under 133% FPL: and children 5 -18 under 100% FPL) will be at current Medicaid FMAP rates.

10) Baseline (2008) estimated (caseload) expenditures for the new population(s) is grown by 4.0% for children and 9.0% for adults into 2017 based on historical caseload growth and PMPM changes for similar Medicaid populations. Percentages include 2% for population growth under assumption #8.

11) Medically needy still need impacts calculated (need CMS interpretation)

12) SAVINGS - CHIP program; FMAP for CHIP expected to be 100% federal from October 1, 2013 through September 30, 2019. Impacts in 2016 are shown at 75% due to timing. Impacts in 2020 are shown at 25% due to timing, while impacts for 2021 are completely left off analysis due to dates listed in bill. Simple estimate based on 2011 budget grown annually at 6% for estimated cost increases. Note that CHIP additional FMAP (23%) could be expanded into future years, but is only carried to September 2019 in the reform bill.

13) SAVINGS - MHSP program; Currently funded with 100% State funds, now will receive Federal funding. If the HIFA waiver is not moved then most of this population would qualify under reform. The amount of savings is unclear if the HIFA waiver is moved prior to January 1, 2014.

14) (Inpatient Hospital Tax) Disproportionate Share Hospital (DSH) payments would be reduced under the proposal beginning in 2017. However, there is no savings to the state as tax amounts are 100% allocated back as payments. Less payments would have an equal decline in tax; this equates to less Federal costs and money to state hospitals for DSH.

15) Administrative costs. Administrative costs total 6.2% of total benefits with the state share equal to 2.6% of total benefit costs. Estimate assumes that administrative costs ratio(s) would continue to equal 6.2% of new expenditures overall and 2.6% for the state share. For example under this assumption, if benefit expenditures double, administrative costs overall and to the state would also double.

16) Administrative costs in 2014 are estimated at a full year amount as start-up costs assumed to be higher than a half year amount.

17) ** Montana is analyzing potential costs of IT system changes for health care reform; the preliminary estimate is $1.9 million state costs overall. Changes include eligibility determination, health insurance exchange, Medicaid claims processing, and federal reporting requirements. The bill would require the changes to occur prior to January 1, 2014. It is estimated that a majority of the system update costs would be born in SFY 2013. Assume costs of $750,000 in SFY 2012 and $1,150,000 in SFY 2013.

Attachment 3

National Conference of State Legislatures *444 North Capitol Street, N.W., Suite 515* *Washington, D.C. 20001*

SUMMARY OF THE STATE GRANT OPPORTUNITIES IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: H.R. 3590
(May 24, 2010)

Rachel Morgan, Senior Health Policy Specialist

TABLE OF CONTENTS

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Insurance Reforms					
HEALTH INSURANCE CONSUMER INFORMATION.	Title I, Subtitle A, Sec. 1002	FY 2010	Appropriated $30 million for the FY 2010. Additional funding is authorized to be appropriated as necessary for subsequent fiscal years.	None	• Authorizes grants to states for the establishment, expansion, and or provision of support for— 1. offices of health insurance consumer assistance; or 2. health insurance ombudsman programs. **ELIGIBILITY** • To be eligible a state must designate an independent office of health insurance consumer assistance, or ombudsman that receives and responds to inquiries and complaints concerning health insurance coverage with respect to federal health insurance requirements and under state law. • Programs must operate in compliance with criteria established by HHS. **DUTIES**. The office of health insurance consumer assistance or health insurance ombudsman will: • assist with the filing of complaints and appeals, including filing appeals with the internal appeal or grievance process of the group health plan or health insurance issuer involved and providing information about the external appeal process; • collect, track, and quantify problems and inquiries encountered by consumers; • educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage; • assist consumers with enrollment in a group health plan or health insurance coverage by providing information, • referral, and assistance; and • resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986. **DATA COLLECTION**. As a condition of receiving a grant an office of health insurance consumer assistance or ombudsman program will be required to collect and report data to HHS on the types of problems and inquiries encountered by consumers.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Insurance Reforms					
HEALTH INSURANCE CONSUMER INFORMATION (continued)	Title I, Subtitle A, Sec. 1002	FY 2010	Appropriated $30 million for the FY 2010. Additional funding is authorized to be appropriated as necessary for subsequent fiscal years.	None	**DATA COLLECTION**. HHS will use the data to identify areas where more enforcement action is necessary and share the information with the insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of these agencies. **CORRESPONDING INFORMATION** • **Health Care Reform Insurance Web Portal Requirements**. Interim final rules 45 CFR Part 159 published May 10, 2010. Comments will be accepted on the rule until June 4, 2010. The portal must be available for public use no later than July 1, 2010.
PREMIUM REVIEW GRANTS	Title I, Subtitle A, Sec. 1003	FY 2010	Appropriates $250 million beginning FY 2010 through FY 2014. No eligible state will receive less than $1 million or more than $5 million for a grant year. Grant amounts will be determined through an HHS formula allocation.	None	**PREMIUM REVIEW GRANTS DURING 2010 THROUGH 2014.** Authorizes the awarding of grants to states beginning with FY 2010 and over a five-year period to assist in carrying out the following: • reviewing and approving premium increases for health insurance coverage; • providing information and recommendations to HHS; and • establishing centers to analyze and organize information, and to make the information available to the issuers, health care providers, health researchers, health care policy makers, and the general public. **MEDICAL REIMBURSEMENT DATA CENTERS** A center must— • develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates; • use the best available statistical methods and data processing technology to develop such fee schedules and other database tools; • regularly update such fee schedules and other database tools to reflect changes in charges for medical services; • make health care cost information readily available to the public through an Internet website that allows consumers to understand the amounts that health care providers in their area charge for particular medical services; and

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Insurance Reforms					
PREMIUM REVIEW GRANTS (continued)	Title I, Subtitle A, Sec. 1003	FY 2010	Appropriates $250 million beginning FY 2010 through FY 2014. No eligible state will receive less than $1 million or more than $5 million for a grant year. Grant amounts will be determined through an HHS formula allocation.	None	**MEDICAL REIMBURSEMENT DATA CENTERS** A center must— • regularly publish information concerning the statistical methodologies used by the center to analyze health charge data and make such data available to researchers and policy makers. • adopt by-laws that ensure that the center is independent and free from all conflicts of interest and not controlled or influenced by and does not have any corporate relation to any individual or entity that may make or receive payments for health care services based on the centers analysis. **CORRESPONDING INFORMATION** • States are required by Section 1003 of the Patient Protection and Affordable Care Act to work with the Secretary in establishing a process for the annual review of premium increases for health insurance coverage beginning with the 2010 plan year. • HHS Request for information April 14, 2010, 45 CFR Parts 146 and 148.
ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES—PLANNING AND ESTABLISHMENT GRANTS	Title I, Subtitle D, Part 2, Sec. 1311	FY 2011	As determined by the Secretary of Health and Human Services for each fiscal year.	None	**PLANNING AND ESTABLISHMENT GRANTS** Appropriates funding for grants to states to support planning activities relating to the establishment of an American Health Benefit Exchange. Grants will be awarded within 1 year of the date of enactment of health reform legislation. The secretary may renew a grant if a state is making progress toward establishing an exchange; and implementing a consumer assistance program, a premium review process, and health insurance market reforms and is meeting the benchmarks the secretary has established. **LIMITATION** No grant may be awarded after January 1, 2015.

GRANT PROGRAM TITLE	Citation	Implementation Date	Funding	Matching Requirements	SUMMARY
Insurance Reforms					
ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES— PLANNING AND ESTABLISHMENT GRANTS (CONTINUED)	Title I, Subtitle D, Part 2, Sec. 1311	FY 2011	As determined by the Secretary of Health and Human Services for each fiscal year.	None	**CORRESPONDING INFORMATION** • States are required by Section 1311 of the Patient Protection and Affordable Care Act to establish an American Health Benefit Exchange by January 1, 2014 for the state that: **1.** Facilitates the purchase of qualifies health plans, **2.** Provide for the establishment of a Small Business Health Option Program designed to assist small employers in the state in facilitating enrollment of their employees in a qualified health plan.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Health Workforce					
School-Based Health Clinic/ Center Grants (SBHCs)	Title IV, Subtitle B, Sec. 4101	FY 2010	Appropriates $50 million for fiscal years 2010 through 2013	None	Establishes a grant program for the establishment and operation of school-based health centers (SBHC). To be eligible for a grant an entity must: • Be a SBHC or a sponsoring facility of an SBHC, and • Submit an application containing information that awarded funds will only be used for authorized services or allowed by federal, state or local law. • In awarding grants preference will be given to SBHC that serve a large population of children eligible for medical assistance or the state child health plan. • Funds may be used for; 1. Facilities including acquisition or improvement of land, acquisition, construction, expansion, replacement, or other improvements of any building or other facility, 2. Equipment, or 3. Similar expenditures. • No funds may be used for personnel or to provide services.
Continuing Educational Support for Health Professionals Serving in Underserved Communities	Title V, Subtitle E, Sec. 5504	FY 2010	Authorizes $5 million for FY 2010 through 2014 and such sums as necessary for subsequent fiscal years	None	Establishes grants for eligible entities including health professions schools, academic health centers, **State or local governments**, or other appropriate public or private nonprofit entities to support activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and tele-learning activities, with priority for primary care.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Health Workforce					
Demonstration Projects to Address Health Professions Workforce Needs	Title V, Subtitle F, Sec. 5507	FY 2011	$85,000,000 for each of fiscal years 2010 through 2014	None	• Establishes grants to conduct a demonstration project designed to provide low-income individuals with an opportunity to receive an education and training for occupations in the health care field. • Eligible entities include states, Indian tribes or tribal organizations, institutions of higher education, a local workforce investment board, or a sponsor of an apprenticeship program. • Within 18 months of enactment HHS in conjunction with the Department of Labor will award grants to **six-states** to conduct this demonstration project over a three-year period for purposes of developing core training competencies and certification programs for personal or home care aides. • The core training competencies for personal or home care aides include competencies with respect to the following areas: 1. The role of the personal or home care aide. 2. Consumer rights, ethics, and confidentiality. 3. Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills. 4. Personal care skills. 5. Health care support. 6. Nutritional support. 7. Infection control. 8. Safety and emergency training. 9. Training specific to an individual consumer's needs. 10. Self-care. **REQUIREMENTS FOR STATES** Participating states will be required to • implement the core training competencies, and • develop written materials and protocols for the core training competencies, including the development of a certification test for personal or home care aides who have completed the training competencies.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Medicaid					
STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS **PLANNING GRANTS**	Title I, Subtitle I, Sec. 2703 (a)	January 1, 2011	$25 million. Funding will be available until expended.	States must contribute an amount equal to the State Medicaid match for each fiscal year the grant is awarded.	**PLANNING GRANTS** • Authorizes planning grants for states choosing to participate in the new Medicaid state plan option promoting health homes for enrollees with chronic conditions. • The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) or a health team selected by an eligible individual with chronic conditions to provide health home services. • Participants in the plan must be Medicaid enrollees with at least two chronic conditions or with one chronic condition and at risk of developing another chronic condition. • The designated provider or a team of health professionals will offer the following services: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant and as feasible use health information technology to link such services. • The plan option will provide an enhanced match of 90 percent FMAP for two years. • The state plan amendment must include a requirement for participating hospitals to establish procedures for referring participating beneficiaries who seek or need treatment in a hospital emergency department to designated providers. • Requires states to consult and coordinate with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among beneficiaries with chronic conditions. • State plan amendments must include: 1. a methodology for tracking avoidable hospital readmissions and calculating savings as a result of improved management, and 2. a proposal for use of health information technology in providing health home services, and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Medicaid					
PROGRAM FOR HEALTHY LIFESTYLES	Title IV, Subtitle B, Sec. 4108	January 1, 2011	$100 million	None	Sec. 4108 **c**reates a **grant program for states** to provide incentives to Medicaid beneficiaries who participate in a program to develop a healthy lifestyle. These programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes, and may address co-morbidities, such as depression, associated with these conditions. Grants will be awarded over a five-year period, and the program must be carried out by a State within a three-year period.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Medicare					
Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards	Title X, Subtitle C, Sec. 10323	FY 2010	Appropriates $23 million for FY2010 through 2014, and $20 million for each five fiscal year period thereafter.	None	• Establishes a program of competitive **grants** for the purpose of screening at-risk individuals for environmental health conditions, and • Development and dissemination of public information concerning the availability of screening, treatment, and Medicare coverage under the program. **Eligible Entities** • Entities eligible to apply for this grant include: 1. A hospital or community health center, **2.** A federally qualified health center (FQHC), **3.** A facility of the Indian Health Service, **4.** A National Cancer Institute-designated cancer center, **5.** **An agency of any state or local government**, **6.** A nonprofit organization, and **7.** Any other entity the secretary determines appropriate.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
QUALITY, PREVENTION & WELLNESS					
Grants for Early Childhood Home Visitation Programs	Title I, IV, Sec. 2951	September 2010	Appropriates $100 million for fiscal year (FY) 2010, $250 million for FY 2011, $350 million for FY 2012, $400 million for FY 2013, and $400 million for FY 2014. Reserves three percent of available funding for grants to Indian tribes.	None	▪ Authorizes the secretary to award grants to states for the purpose of establishing an early childhood home visitation program to promote the following: 1. Improvements in maternal and prenatal health, 2. Infant health, 3. Child health and development, 4. Parenting related to child development outcomes, and 5. School readiness in child abuse, neglect and injuries ▪ Authorizes grant awardees to use funds in the initial six month period for the purpose of for planning and implementation activities to assist with the establishment of the program. ▪ **Program requirements include:** 1. Quantifiable, measurable improvements in benchmark areas for eligible families participating in the program in each of the following areas: ▪ Improved maternal newborn health, ▪ Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits, ▪ Improvement in school readiness and achievement, ▪ Reduction in crime or domestic violence, ▪ Improvements in the coordination and referral of community resources and supports. ▪ Awardees are expected to develop and implement a plan to improve outcomes in each of the areas listed. • Directs states to file a report with the secretary information demonstrating improvements in at least four of these areas after the end of the first three year period. Failure to comply or demonstrate improvement will result in termination of the grant. ▪ Requires submission of a final report to the secretary no later than December 31, 2015.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Quality, Prevention & Wellness					
Grants for Early Childhood Home Visitation Programs	**Sec. 2951**	September 2010	Appropriates $100 million for fiscal year (FY) 2010, $250 million for FY 2011, $350 million for FY 2012, $400 million for FY 2013, and $400 million for FY 2014. Reserves three percent of available funding for grants to Indian tribes.	None	**Sec. 2951 (continued) Grants for Early Childhood Home Visitation Programs** ▪ **Core Program Components** 1. Service Delivery Model or Models ▪ Requires that the model conforms to a clear consistent home visitation model that has been in existence for at least three years and is researched-based, grounded in empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education with quality home visitation program standards, with demonstrated positive outcomes, or ▪ The model conforms to a promising and new approach to achieve the benchmark areas specified and the participant outcomes and has been developed or identified by a national organization or institute of higher education, and will be evaluated through a well-designed and rigorous process. 2. Majority of grant funding is used for evidence-based models. Prohibits the use of more than 25 percent of awarded funding to in a given fiscal year for operation of the service delivery model program. 3. Criteria for evidence of effectiveness of models. Directs the secretary to establish criteria for evidence of effectiveness of the service delivery models. ▪ Requires that the program employ well-trained staff such as nurses, social workers, educators, and child development specialists.

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Grants for Early Childhood Home Visitation Programs	**Sec. 2951**	September 2010	Appropriates $100 million for fiscal year (FY) 2010, $250 million for FY 2011, $350 million for FY 2012, $400 million for FY 2013, and $400 million for FY 2014. Reserves three percent of available funding for grants to Indian tribes.	None	▪ **Service Priorities** 1. Eligible families in the community in need of services as identified by the state needs assessment, 2. Low-income families, 3. Families including those, ▪ who are pregnant women under age 21, ▪ with a history of child abuse or neglect, ▪ with a history of substance abuse, ▪ who are users of tobacco products at home, ▪ have children with low student achievement, ▪ have children with developmental delays, and ▪ include individuals who are serving or have formerly served in the Armed Forces. ▪ **Maintenance of Effort Requirement**–requires states to maintain funding for other sources for early childhood home visitation programs and initiatives. Eligible entities are defined as meaning a state, an Indian tribe, tribal organization, or urban Indian organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.
ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND	**Title X, Subtitle B, Part 2, Sec. 10212**	FY 2010	$25,000,000 for each of fiscal years 2010 through 2019.	None	• Directs the Secretary of Health and Human Services (HHS) in coordination with the Secretary of Education to establish a Pregnancy Assistance Fund to be administered by HHS and to award competitive grants to states for the purpose of assisting pregnant and parenting teens and women. • States may provide grant funding to eligible institutions of higher education to support the establishment, maintenance, and operation of pregnant and parenting student services. • Funding must be used to supplement and not supplant existing funds for these services. • In order to be eligible for funding, it requires that institutions of higher education provide matching support equal to 25 percent of the federal funds provided.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Quality, Prevention & Wellness					
ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND (continued)	**Title X, Subtitle B, Part 2, Sec. 10212**	FY 2010	$25,000,000 for each of fiscal years 2010 through 2019.	None	• Funding must be used for the following programs and activities: 1. Conduct a needs assessment on campus and within the local community, ▪ to assess pregnancy and parenting resources, located on the campus or within the local community, that are available to meet the; and ▪ to set goals for, • improving the resources for pregnant, parenting, and prospective parenting students; and • improving access to the resources. ▪ Conduct an annual assessment of the institutions of higher education on their performance in meeting the following needs of students: • The inclusion of maternity coverage and the availability of riders for additional family members in student health care. • Family housing. • Child care. • Flexible or alternative academic scheduling, such as telecommuting programs, to enable pregnant or parenting students to continue their education or stay in school. (v) Education to improve parenting skills for mothers and fathers and to strengthen marriages. • Maternity and baby clothing, baby food (including formula), baby furniture, and similar items to assist parents and prospective parents in meeting the material needs of their children. • Post-partum counseling. 2. Identify public and private service providers, located on the campus of the institution or within the local community that is qualified to meet the needs identified, and establishes programs with qualified providers to address them. 3. Assist pregnant and parenting students, fathers or spouses in locating and obtaining needed services.

Grant Program Title	Citation	Implementation Date	Funding	Matching Requirements	Summary
Quality, Prevention & Wellness					
ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND (continued)	**Title X, Subtitle B, Part 2, Sec. 10212**	FY 2010	$25,000,000 for each of fiscal years 2010 through 2019.	None	4. If appropriate, provide referrals for prenatal care and delivery, infant or foster care, or adoption, to a student who requests the information. Referrals may only be made to providers that service the following: ▪ Parents. ▪ Prospective parents awaiting adoption. ▪ Women who are pregnant and plan on parenting or placing the child for adoption. ▪ Parenting or prospective parenting couples. • States will be required to report annually on the institutions receiving funds and the number of students served by service. • States may make funding available to high schools and community service centers for the same purpose funds are awarded to institutions of higher education with all the same conditions and requirements imposed. • States may also provide funding to their attorney general to assist statewide offices in providing intervention services, accompaniment, and supportive social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault, or stalking. Funding may also be used to provide technical assistance and training relating to violence against eligible pregnant women to be made available to law enforcement agencies, and courts: professionals working in legal, social service, and health care settings; nonprofit organizations; and faith-based organizations. • Funding for state attorneys general must be provided by application through the state.