Patient Protection and Affordable Care Act (P.L. 111-148): Potential Funding Opportunities for States

The following chart provides a brief summary of many of the funding opportunities contained in the Patient Protection and Affordable Care Act (PPACA), which was signed into law on March 23, 2010 (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). In some instances the law would make funding available for the current federal fiscal year 2010. However, the precise timing, funding amounts, and distribution method that will be used by the Secretary of Health and Human Services (HHS) remains unclear at this time. The chart does not discuss the enhanced FMAP for the Medicaid expansion that takes effect in 2014 or the two-year mandatory increase in reimbursement for certain services delivered by Medicaid primary care physicians. While the chart includes descriptions and limitations associated with the programs, it does not reflect the entirety of the requirements, including reporting requirements, for each initiative discussed.

Several provisions of the PPACA authorize new programs or discretionary funding. Such provisions may authorize a specified level of funding to be appropriated for each federal fiscal year or it may be vague (providing "such sums as may be necessary"). The authorization of appropriations does not provide or guarantee funding will be provided, but rather is intended to provide guidance regarding the amount of funds appropriate to carry out the authorized program/initiative. Through a separate process, Congress will determine if and how much funding to appropriate for these discretionary agencies and programs. These decisions will be made during consideration of the fiscal year 2011 appropriations measures and in each subsequent annual appropriations process.[1]

In addition, PPACA directly provides funding for some agencies and programs, bypassing the two-step authorization-appropriation process. Such spending is referred to as direct spending.[2]

Additional information about the program requirements and limitations may be found at: http://finance.senate.gov/legislation/details/?id=61f4fb98-a3d0-d85c-d33f-f2c598e1d138[3]

[1] The normal appropriations process typically begins with the President's budget proposal in early February. The House and Senate then move to adopt a budget resolution. Both chambers then consider appropriations legislation to finalize the specific funding available for the federal fiscal year beginning September 1. See: "Overview of the Authorization-Appropriation Process", Congressional Research Services: http://www.rules.house.gov/archives/rs20371.pdf)

[2] Some direct spending is entitlement program spending funded by permanent appropriations in the authorizing law. Other direct spending – referred to as appropriated entitlements – such as Medicaid, is funded in appropriations acts, but the amount appropriated is controlled by the authorizing legislation. See: "Overview of the Authorization-Appropriation Process", Congressional Research Services: http://www.rules.house.gov/archives/rs20371.pdf

[3] The pages referenced in the table correspond to the PDF document posted on the Senate Finance Committee website. The text of the reconciliation measure (P.L.111-152) can be found at: http://www.rules.house.gov/bills_details.aspx?NewsID=4606

Program/ Initiative	Description	Funding	Availability	Limitation
Consumer related initiatives (Page 37, Section 1002)	• HHS will award grants to states to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. • State must have independent office of health insurance consumer assistance, or an ombudsman, that coordinates with state health insurance regulators and consumer assistance organizations concerning federal health insurance coverage requirements and state law.	• Direct appropriation to HHS for $30 million in grants to states for the first fiscal year. [4] • In subsequent years, there is authorization for such sums as necessary.	• Funds remain available until expended.	
Annual rate review process for health insurance premiums (Page 40, Section 1003)	• HHS will award grants to states to establish a process for annual review, beginning with the 2010 plan year, of unreasonable increases in premiums for health coverage. States grant recipients would have to provide HHS with data on premium increase trends and make recommendations on insurer participation in the	• Direct appropriation to HHS of $250 million for grants to states to support the review process. • HHS determines funding allocation formula, considering the number of health plans in a state and population. • Eligible states would receive between $1 and $5 million per grant year.	• Grant program is for a five year period, fiscal year 2010 through fiscal year 2014. • At the end of FY 2014, any remaining funds will be available as grants to eligible states for planning and implementation of certain insurance reforms and consumer protection related provisions.	• State must provide information to HHS and make recommendations to the Exchange based on its rate reviews.

[4] The effective date is the date of enactment, March 23, 2010.

Program/ Initiative	Description	Funding	Availability	Limitation
	state-based exchange. • Insurers would also submit information to HHS. • States			
High Risk Pools (HRP) ***(Page 45, Section 1101)***	• HHS will establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals until January 1, 2014. • HHS may operate a program directly or contract with states and other eligible entities.	• Direct appropriation of $5 billion to HHS to pay claims for HRP enrollees, as of January 1, 2010.	• HHS would establish program within 90 days after the date of enactment.	• MOE on the annual funding amount expended for the operation of one or more state HRPs during the year prior to when a state enters into a contract to operate a temporary HRP.
Health Insurance Exchange State Option ***(Page 130, Section 1311)***	• HHS will award grants to states for planning and activities related to the establishment of a state-based Exchange and a Small Business Health Options Program (SHOP). • Prior to January 1, 2013, states must choose whether they will establish and operate an Exchange. • In the case of a state that chooses not to establish an Exchange, there is a federal fallback to operate the Exchange.	• Direct appropriation to HHS. The amount will be based on the Secretary's determination of the total amount of funding that would be necessary for purposes of the grant program. • HHS determines the allocation formula for making grants to states. • HHS would reimburse each state for reasonable start-up costs for any exchange or SHOP exchange.	• Grants would be available within one year of enactment. • Grants may be renewed prior to 2015 if a state demonstrates it is making progress in meeting Exchange requirements. • No grants will be awarded after January 1, 2015.	• No payments would be available for operational costs after initial start-up completed. • State must ensure exchange is self-sustaining beginning January 1, 2015. Exchange may assess each exchange participating plan its proportional share of such costs.
Transitional Reinsurance	• By January 1, 2014, states are required to establish	• Federal assessments to insurers will total $25	• Effective for plays years beginning in 2014 through	• By January 1, 2014, states must adopt state law or

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Program for Individual and Small Group Markets (page 226, Section 1341)	(or enter into contract with) one or more applicable entities to operate a temporary reinsurance program which would provide reimbursement for partial costs of premiums. • All insurers and Third Party Administrators (TPAs) are required to make payments to the reinsurance entity. Non-grandfathered individual market plans covering high-risk individuals will receive payments from the reinsurance entity.	billion over the period 2014 through 2016. • States may collect additional amounts from insurers, including for administrative expenses to operate the program.	2016. • Insurer contributions are specified for plan years 2014, 2015, and 2016. • Remaining insurer payments may be used for the state reinsurance program in plan years 2017 and 2018.	regulation concerning guidelines for this program. • HHS can stop taking applications for participation in the program based on the availability of funding.
Enrollment health information technology (HIT) for health and human services programs (Page 370, Section 1561)	• HHS grants to eligible entities, including states, to develop new and adapt existing technology systems to implement HIT enrollment standards and protocols. • HIT systems will be used to enroll individuals in federal and state health and human services programs.	• Not specified	• Enrollment HIT systems adopted using these grants would be available to other qualified state, political subdivisions, or other qualified entities at no cost.	
Medicaid Community First Choice Option (page 461, Section 2401)	• Establishes the Community First Choice program. • States that take up the	• States that take up the option will receive a 6 percentage point increase in FMAP for HCBS	• States may take up the option as of October 1, 2011.[5]	• States that take up the option would be required to make certain HCBS attendant services and

[5] The reconciliation measure (P.L. 111-152) changed the effective date to October 1, 2011 from October 1, 2010.

Program/ Initiative	Description	Funding	Availability	Limitation
	option would receive an FMAP increase for providing HCBS for people with disabilities who require an institutional level of care.	attendant services.		supports available to eligible individuals.
Medicaid Money Follows the Person demonstration program (page 482, Section 2403)	• Extends existing demonstration authority to award grants to states for the Medicaid Money Follows the Person program, established by the Deficit Reduction Act (P.L. 109-171).[6]	• Direct appropriation to HHS for $2.25 billion to extend the program.	• Funding available for fiscal years 2011 through 2016.	• Existing program requirements, with a modification to reduce the length of stay requirement to 90 days from 6 months.
Medicaid home and community based services (HCBS) (Page 2141, Section 10202)	• Creates the State Balancing Incentives Program to provide a temporary FMAP increase for HCBS for states that undertake structural reforms to increase diversion from institutions and expand the number of people receiving HCBS.	• States spending less than 25% of total long-term care services and supports (LTSS) expenditures on HCBS will be eligible to receive a 5% increase; states with 25-50% will receive a 2% increase.		
Aging and Disability Resource Centers (ADRCs) (page 484, Section 2405)	• The ADRC program provides states with funding to streamline access to long-term care supports and services.	• Direct appropriation to HHS-AoA of $10 million annually.	• Funding available for each fiscal year 2010 through 2014.	• Existing program requirements.
Maternal, Infant, and Early Childhood Home Visitation Grant	• The home visitation program would provide grants to states and other eligible entities to implement evidenced-	• Direct appropriation to HHS totaling $1.5 billion over 5 years.	• Specific allocation provided for fiscal years 2010 through 2014. • HHS determines the time	• State grant recipients must conduct a statewide needs assessment. • Grant funds must

[6] See: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_public_laws&docid=f:publ171.109.pdf

Program/ Initiative	Description	Funding	Availability	Limitation
Program (pg 561, Section 2951)	based models to improve services for families in at-risk communities.		period for the grant. • Grants made in a fiscal year will be available through the end of the second succeeding fiscal year after the award.	supplement, not supplant, state funds.
Personal Responsibility Education Grant Program (page 596, Section 2953)	• Personal responsibility education grant program focused on educating adolescents about abstinence and contraception.	• $75 million per year • State allotments with minimum grant amount to states would $250,000. • State allotments will be determined by the formula specified in the law.	• Fiscal years 2010 through 2014. • Allotments for a fiscal year remain available through the end of the second succeeding fiscal year.	• Grant funding must be used to supplement, not supplant, state funding for similar programs/ initiatives in fiscal year 2009. • If a state does not submit an application for fiscal year 2010 or 2011, the state will not be eligible to submit an application to receive funds from the allotted amount for the state for in fiscal years 2012 through 2014. Instead, HHS could use these funds to award three-year grants to eligible local entities – in states that do not submit applications – for fiscal years 2012 through 2014. HHS also will use unexpended amounts from state allotments that would otherwise expire to award a three-year grant to eligible entities for fiscal years 2012 through 2014.

Program/ Initiative	Description	Funding	Availability	Limitation
Medicaid Health Home for Enrollees with Chronic Conditions: planning grant (page 522, Section 2703)	• Beginning January 1, 2011, there is a Medicaid state option to provide coordinated care to enrollees with chronic conditions. • HHS to establish minimum standards for health homes. • HHS will award planning grants to states to develop a state plan amendment.	• $25 million maximum planning grant award per state. A total amount for planning grants is not specified. • States will receive a 90 percent FMAP for such health home services during the first eight fiscal year quarters that the state plan amendment is in effect.	• HHS may make planning grants awards to states beginning January 1, 2011. • Planning grant funding available until expended.	• State contribution required in order to receive a planning grant.
Medicaid Integrated Care Hospitalization Demonstration Program (page 532, Section 2704)	• Establishes a demonstration program to allow states to use bundled payments to promote integration of care around hospitalization.	• HHS may select up to eight states to participate. • No specific funding authorization included in this section. [7]	• January 1, 2012 through December 31, 2016.	•
Medicaid Global Payment System Demonstration Project (page 536, Section 2705)	• Establishes the Medicaid Global Payment System demonstration program to allow states to test paying a safety net hospital system or network using a global capitated payment model. • Will operate in coordination with the Center for Medicare and Medicaid Innovation. • Budget neutrality requirements under	• HHS may select up to five states to participate. • Authorization for an appropriation of such sums as necessary.	• Fiscal years 2010 through 2012.	

[7] While no specific funding was authorized, HHS-CMS may have the flexibility to operate demonstration programs using other authority, for example existing authority and through the new Center for Medicare and Medicaid Innovation.

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	Section 1115A will not apply during the testing and evaluation period for the demonstration project.			
Pediatric Accountable Care Organization Demonstration Program (page 538, Section 2706)	• Establishes the Pediatric Accountable Care Organization Demonstration Project which authorizes a participating state to allow pediatric medical providers that meet certain requirements to be recognized as an accountable care organization for purposes of receiving incentive payments .	• Authorization for such sums as necessary.	• Authorizes program from January 1, 2012 through December 31, 2016.	• Budget savings requirement.
Medicaid Emergency Psychiatric Demonstration Project (page 540, Section 2707)	• Establishes program for emergency psychiatric demonstration project to provide incentive payments to certain institutions for mental disease.	• Appropriates $75 million for fiscal year 2011. • HHS establishes method to allocate funds.	• Funds allocated beginning fiscal year 2011. • Three year period for demonstration project. • Funds available for obligation through December 31, 2015.	
Trauma Care Centers (page 1081, Section 3505)	• Grant program to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties. • States would apply for grant and in turn award grants to eligible entities.	• Authorization for $100 million for each fiscal year 2010 through 2015. • Specific distribution method based on approved appropriation for any fiscal year.	• Authorizes funding for fiscal years 2010 through 2015.	• States must award at least 40% of their grant funding to safety net trauma centers. • A state may not use more than 20% of its grant for administrative expenses. • The state must supplement, not supplant, state funding otherwise

Program/ Initiative	Description	Funding	Availability	Limitation
				available for similar purposes.
Medicaid Preventive Services (page 1169, Section 4106)	• Provides FMAP incentive payment to states that eliminate cost-sharing requirements for Medicaid clinical preventive services that have been recommended by the U.S. Preventive Services Task Force (USPSTF) and for vaccines for adults.	• 1 percentage point increase in FMAP for states that eliminate cost sharing for preventive services and vaccines for adults.	• Enhanced match available beginning January 1, 2013.	
Medicaid Chronic Disease Incentive Payment Program (page 1174, Section 4108)	• HHS-Centers for Disease Control and Prevention (CDC) to award grants to states to test approaches that may encourage behavior modification for healthy lifestyles among Medicaid enrollees and to determine scalable solutions. • HHS to conduct education/outreach campaign to make states aware of grant program.	• Appropriates $100 million for the 5- year period beginning by January 1, 2011.	• Grants to states awarded after HHS develops program criteria, but no later than January 1, 2011. • Grants to states will be for a 5- year period, beginning by January 1, 2011. • State initiatives will be carried out for at least a 3-year period. • Amounts appropriated remain available until expended.	
Community Transformation Grants (page 1182, Section 4201)	• Establishes competitive grant program for states and local governmental agencies and community-based organizations to promote evidence-based community preventive health activities intended to reduce chronic disease	• Authorization for such sums as may be necessary for each fiscal year 2010 through 2014.	• Authorization of funding fiscal years 2010 through 2014.	

Program/ Initiative	Description	Funding	Availability	Limitation
	rates, address health disparities, etc.			
Healthy Aging, Living Well public health grant program (page 1188, Section 4202)	• CDC to award grants to states or local health departments and Indian tribes for pilot programs to provide public health community interventions, screenings, etc. for individuals between ages of 55 and 64.	• Authorizes such sums as necessary.	• Authorization for funding for 5-year pilot programs, fiscal years 2010 through 2014	
Immunization Coverage Improvement Program (Page 1199, Section 4204)	• CDC demonstration program to award grants to states to improve immunization coverage for children, adolescents, and adults. • Grants for implementing interventions recommended by the Task Force on Community Preventive Services.	• Authorizes such sums as necessary.	• Authorization for funding for fiscal years 2010 through 2014.	
CHIP Obesity Demonstration Program (page 1242, Section 4306)	• Extends funding for the childhood obesity demonstration program established under CHIPRA (P.L. 111-3).	• Direct appropriation to HHS-CMS totaling $25 million.	• Fiscal years 2010 through 2014.	
CHIP Outreach Grants (page 2161, Section 10203)	• Extends and increases funding for a program to award grants to states and other eligible entities to improve outreach and enrollment in the CHIP program, as established under CHIPRA (P.L. 111-3).	• Direct appropriation for $140 million for fiscal years 2009 through 2015. CHIPRA originally appropriated $100 million for fiscal years 2009 through 2013.	• Funding is extended for an additional two years, fiscal years 2014 and 2015.	• Maintenance of effort on state funding for outreach and enrollment activities, based on state spending in the fiscal year preceding the fiscal year of the grant award.

Program/ Initiative	Description	Funding	Availability	Limitation
State Workforce Development Grants (page 1274, Section 5102)	• Health care workforce development grant program for states to develop and implement workforce strategies at the state and local level. • Administered by the Health Resources and Services Administration (HRSA) within HHS.	• Planning grants: authorization for $8 million for fiscal year 2010 and such sums as necessary thereafter. Up to $150,000 per state partnership. • Implementation grants: authorization for $150 million for fiscal year 2010. Competitive grant award process.	• Planning grants: available starting federal fiscal year 2010. Grants awarded for activities for up to one year. • Implementation grants: grants may be used for up to 2 years. HRSA may extend grant funding for one year for high performing grantees for eligible activities.	• Planning grants require a minimum 15% match (in cash or in kind). Match source may be from other federal, state, local or private sources. • Implementation grants require a minimum 25% match (in cash or in kind). Match source may be from other federal, state, local or private sources. • At least 60% of implementation grant funds must be used to make grants to address health care workforce development needs.
State and Regional Centers for Health Workforce Analysis (Page 1285, Section 5103)	• HHS to award grants to states and eligible entities to support data collection and analysis and provide technical assistance to local entities for such activities. Data will be used by the National Center for Health Care Workforce Analysis. • Eligible entities may also be selected to conduct longitudinal evaluation of individuals who have received education, training, or financial assistance from certain workforce programs.	• Authorization for $4.5 million per year for each of fiscal years 2010 through 2014. • Authorization for such sums as necessary for longitudinal analysis for fiscal years 2010 through 2014.	• Authorizes funding for fiscal years 2010 through 2014.	• State/regional center must coordinate with national center.

Program/ Initiative	Description	Funding	Availability	Limitation
Grants to Promote the Community Health Workforce (Page 1364, Section 5313)	• CDC to award grants to states and eligible state agencies to use of community health workers to promote positive health behaviors and outcomes in medically underserved communities.	• Authorization for such sums as necessary.	• Authorizes funding for fiscal years 2010 through 2014.	
Primary Care Extension Program (Page 1404, Section 5405)	• AHRQ to administer a Primary Care Extension Program. • HHS will competitively award grants to states to establish state- or multistate-level Primary Care Extension Program State Hubs. States must develop a six year plan.	• Authorization for $120 million for each of fiscal years 2011 and 2012, and such sums as may be necessary for fiscal years 2013 and 2014.	• Program grants would be awarded to state or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of six years. • Two-year planning grants are awarded to state or multistate entities with the goal developing a plan for a Hub. • States may receive additional assistance after the six year of support if they receive satisfactory evaluations.	• State may not use more than 10% of grant for admin. • Grant funds cannot be used for funding direct patient care.
Elder Justice Services (page 1763, Section 6701)	• Expands the permissible uses for grants under the Social Service Block Grant (SSBG) program to include elder justice related activities. • Creates Elder Justice Coordinating Council and an Advisory Board on Elder Abuse, Neglect, and Exploitation.	• Authorizes such sums as necessary for the Coordinating Council provisions.	• Not specified.	

Program/ Initiative	Description	Funding	Availability	Limitation
Adult Protective Services (APS) Grant Program (page 1795, Section 2042)	• Establishes program for HHS to award grants to states to enhance the provision of APS. •	• Authorizes $100 million for each of fiscal years 2011 through 2014 for adult protective services grants. Grant amount is based on appropriated funds multiplied by percentage of total number of elders in that state. Establishes a minimum grant amount for states and territories.	• Authorizes funding for fiscal years 2011 through 2014	• Grants may not supplant other federal, state and local resource for such purposes.
State Demonstration Program Concerning Elder Abuse (Page 1798, Section	• Establishes grant program for states to conduct demonstration programs to test methods of elder abuse detection or prevention.	• Authorizes $25 million for each of fiscal years 2011 through 2014.	• Authorizes funding for fiscal years 2011 through 2014.	
State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation (Page 2369, Section 10607)	• HHS to award demonstration grants to states to develop alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations.	• Authorizes $50 million for the five fiscal years beginning with 2011 for the demonstration projects and related provisions in this section. • HHS may use part of the appropriated funds to provide initial planning grants to states, up to $500,000 per state. • Five percent of the amount appropriated each year is reserved for evaluation of the state demonstration programs.	• Authorizes grant funding to be awarded for up to 5 years.	