

Department of Health ARRA Tracking – Teri Green

Item number	DOH Contact	Program Description	ARRA						
			Total Dollars	Total Wyoming Dollars	Eligibility/Criteria Factors/Conditions	Duration	State Budget Impact	Implementation Requirements Department Approach	Deadline
	Teri Green	<p>FMAP</p> <p><i>B, Title V, Sec. 5001</i></p> <p>White Papers:</p> <ul style="list-style-type: none"> • ARRA FMAP • ARRA Clawback Calculations <p>Pursuant to the American Recovery and Reinvestment Act, (ARRA) each state will receive a FMAP increase of 6.2 %, effective October 1, 2008 and extending through December 31, 2010. This increase (total \$87 billion) will provide, on a temporary basis, additional federal matching funds to help states maintain their Medicaid programs in the face of recession-driven revenue declines and caseload increases. The FMAP increase applies to Medicaid, Foster Care and Adoption Assistance. Three types of temporary assistance are available during the period October 1, 2008, through December 31, 2010.</p>	\$87 Billion	Will potentially result in \$59 million or more for Wyoming Medicaid, based upon current budget	Reporting Requirements	Through December 2010	The state budget impact will be directly proportionate to the increased match.	Pending instruction from Feds	None
	Teri Green	<p><u>Additional FMAP</u></p> <p><i>B, Title V, Sec. 5001</i></p> <p><i>Unemployment-Related FMAP Increase</i> –Further opportunities in the ARRA provide for additional FMAP if a state experienced at least a 1.5 percentage point growth in its unemployment rate calculated as the growth between the state’s average monthly unemployment rate for the three-consecutive-month period and the lowest average monthly unemployment rate for the state for any three-consecutive-month period proceeding the most recent period, but beginning on or after Jan. 1, 2006.</p>		At this point Wyoming does not qualify for this additional increase. If Wyoming would qualify for any of the consecutive 3 month periods, the additional FMAP would be as follows:					<p>Update as of May 13, 2009: For the most current three month period, we are around 4.0, our base is 2.8. We need to be at 4.3 to receive additional match on top of the base.</p>

	Lloyd Wilder Department of Insurance Need to transfer	<p><u>COBRA Healthcare for the Unemployed</u></p> <p>Background: In general, to be eligible for COBRA a worker must have worked for an employer with 20 or more employees, have been enrolled in the employer's health plan, and have lost his/her health coverage due to termination of employment for reasons other than gross misconduct. Under COBRA, workers must pay 100% of the premium plus 2% in administrative costs.</p>							
	Teri Green Cliff Mikesell Kim Latta	<p><u>Moratoriums</u></p> <p>In 2007 and 2008, CMS issued seven Medicaid regulations that generated controversy during the 110th Congress. To address concerns with the impact of the regulations, Congress passed a law that imposed moratoria on six of the Medicaid regulations until April 1, 2009 (excluding the rule on outpatient hospital facility and clinic services). The seven Medicaid regulations covered the following Medicaid areas:</p> <ul style="list-style-type: none"> • Graduate Medical Education, • Cost Limit for Public Providers, • Rehabilitation Services, • Targeted Case Management, • School-Based Services, • Provider Taxes, and • Outpatient Hospital Services. <p>The provision in the ARRA extends the moratorium through June 30, 2009 for the regulations pertaining to: targeted case management, provider taxes, and school based administration and transportation services. It also adds a moratorium to the regulation for outpatient hospital services through June 30, 2009 (includes expenditures for services furnished from December 8, 2008-June 30, 2009</p>	-0-	-0-	There is no significant impact to Wyoming Medicaid based on this provision. Wyoming does not participate in school based services/transportation or provider taxes. We are prepared administratively to implement the other regulation. There is no funding in the provision and no fiscal impact to Wyoming.		None	The provision sets forth a "Sense of Congress" that the Secretary of HHS should not promulgate final regulations for cost limits to certain providers, graduate medical education, and rehabilitative services.	
	Linda O'Grady	<p><u>Qualified Individuals - QI</u></p> <p><i>B, Title V, Sec. 5005</i></p> <p>Medicare Savings Programs cover individuals who are income eligible under 100% of the Federal Poverty Level. Qualified Medicare Beneficiaries' (QI) benefits include payment of Medicare premiums, deductibles and cost sharing. Certain low-income individuals who are aged or have disabilities as defined</p>	From January 1,2010, through September 30,2010, the total allocation amount	These expenditures for Medicare premiums are paid at 100% federal funding so there should			This program has always been extended regardless of the sunset dates. The provision in the ARRA will extend this program through	Extension of the Qualifying Individual Program. The ARRA provides a for a one-year extension of the qualifying individual program (through December 2010) with an allocation of \$412.5 million for the period between January 1, 2010 and September 30, 2010 and \$150 million for the period between October 1, 2010 and December 31, 2010.	

		<p>under the Supplemental Security Income (SSI) program and who are eligible for Medicare are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program.</p> <p>The QI program is paid 100% by the federal government from the Part B Trust fund. The total amount of federal QI spending is limited each year and allocated among the states. States are required to cover only the number of people that would bring their annual spending on these population groups to their allocation levels</p>	<p>would be \$412.5 million, and</p> <p>October 1, 2010, through December 31, 2010, the total allocation amount would be \$150 million.</p>	be no impact.			<p>December 31, 2010, allowing Wyoming Medicaid to continue paying a portion of the Medicare cost for qualified recipients. Wyoming currently has 470 recipients in this program.</p>	(SCI)
<p><u>Jim Bush</u> Andy Corbin Teri Green Lee Clabots</p>	<p>HIT B, Title IV, Sec. 4201</p> <p>White Papers:</p> <ul style="list-style-type: none"> • HIT • HIT Work Plan • Wyoming Vision for HIE • IT Project White Paper <p>The ARRA Health Information Technology (HIT) funding includes \$2 billion in "jump-start" funding the Office of the National Coordinator for Health Information Technology. This is immediate, discretionary funding that the national coordinator can distribute via grants or low-interest loans to hospitals and physician practices for implementation of electronic health records and other HIT. The Department of Health and Human Services will define the degree to which jump-start funds are grants or loans.</p> <p>The funding also includes \$17 billion in Medicare and Medicaid incentive payments for medical providers over a period of several years. Physicians who have not adopted certified electronic records systems by 2014 will see decreased reimbursement. Currently states do not receive federal financial participation for the purchase, adoption and use of electronic health records, or for the operation and maintenance of such systems.</p> <ul style="list-style-type: none"> • HIE Letter of Intent • Blumenthal grant POC 	<p>\$ 2 Billion +</p> <p>\$ 17 Billion</p>		<p>The HIT provision in the ARRA authorizes a 100% federal match for a portion of payments to encourage the adoption of EHR technology (including support services and maintenance) to certain Medicaid providers who meet certain requirements. The state must prove to the Secretary that allowable costs are paid directly to the provider without any deduction or rebate; that the provider is responsible for payment of the EHR technology costs not provided for; and, that for costs not associated with purchase and initial implementation, the provider certifies meaningful use of the EHR technology. Across</p>	<p>Possible long-term savings through reduced medical errors</p>	<p>Through 2019</p>	<p>Here is a report on the ATA webinar and the telehealth meeting from today. During the webinar they went over the various amounts as was outlined in the email I sent earlier today, they supplemented with some of the timetables, for example they said the plan for spending and allocations would be out Thursday, and even if not all out then, most are expected long before the 5/1/09 deadline written into the act, so keeping a close eye on their web pages will be required. They also reminded us that the usual appropriations bills will be coming soon, which seems to include an additional \$15 million for small hospitals to</p>	

					<p>all eligible provider categories the provision provides Medicaid incentives towards the use of certified EHR technology based on a provider's involvement in the Medicaid program or other care for the uninsured and low-income populations. In addition the ARRA also allows for expanded funding to pediatricians, federally qualified health clinics (FQHCs), and rural health clinics (RHCs).</p> <ul style="list-style-type: none"> • 100 percent federal payment for state payments to certain Medicaid providers attributable to certified EHR technology. • 90 percent federal payment for state payments attributable to reasonable administrative expenses for EHR technology. 		<p>improve their HIT capabilities. Their list of 6 things to do now include</p> <ol style="list-style-type: none"> 1) Immediate assessment of past and current proposals - what is "shovel ready". 2) Identify priorities where money could go- focusing on one time capital expenditures, not ongoing costs. 3) assign staff to the grant writing who can also review the various agencies (Commerce, USDA and HHS) for timely updates as the grant process shapes up. 4) Identify sources for matching funds 5) Identify new extensions of existing funds- such as our FCC grant money, and expansion with the IHS, FQHC's , etc) 6) Look for new partners. <p>Most was fairly general at this stage but I feel the ATA site will help us stay on top of those funding resources.</p> <p>At the Telehealth work group, we had a great turnout with Joe Ahern from the OCIO, WMS, WHA, UW, both CRMC and WMC, and others. We are moving forward with our clinical</p>	
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								<p>consultations and emergency consult elements of telehealth, and CRMC has filled the first of their two positions- thanks to the OHRP grant. After the legislative session the second position will be filled, presuming the \$235K request continues to survive. The telehealth bill (HB 0281) passed the senate committee yesterday without amendment unanimously, so if it makes it through the senate floor without changes it will be a go. We then discussed ARRA, and how the Governor has asked you to be the point for health on the stimulus bill, as far as the State was concerned. I think this committee is a good way to help you get input from the various constituencies. Some of the things we pointed out to them I am excited about is , for example, how there is up to \$75,000 per physician for implementation of EHR's under Medicaid. Sheila Bush from the WMS was very interested in hearing about that, and it could really kick-start acceptance and use of the THR. Hospitals look like they could get \$2</p>	
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								<p>million for the same. Coordination of grants looks to be key here, so I asked this group what they felt the key areas that should be considered as a focus should be. These include</p> <ol style="list-style-type: none"> 1) Expansion of the FCC grant under the Broadband capabilities part of the act. 2) Physician incentives to adopt the THR 3) Funding of set-up of the networking and scheduling components for the Telehealth network for consultations and emergencies, and publication of a provider directory. 4) 2 new bridges 5) connecting the IHS into the system 6) partnering with the VA (they were at this meeting as well and want to participate.) 7) helping providers who want to provide consults and participate with telehealth with the equipment to do so. 8) Doing comparative effectiveness studies. 	
	<p>Update as of May 13, 2009: The Department is creating a "library" of information to use when the grant criteria becomes available. We are working on setting up the Sharepoint site to gather data from our providers so we can write our "shopping List" for the grant for telehealth and the THR. We have the first draft completed. After final review we will post and start working on getting providers to log in and complete information for their facility.</p>								
	<p><u>Health Information Technology (Health IT)</u></p>								

- The ARRA has three major components relating to the development of health IT that will be of interest to states: (1) a grant program for states (or state-designated entities) to plan for and help build an electronic health records (HER) exchange; (2) a loan program, to be administered by states, to help providers purchase the equipment they need to “plug into” the exchange; and (3) financial assistance to providers through Medicaid for the purchase and use of health IT equipment, with no matching funds required.
- The bill gives the states a great deal of responsibility for planning and helping create a nationwide EHR exchange. States will need to develop capacity in their Medicaid programs and other agencies to deliver and oversee the provider payments for EHRs.
- States receiving health IT grants will need to move quickly to create a business and oversight plan for the exchange—which includes choosing how patient records will be transmitted, stored, and protected and how the exchange will be financed. It appears that the grants could also be used to purchase and house the exchange directly or support industry-based construction.
- Governors will need to focus on three major activities to get the full advantage of this funding: (1) Agency capacity and potential legislation will be needed to get the Medicaid-based incentives implemented and ensure accountability; (2) states should immediately begin planning with stakeholders how to govern an EHR exchange and how to ensure standards-based purchases by providers; and (3) states will need to work with HHS and begin their own planning efforts to design grant and loan programs that reflect state interests and contribute to other health care reform efforts.

Electronic Health Record (EHR) Technology

Incentives for Providers to Adopt EHR Technology - \$63,750 (per Medicaid Provider) [B.IV]

Under the ARRA, the federal government will provide contributions for amounts states pay to eligible Medicaid providers to encourage the adoption of EHR technology, in order to promote health care quality and the exchange of health care information. The contributions can be as much as \$21,250 per provider for the first year of payments (which may not be later than 2016), and as much as \$8,500 for up to five years thereafter. Providers eligible for both Medicare and Medicaid incentive payments are required to choose one.

Eligible providers include physicians, nurses and midwife nurses who are not hospital based and whose patient volume is at least 30 percent attributable to Medicare. Such providers are eligible for payment of up to 85 percent of their net allowable technology costs, up to the maximum and subject to specified annual limits. Acute care hospitals with Medicaid patient volume of 10 percent or more and children’s hospitals with any Medicaid volume are also eligible. Payments to hospitals are limited to amounts analogous to those specified for Medicare hospitals in § 4312 of the Act.

In order to be eligible for federal contributions, states must provide assurances that the amounts are paid directly to Medicaid providers without deductions or rebates. States may receive contributions for the administrative costs of making payments to encourage the use of certified EHR technology. Additionally, the state must conduct adequate oversight of its EHR technology encouragement program.

Incentives for Hospitals to adopt EHR Technology - Variable Amount (per Hospital) [B.IV]

The ARRA provides funding for hospitals that are “meaningful users” of EHR technology, as defined by the ARRA. The hospital must demonstrate (via attestation, claim submission, survey, or other method specified by the Secretary) that meaningful EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care coordination. Information relating to clinical quality measures must be submitted in a form and manner specified by the Secretary.

The amount of federal funding for each hospital using EHR technology is determined by a formula contained in Section 4102(a)(1) of the ARRA, with a base amount of \$2 million. Critical Access Hospitals may receive additional EHR technology-related payments under Section 4102(a)(2) of the ARRA.

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C. National Coordinator for Health Information Technology

Grants to the Office of the National Coordinator for Health Information Technology - \$2 billion [A.VIII]

The ARRA allocates \$2 billion to the Department of Health and Human Services’ Office of the National Coordinator for Health Information Technology (ONCHIT) for efforts to create a national medical record database. Of this allocation, **\$300 million** is designated for “regional or sub-national efforts” toward health information exchange.

Immediate Funding to Strengthen the Health Information - At least \$300 million Technology Infrastructure [A.XIII]

The ARRA requires the Secretary of Health and Human Services (HHS Secretary) to promote the use and exchange of electronic health information (HIT). Funds are to be administered through federal agencies with expertise to support the following: (1) HIT architecture to support the secure electronic exchange of information; (2) electronic health records for providers not eligible for HIT incentive payments under Medicare and Medicaid; (3) training and dissemination of information on best practices to integrate HIT into health care delivery; (4) telemedicine; (5) interoperable clinical data repositories; (6) technologies and best practices for protecting health information; and (7) HIT use by public health departments.

The HHS Secretary is required to invest \$300 million to support regional health information exchanges, and may use funds to carry out other authorized activities.

Health Information Technology Implementation Assistance [A.XIII]

The ARRA requires the HHS Secretary, acting through the National Coordinator for HIT, in consultation with NIST and other agencies, to establish an HIT extension program to assist providers in adopting and using certified electronic health resource technology. The Secretary is also required to support HIT Regional Extension Centers affiliated with non-profit organizations to provide assistance to providers in the region. The Secretary is required to give priority to public, non-profit, and critical access hospitals, community health centers, individual and small group practices, and entities that serve the uninsured, underinsured and medically underserved individuals. Funded entities may receive up to four years of funding to cover up to 50 percent of their capital and annual operating and maintenance expenditures.

The HHS Secretary is required to publish a notice describing the program and the availability of funds within 90 days of the date of enactment (by May 18, 2009). Each regional center receiving funding would be required to submit to a biennial evaluation of its performance against specified objectives, and continued funding after two years is contingent on receiving a positive evaluation. The HHS Secretary may require an annual report. An annual review by the National Coordinator for HIT is required.

State Grants to Promote Health Information Technology [A.XIII]

The National Coordinator for HIT is authorized to award planning and implementation grants to states or qualified state-designated entities to facilitate and expand electronic health information exchange.

The state or state-designated entity (as defined under § 3013(f) of the Public Health Service Act) must submit a plan describing the activities to be carried out to facilitate HIT exchange. States must contribute a certain portion of matching funds after FY 2011 and

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the HHS Secretary has the discretion to require such matching funds before then. The Secretary may require annual reports. An annual review by the National Coordinator for HIT is required.

Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology [A.XIII]

The National Coordinator for HIT is authorized to award competitive grants to states and Indian tribes to establish loan programs for health care providers to purchase EHR technology, train personnel in the use of that technology and improve the secure exchange of health information. Grantees would be required to (1) establish a qualified HIT loan fund, (2) submit a strategic plan, updated annually, that describes the intended uses of the funds and provides assurances of their proper use by health care providers, and (3) provide matching funds (at least \$1 for every \$5 of federal funds).

No awards are permitted under this subsection before January 1, 2010. The HHS Secretary may require an annual report. An annual review by National Coordinator for HIT is required.

Demonstration Program to Integrate Information Technology Into Clinical Education [A.XIII]

The ARRA authorizes the HHS Secretary to award competitive grants to graduate health education programs to integrate HIT into the clinical education curriculum. Grantees must submit a strategic plan. The grant cannot cover more than 50 percent of the costs of any assisted activity (absent a waiver). The HHS Secretary may require an annual report. An annual review by the National Coordinator for HIT is required.

Information Technology Professionals in Health Care [A.XIII]

The ARRA requires the HHS Secretary to provide financial assistance to universities to establish or expand medical informatics programs, in consultation with the Director of the National Science Foundation. Such grants cannot cover more than 50 percent of the costs of any assisted activity (absent a waiver). The HHS Secretary may require an annual report. An annual review by the National Coordinator for HIT is required.

D. National Institute of Standards and Technology

Research and Development Programs [A.XIII]

The ARRA requires the National Institute of Standards and Technology (NIST), in consultation with the National Science Foundation (NSF) and other federal agencies, to award competitive grants to universities or research consortia for establishing multidisciplinary Centers for Health Care Information Enterprise Integration. The Centers are to generate innovative approaches to the development of a fully interoperable national health care infrastructure, as well as develop and use HIT.

Grants are to be awarded on a "merit-reviewed, competitive basis." The NIST Director will establish rules governing submission of applications, which must, at minimum, describe the proposed Center's research projects, how the Center will promote interdisciplinary collaboration, technology transfer activities to diffuse research results, and how the Center will contribute to education and training.

	Linda O'Grady	<u>Transitional Medical Assistance</u> <i>B, Title V, Sec. 5004</i>		We currently budget for this program on an ongoing basis				We recommend exercising the state's option to extend the program to 12 months, which would provide more time for clients to obtain insurance and would
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		<p>States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires states to provide at least six, and up to 12 months of coverage for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. These work-related TMA requirements have been funded by a series of short-term extensions, most recently through June 30, 2009.</p> <p>The TMA provision of the ARRA extends work-related TMA under Section 1925 for 18 months through December 31, 2010. The provision also would give States the flexibility to extend an initial eligibility period of 12 months of Medicaid coverage to families transitioning from welfare to work, in which case the additional 6-month extension would not apply. The ARRA gives states the option of waiving the requirement that a family must have received Medicaid in at least three of the last six months in order to qualify.</p>		<p>since it has always been extended regardless of the sunset dates.</p> <p>When a child is eligible under this group of TMA – they do not lose eligibility since they have continuous coverage for 12 months so I only looked at the program code for adults – A68.</p> <p>Expenditures last SFY - \$5,300,000 50% 2,650,000 (state share)</p> <p>With ARRA 43.8% \$2,321,400 (state share)</p> <p>\$338,600 reduction/ year \$677,200 2 years</p> <p>If we were to elect the state plan options to make some</p>			<p>make the program more efficient and effective. We will need a new system report to monitor this program in order to meet the reporting requirements.</p> <p>• Extension of Transitional Medical Assistance (TMA). The ARRA provides for an eighteen-month extension of work-related TMA (through December 31, 2010). States may use a 12-month, rather than 6-month, initial extension period for families transitioning from welfare to work (in which case the additional 6-month extension no longer applies). States may also grant extensions to families that have received such aid for less than three months. States are subject to statistical reporting requirements, with reports due to HHS. (SC1)</p>
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				changes to how we determine eligibility, the expenditures would grow. Not sure how many additional would be eligible but the cost would be approximately \$4000 a year.				
Linda O'Grady	<p><u>Protections for Indians under Medicaid</u></p> <p><i>B, Title V, Sec. 5006</i></p> <p>No cost sharing or premiums may be imposed on Indians receiving items or services through the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services; provider payments may not be reduced. The bill also exempts tribal property from resource consideration in eligibility determination for medical assistance. The bill continues exemption from estate recovery of certain Indian property. The bill also includes provisions concerning access to Indian health care providers in managed care. The legislation requires states with one or more Indian Health Program or Urban Indian Organization furnishing health care services to seek advice from these organizations on an ongoing basis and on state plan amendments, waiver requests, or demonstration projects likely to have a direct effect on them.</p>	\$ 134 million	-0-				<p>Impact on WY Medicaid: Minimal. Medicaid does not impose premiums or cost sharing on services provided by I H S, since these services are paid by encounter rates set by the federal government and reimbursed with 100% federal fund. When a Medicaid eligible American Indian receives services from Medicaid providers outside of I H S, a copayment is required for adult clients. Since I H S or the Tribe pays this copayment it limits their funds. A minor MMIS change will be required to exempt these clients from copayment and a special card may be required.</p>	
Renee Propps	<u>Disproportionate Share Hospitals</u>		Estimated additional DSH			The state budget impact will be in	Administrative Requirements	

		<p>White Paper:</p> <ul style="list-style-type: none"> • DSH <p>B, Title V, Sec. 5002</p> <p>program. Federal partners for Medicaid are Health and Human Services, Centers for Medicare and Medicaid Services (CMS).</p> <p>DSH is a Federally Mandated Program that requires states to make disproportionate share (DSH) adjustments to the payment rates of certain hospitals treating large numbers of low income and Medicaid patients — recognizing the disadvantaged situation of those hospitals. States must define, in their state Medicaid plan, hospitals qualifying as DSH hospitals and DSH payment formulas. DSH hospitals must include <i>at least</i> all hospitals meeting minimum criteria and may not include hospitals that have a Medicaid utilization rate below 5%.</p> <p>The DSH payment formula must also meet minimum criteria, and DSH payments for any specific hospital cannot exceed a hospital-specific cap based on the unreimbursed costs of providing hospital services to Medicaid and uninsured patients. However, within these broad guidelines states also have a great deal of discretion in designating DSH hospitals and calculating adjustments for them. For this reason, Congress has required states to report the methods used to identify and pay DSH hospitals and the payments made to each of the identified hospitals. Beginning in FY2004 and for certain subsequent fiscal years, states are allotted 16% more than the amounts previously available. In addition, the number of states able to qualify for low DSH payments and the allotments for those low DSH states were raised. Wyoming is a “low-DSH” state and because of our methodology we fall 2 years behind many states</p>		<p>Funds for Wyoming:</p> <p>2.5% (\$5,543) for 2009.</p>			<p>proportion to federal match</p>	<p>Temporary Increase in Disproportionate Share Hospital (DSH) Allotments. The ARRA provides for a temporary increase in the DSH allotment for each state. For FY 2009, this provision will increase DSH allotments by 2.5 percent above the allotments states would have received under preexisting law. States’ DSH allotments in FY 2010 will be equal to the FY 2009 allotments further increased by 2.5 percent. These increases will only apply if the state would not receive a larger increase under preexisting law. DHS allotments for FY 2011 and beyond will be calculated without regard to the temporary increases.</p>
		<p><u>Pandemic Flu Preparedness</u></p>	<p>The final ARRA conference agreement does not include funding for pandemic influenza preparedness and biomedical advanced research and development.</p>					
		<p><u>Public Health and Wellness</u></p> <p>A, Title VIII, Prevention and Wellness Fund</p> <p>White Papers:</p>	<p>The conference agreement includes \$1,000,000,000 for the Prevention and Wellness Fund. Up to 0.5 percent of the funds provided may be used for management and oversight expenses. Additionally, the conference agreement includes language proposed by the House that funding may be transferred to other appropriation accounts of the Department of Health and Human Services (HHS), as determined by the Secretary of HHS to be appropriate.</p>					

<p>Linda Chasson</p> <p>Molly Bruner</p> <p>Immunization – Robert Greenwelge</p>	<ul style="list-style-type: none"> ● Immunization ● ASC White Paper ● HAI 	<p>Within the total, the conference agreement includes \$300,000,000 to be transferred to the Centers for Disease Control and Prevention (CDC) to carry out the section 317 immunization program. Within the total, the conference agreement includes \$50,000,000 to be provided to States for carrying out activities to implement healthcare-associated infections (HAI) reduction strategies. Also within the total, the conference agreement includes \$650,000,000 to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act, as determined by the Secretary, that deliver specific, measurable health outcomes that address chronic disease rates. The conference committee agreed to \$1 billion in funding for the prevention and wellness fund. Up to 0.5 percent of the funding may be allocated to management and oversight. The conference committee includes language that funding may be transferred to other appropriate accounts within HHS as determined by the Secretary. Within the \$1 billion, \$650 million is allocated to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act that deliver specific, measurable health outcomes that address chronic disease rates.</p> <p>Under the broad category of Direct Appropriations, CDC will receive \$ 1 billion in the ARRA bill. Of this amount, \$ 300 million is categorically appropriated to Immunizations</p> <ul style="list-style-type: none"> · CDC has established a planning committee to develop a comprehensive outline of how the non-immunization funds will be used. This plan must be submitted and reviewed by the House and Senate before the appropriation will be sent. · The Immunization Services Division has established a working group to discuss how the \$300 million immunization carve out will be utilized. · The immunization portion is expected to be transmitted to the CDC Financial Management Office (FMO) in early April. · At this time, it is not known how much will be provided in spending authority for operations or vaccine purchase authority. · It is likely that these funds will be made available via a Supplemental Grant Application/Award process which will be developed by the Procurement and Grants Office (PGO). Supplemental applications are expected to be due 30 days after publication by PGO in the Federal Register. <p>Sent to: SHOs, SHO assistants, Senior Deputies; Alumni; State Legislative Liaisons and ASTHO Affiliates</p> <p>INFORMATION IS CHANGING MOMENT TO MOMENT. THE FOLLOWING INFORMATION IS CURRENT AS OF NOON FRIDAY FEBRUARY 23.</p> <ul style="list-style-type: none"> ● It is unknown how much of the \$650 Million of Prevention and Wellness (P&W) will go to state health departments. ● No definitive models or funding mechanisms have been adopted for how the \$650 Million for Prevention and Wellness will be used by the HHS Secretary. ● These dollars may not move as quickly as stimulus dollars in other areas, so there can be more thought on how they can be a down payment on health reform ● The White House and Dora Hughes are formulating plans and looking for a large initiative integrated across HHS. ● HHS may hold back \$550 million to invest in the "big idea." CDC may or may not get to manage the dollars for the big idea. ● Dr. Besser is chairing the internal HHS stimulus workgroup on the P&W dollars. The workgroup is reviewing over 80 proposals from across HHS for P&W activities seeking funding ● It is unclear how much funding will be passed to CDC. Rumor has it that CDC would get \$100 M for Healthy Communities and perhaps another \$1M for a few other areas yet to be determined ● Congress provided \$300M for the Sec 317 Immunization Program in the stimulus package. ASTHO is participating in a working group with CDC and states to provide input on the funding allocation formula and reporting requirements. Additionally, many states have referred to data from FFIS on state allocations of 317 stimulus funding. CDC's Immunization Program informed ASTHO that these data are not accurate, as allocations have not yet been determined. We urge caution in using these allocations to make plans for spending the immunization dollars.
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			<ul style="list-style-type: none"> The stimulus package included \$50M for states to address Healthcare-Associated Infections. ASTHO is talking with HHS and CDC officials about options, and is planning to convene a conference call for states to provide input to CDC. <p>PUBLIC HEALTH AND COMMUNITY PREVENTION WILL BE JUDGED BY HOW SUCCESSFULLY WE MOVE THE MONEY WE RECEIVE AND HOW WE DEMONSTRATE 2 THINGS:</p> <ol style="list-style-type: none"> Health Impact on a national scale Economic impact in lowering health expenditures <p>That of the amount provided in this paragraph, \$650,000,000 shall be to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the PHS Act, as determined by the Secretary, that deliver specific, measurable health outcomes that address chronic disease rates: <i>Provided further</i>, That funds appropriated in the preceding proviso may be transferred to other appropriation accounts of the Department of Health and Human Services, as determined by the Secretary to be appropriate: <i>Provided further</i>, That of the amount appropriated in this paragraph, \$50,000,000 shall be provided to States for an additional amount to carry out activities to implement healthcare associated infections reduction strategies:</p> <p>APRIL 16 UPDATE ON IMMUNIZATION: Of the \$300 million, there will be a total of \$198 million provided to the 64 immunization projects in a non-competitive manner. Of this amount, Wyoming will receive \$409,026. CDC has made a commitment that at least 75% of the non competitive funds must be used for vaccines. The remaining \$102 million of the targeted \$300 million will be used to competitively fund several demonstration projects, which are only available to CDC immunization projects.</p>
Teri Green / Joe Grandpre for THR		<p><u>Healthcare Effectiveness</u></p> <p><i>A, Title VIII, Department of Health & Human Services, Agency for Healthcare Research Quality</i></p>	<p>Research - NGA memo p. 20; \$1.1B provided to speed development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies. \$1.1 billion for comparative effectiveness research. The funding is to be used to conduct or support research to evaluate and compare the clinical outcomes, effectiveness, risk and benefits of two or more medical treatments and services that address a particular medical condition. The conference report includes special language that indicates that the conferees do not intend for the comparative effectiveness research funding be used to mandate coverage, reimbursement, or other policies for any public or private payers. That within the amount available in this paragraph for the Agency for Healthcare Research and Quality, not more than 1 percent shall be made available for additional full-time equivalents.</p> <p>In addition, \$400,000,000 shall be available for comparative effectiveness research to be allocated at the discretion of the Secretary of Health and Human Services (“Secretary”): <i>Provided</i>, That the funding appropriated in this paragraph shall be used to accelerate the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies, through efforts that: (1) conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions; and (2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data: Some funding may be available for agencies for work with the evidence-based health promotion and disease prevention programs.</p>
		<p><u>Federally Qualified Health Centers/ Community Health</u></p>	<p>NGA memo p. 20; \$1.5B directed to federally qualify health centers (FQHCs) for construction, modernization, health information technology</p>

		<p>Centers Title VIII HHS</p> <p><i>A, Title VIII, Department of Health & Human Services, Health Resources and Services</i></p>	<p>and improvements. Additional \$500M appropriated for FQHC grant funding for services and operations \$1.5 billion available for grants for construction, renovation and equipment, and for the acquisition of health information technology systems, for health centers including health center controlled networks receiving operating grants under section 330 of the Public Health System</p> <table border="1" data-bbox="1212 240 2467 391"> <thead> <tr> <th>State</th> <th>Number of Grants</th> <th>Amount</th> <th>Projected New/Retained Jobs</th> <th>Estimated New Patients</th> <th>Estimated New Uninsured Patients</th> </tr> </thead> <tbody> <tr> <td>WY</td> <td>5</td> <td>\$764,943</td> <td>12</td> <td>3,312</td> <td>1,880</td> </tr> </tbody> </table>	State	Number of Grants	Amount	Projected New/Retained Jobs	Estimated New Patients	Estimated New Uninsured Patients	WY	5	\$764,943	12	3,312	1,880
State	Number of Grants	Amount	Projected New/Retained Jobs	Estimated New Patients	Estimated New Uninsured Patients										
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	Michelle Ammerman	<p>Aging Services</p> <p><i>A, Title VIII, Administration on Aging, Aging Services Program</i></p> <ul style="list-style-type: none"> * AoA ARRA Funding Distribution for Nutrition Services * ARRA Nutrition FAQs * ARRA Nutrition Funding * C1 WP ARRA Nutrition * C2 Request ARRA Nutrition 	<p>Senior Nutrition Programs - The conference committee includes \$100 million in additional funding for senior nutrition programs as proposed by the Senate. Within the \$100 million, the conferees determined that \$65 million must be allocated to congregate meals and \$32 million is available to home-delivered nutrition services. \$3 million is also provided to the Native American nutrition services. The funding is available immediately upon enactment of the legislation.</p> <p>There is a state match requirement for this grant.</p> <p>As of March 30, 2009 the Potential AoA Funding Distribution for Nutrition Services for Wyoming is: Congregate Nutrition - \$325,000; Home-Delivered Nutrition - \$160,000.</p> <ul style="list-style-type: none"> * The Administration on Aging is still working to define all of the rules, so no action can be taken at this time. 												
	Not DOH	<p>Payments to Social Security, Supplemental Security Income, Railroad Retirement Benefits, and Veterans Disability Compensation or Pension Benefits (Sec. 2201):</p>	<p>A one-time \$250 payment will be issued to an individual eligible under the enumerated programs in any month during the three month period prior to the enactment of the stimulus. This payment does not apply to individuals who receive SSI while in a Medicaid institution. An individual eligible under more than one program will receive only one payment. The Secretary of the Treasury must issue the payment as soon as possible, but no later than 120 days after enactment. Payments are disregarded as a resource for purposes of eligibility under any federal program or any state or local program financed in whole or in part with federal funds. This disregard is effective for the month of receipt and the following nine months. The payments are not considered taxable income.</p>												
	Jim Rolf	<p><u>Community Services Block Grant:</u></p>	<p>\$1 billion of additional funding is provided for the CSBG program. The Conference agreed to the Senate language that would make the entire amount available within enactment of the program. The agreement includes language that will permit states to reserve 1 percent of their allocation for benefit coordination services and to distribute the remaining funds directly to local eligible entities. It also permits states to increase the income eligibility ceiling from 125 percent to 200 percent of the federal poverty level (FPL) for services furnished under the CSBG for FY09 and FY10.</p> <p>During the call on February 17, a question was asked concerning whether CSBG funding that requires coordination of benefits would be allowed to support Aging and Disability Resource Centers. Following NASUA's review of the language of the bill, we note it provides that one percent of the funding "shall be used for benefits enrollment activities relating to identification and enrollment of eligible individuals and families in Federal, State and local benefit programs" but does not define benefit enrollment activities nor does it give any other detail about how that may be accomplished. The funding for CSBG must flow through designated "eligible entities" and relates specifically to housing, healthcare, employment, and nutrition.</p> <p>Wyoming's share of the \$1 billion in CSBG stimulus money will be \$5 million and the application for the funds must be received by May 29, 2009. There is no administration funding included, however there is adequate funding from the federal CSBG funding from the ongoing CSBG program for administration.</p>												

			<p>Update as of May 13, 2009: The NAFR has been approved for the CSBG-ARRA program. We are preparing an application that is due at the Administration of Children & Families/Office of Community Services by May 29 and are awaiting the governor's signature on a letter certifying that the Department of Health is the agency designated to oversee program activities.</p>
		<p>Rural Community Facilities Program (Division A, Title I): <i>A, Title I, Rural Housing Services, Rural Community Facilities Program Account</i></p>	<p>\$130 million is set aside in the bill for the cost of direct loans and grants for essential rural community facilities programs, including hospitals, health clinics, health and safety vehicles and equipment, public buildings and child and elder care facilities, as authorized by section 306 and described in section 381E(d)(1) of the Consolidated Farm and Rural Development Act.</p>
		<p>Centers for Independent Living (Division A, Title VIII): <i>A, Title VIII, Department of Education, Rehabilitation Services and Disability Research</i></p>	<p>The bill provides for \$87.5 million for independent living centers. \$680 million is added to the Rehabilitation Act of 1973 of which \$34.3 million "shall be for services for older blind individuals." This funding is described in the bill under the Department of Education</p>
Jim Rolf Mary Randolph		<p><u>Homelessness Prevention</u> (Title XII Department of Housing and Urban Development)</p>	<p>\$1.5 billion is set aside for homelessness prevention and rapid re-housing activities including short term and medium term rental assistance, housing relocation and stabilization services. Funding will be available until September 30, 2011 and shall be allocated to eligible grantees as defined in the McKinney-Vento Homelessness Act by formula. Grantees may use up to five percent of any grant for administrative costs. Grantees must collect data on how the funds are used and the persons served using the HUD Management Information System or comparable data base. 60 percent of the funds must be spent within two years of the funds becoming available and 100 percent within three years. Up to one half of one percent is available for staffing, training, technical assistance, technology, monitoring and evaluation.</p> <p>"For homelessness prevention and rapid re-housing activities, \$1,500,000,000, to remain available until September 30, 2011: <i>Provided</i>, That funds provided under this heading shall be used for the provision of short-term or medium-term rental assistance; housing relocation and stabilization services including housing search, mediation or outreach to property owners, credit repair, security or utility deposits, utility payments, rental assistance for a final month at a location, moving cost assistance, and case management; or other appropriate activities for homelessness prevention and rapid re-housing of persons who have become homeless:</p> <p><i>Provided further</i>, That grantees receiving such assistance shall collect data on the use of the funds awarded and persons served with this assistance in the HUD Homeless Management Information System ("HMIS") or other comparable database: <i>Provided further</i>, That grantees may use up to 5 percent of any grant for administrative costs: <i>Provided further</i>, That funding made available under this heading shall be allocated to eligible grantees (as defined and designated in sections 411 and 412 of subtitle B of title IV of the McKinney-Vento Homeless Assistance Act, (the "Act")) pursuant to the formula authorized by section 413 of the Act: <i>Provided further</i>, That the Secretary may establish a minimum grant size: <i>Provided further</i>, That grantees shall expend at least 60 percent of the funds for obligation, and 100 percent of funds within 3 years of such date, and the Secretary may recapture unexpended funds in violation of the 2-year expenditure requirement and reallocate such funds to grantees in compliance with that requirement: <i>Provided further</i>, That the Secretary may waive statutory or regulatory provisions (except provisions for fair housing, nondiscrimination, labor standards, and the environment) necessary to facilitate the timely expenditure of funds: <i>Provided further</i>, That the Secretary shall publish a notice to establish such requirements as may be necessary to carry out the provisions of this section within 30 days of enactment of this Act and that this notice shall take effect upon issuance: <i>Provided further</i>, That of the funds provided under this heading, up</p>

			<p>to .5 percent shall be available for staffing, training, technical assistance, technology, monitoring, research and evaluation activities: <i>Provided further</i>, That funds set aside under the previous proviso shall remain available until September 30, 2012: <i>Provided further</i>, That any funds made available under this heading used by the Secretary for personnel expenses related to administering funding under this heading shall be transferred to “Community Planning and Development Personnel Compensation and Benefits” and shall retain the terms and conditions of this account including reprogramming provisions except that the period of availability set forth in the previous proviso shall govern such transferred funds: <i>Provided further</i>, That any funds made available under this heading used by the Secretary for training or other administrative expenses shall be transferred to “Administration, Operations, and Management” for non-personnel expenses of the Department of Housing and Urban Development: <i>Provided further</i>, That any funding made available under this heading used by the Secretary for technology shall be transferred to “Working Capital Fund.”</p> <p>As required by the American Recovery and Reinvestment Act of 2009, HUD published the Notice for the Homelessness Prevention Fund on March 19. It is available at www.hud.gov/recovery. The Notice changes the name of the program to the Homelessness Prevention and Rapid Re-housing Program (HPRP). It identifies eligible grantees and the requirements for receiving funding, eligible activities, eligible participants, reporting requirements, and other critical information for grantees and sub-grantees. In order to receive funding, grantees must submit a substantial amendment to their Consolidated Plan 2008 Action Plan for the HPRP. HUD has created a form that grantees must use for this substantial amendment. It is also posted on the HUD site (form number HUD-40119); along with the certifications grantees must sign. In addition to the Notice and substantial amendment, the following resources will be available for grantees, sub-grantees and other stakeholders:</p> <ol style="list-style-type: none"> 1. March 20th: Q & A document for HPRP posted on HUD’s Homeless Resource Exchange (HRE). 2. March 23rd: On-line “Virtual Help Desk” goes live, for questions about Homelessness Prevention and Rapid Re-housing Program (HPRP) 3. March 25th: Sample community documents related to prevention and rapid re-housing posted to HUD HRE. 4. March 27th: On-line searchable database of Questions and Answers. 5. April 8th: HUD webcast dedicated to HPRP. <p>HUD encourages all interested parties to read the Notice completely and thoroughly and review the Q & A resources before asking questions about HPRP. All questions should be directed to the virtual help desk that will be available on the HUD HRE beginning next Monday (March 23).</p>
Lee Clabots		<p>Veterans Extended Care Facilities (Title X Department of Veterans Affairs):</p> <p><i>A, Title X, Veterans Health Administration, Grants for Construction of State Extended Care Facilities</i></p> <p>White Papers: ARRA VA State Home Construction Grant</p>	<p>States will be eligible to receive grants totaling \$150 million until September 30, 2010 to acquire or construct state nursing homes and domiciliary facilities and to remodel, modify, or alter existing hospital, nursing home, and domiciliary facilities in state homes, for furnishing care to veterans. Veteran Services Construction of State Extended Care Facilities - \$150 million. The ARRA provides additional funding for grants to assist states in the acquisition and construction of extended care facilities as well as the remodeling, altering or modifying existing facilities for furnishing care to veterans. States should submit applications in accordance with 38 U.S.C. § 8135 and 38 C.F.R. §§ 59.20, 59.60.</p>
		<p>Senior Centers:</p> <p><i>A, Title I, Rural Housing Services, Rural Community Facilities Program</i></p>	<p>There is no specific funding set aside for senior centers, but the Rural Development and Community Facilities Programs under the Department of Agriculture, which did receive funding, do allow for funding of senior centers. It appears that the State Fiscal Stabilization Funding would allow for funding for Senior Centers or other senior services. However, the focus of the fund appears to be for education</p>

		Account	and provides that the State Fiscal Stabilization Fund shall be administered by the Department of Education. The bill provides “[T]he Governor shall use 18.2 percent of the State’s allocation under section 14001 for public safety and other government services, which may include assistance for elementary and secondary education and public institutions of higher education and for modernization, renovation, or repair of public school facilities and institutions of higher education facilities, including modernization, renovation, and repairs that are consistent with a recognized green building rating system.” (Emphasis added.) Each state must use 18.2 percent of the funds allocated to the state for these specific purposes. The bill does not define “other government services”.						
		State Nursing Home and Domiciliary Facilities <i>A, Title X, Veterans Health Administration, Grants for Construction of State Extended Care Facilities</i>	GRANTS FOR CONSTRUCTION OF STATE EXTENDED CARE FACILITIES For an additional amount for “Grants for Construction of State Extended Care Facilities”, \$150,000,000, to remain available until September 30, 2010, for grants to assist States to acquire or construct State nursing home and domiciliary facilities and to remodel, modify, or alter existing hospital, nursing home, and domiciliary facilities in State homes, for furnishing care to veterans as authorized by sections 8131 through 8137 of title 38, United States Code.[]						
	Janet Moran	Special Supplemental Nutrition Program for Women, Infants and Children (WIC) <i>A, Title I, Food and Nutrition Service Child Nutrition Programs, Special Supplemental Nutrition Programs for Women, Infants, and Children.</i> http://www.fns.usda.gov/fns/recovery/memos/WIC_022609.pdf	\$500 Million	\$644,035	Funds are intended to be obligated quickly. The Food and Nutrition Service is developing mechanisms to provide funding to State agencies as soon as possible in accordance with the ARRA. More information will be made available soon.			The allocation of these funds would not be required to follow the normal WIC allocation formula.	To be determined by the Food and Nutrition Service.
		\$400 million has been provided to support participation should the Secretary determine that costs or participation exceed budget estimates. The ARRA also provides \$100 million to establish, improve, or administer management information systems for WIC to include changes necessary to meet new legislative or regulatory requirements. The funds will also be used in part to advance the use of electronic benefits transfer in the WIC Program. The Wyoming funding level for the WIC Program is \$644,035.	Update as of May 13, 2009: The NAFR form, the SF-424 form, and budget narrative have been submitted. We will most likely have another request to submit in June.). This particular grant is focused on enhancements/equipment/supplies for our electronic benefit transfer (EBT) food delivery system for the 13,000 WIC participants we serve each month-the amount requested was \$644,035 to pay for additional smart cards, card sleeves, card terminals, state servers for testing, and project management and other related services. The next grant request will be tailored more towards general technology needs and is due June 26.						
	Dr. James Bush Steve Melia	Lead Hazard Control and Healthy Homes <i>A, Title XI, Housing Programs, Office Lead Hazard Control and Health Homes</i> ARRA Lead Grants	For an additional amount for the “Lead Hazard Reduction Program”, as authorized by section 1011 of the Residential Lead- Based Paint Hazard Reduction Act of 1992, and by sections 501 and 502 of the Housing and Urban Development Act of 1974, \$100,000,000, to remain available until September 30, 2011: <i>Provided</i> , That for purposes of environmental review, pursuant to the National Environmental Policy Act of 1969 (42 U.S.C. 4321 et seq.) and other provisions of law that further the purposes of such Act, a grant under the Healthy Homes Initiative, Operation Lead Elimination Action Plan (LEAP), or the Lead Technical Studies program under this heading or under prior appropriations Acts for such purposes under this heading, shall be considered to be funds for a special project for purposes of section 305(e) of the Multifamily Housing Property Disposition Reform Act of 1994: <i>Provided further</i> , That funds shall be awarded first to applicants which had applied under the Lead Hazard Reduction Program Notices of Funding Availability for fiscal year 2008, and were found in the application review to be qualified for award, but were not awarded because of funding limitations, and that any funds which remain after reservation of						

			<p>funds for such grants shall be added to the amount of funds to be awarded under the Lead Hazard Reduction Program Notices of Funding Availability for fiscal year 2009: <i>Provided further</i>, That each applicant for the Lead Hazard Program Notices of Funding Availability for fiscal year 2009 shall submit a detailed plan and strategy that demonstrates adequate capacity that is acceptable to the Secretary to carry out the proposed use of funds: <i>Provided further</i>, That recipients of funds under this heading shall expend at least 50 percent of such funds within 2 years of the date on which funds become available to such jurisdictions for obligation, and expend 100 percent of such funds within 3 years of such date: <i>Provided further</i>, That if a recipient fails to comply with the 2-year expenditure requirement, the Secretary shall recapture all remaining funds awarded to the recipient and reallocate such funds to recipients that are in compliance with those requirements: <i>Provided further</i>, That if a recipient fails to comply with the 3-year expenditure requirement, the Secretary shall recapture the balance of the funds awarded to the recipient: <i>Provided further</i>, That in administering funds appropriated or otherwise made available under this heading, the Secretary may waive or specify alternative requirements for any provision of any statute or regulation in connection with the obligation by the Secretary or the use of these funds (except for requirements related to fair housing, nondiscrimination, labor to “Administration, Operations, and Management”, for non-personnel expenses of the Department of Housing and Urban Development: <i>Provided further</i>, That any funds made available under this heading used by the Secretary for technology shall be transferred to “Working Capital Fund’ standards and the environment), upon a finding that such a waiver is necessary to expedite or facilitate the use of such funds: <i>Provided further</i>, That of the funds made available under this heading, up to .5 percent shall be available for staffing, training, technical assistance, technology, monitoring, travel, enforcement, research and evaluation activities: <i>Provided further</i>, That funds set aside in the previous proviso shall remain available until September 30, 2012: <i>Provided further</i>, That any funds made available under this heading used by the Secretary for personnel expenses related to administering funding under this heading shall be transferred to “Personnel Compensation and Benefits, Office of Lead Hazard Control and Healthy Homes” and shall retain the terms and conditions of this account, including reprogramming provisions, except that the period of availability set forth in the previous proviso shall govern such transferred funds: <i>Provided further</i>, That any funds made available under this heading used by the Secretary for training or other administrative expenses shall be transferred</p>
		<p>Other <i>A, Title I, Rural Housing Services, Rural Community Facilities Program Account</i></p>	<p><u>Other Community Services</u> <i>Rural Community Programs - \$1.51 billion</i> • The ARRA provides the following additional funding: \$1.38 billion, under the Rural Water and Waste Disposal Program, for loans and grants to regional, local, non-profit, and tribal organizations for the development of water and waste disposal systems in rural areas and towns with a population below 10,000. \$130 million, under the Rural Community Facilities Program, for loans and grants to regional, state, local, and tribal organizations for the construction or maintenance of rural community facilities, including hospitals, health clinics, and child and elder care facilities. \$150 million, under the Rural Business Program, for loans and grants to regional, state, local, and tribal organizations for improving business, industry, and employment opportunities in economically-distressed rural communities. The Department of Agriculture administers these programs. Of the pool of funds appropriated in the ARRA to these, and certain other rural programs, 10 percent must be designated for “persistent poverty counties” (defined as those counties in which 20 percent of the population has lived below the federal poverty level for the past 30 years).</p>

		<p>Drug Courts?</p> <p><i>A, Title II, Department of Justice, State and Local Law Enforcement & Assistance</i></p>	<p>LAW ENFORCEMENT AND COMMUNITY SERVICES</p> <p>A. Law Enforcement</p> <p><i>Edward Byrne Memorial Justice Assistance Grants - \$2.225 billion</i></p> <p>The Edward Byrne Memorial Justice Assistance Grant program allocates money to states and local law enforcement agencies to help prevent, fight, and prosecute crime. 42 U.S.C. §§ 3750 <i>et seq.</i> The ARRA provides additional funds to support state and local law enforcement under this program. Of the total additional funds, the Department of Justice will provide \$2 billion by statutory formula to states and local law enforcement agencies to help prevent, fight, and prosecute crime. Additionally, the Department of Justice will provide \$225 million in competitive, peer-reviewed grants, available to units of state, local, and tribal governments for law enforcement assistance to improve the administration of justice, provide services to victims of crime, support critical nurturing and mentoring of at-risk children and youth, and support other similar activities.</p>				<p>The state chooses not to apply for this money as there are no state dollars to continue any program started with federal funds.</p>		
DeAnna Green, Andy Corbin, Heather Theis		<p><u>HITECH Compliance</u></p> <p><i>A, Title XIII, Sec 13001</i></p> <p>Provisions, impacts, and compliance requirements for WDH, State of Wyoming covered entities and affiliated Business Associates contained in Title XIII – Health Information Technology for Economic and Clinical Health Act (HITECH), Section 13400 through 13421 of the American Recovery and Reinvestment Act (ARRA) affecting overall compliance with both HITECH and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).</p>	-0-	-0-	Reporting Requirements Privacy Compliance	On-Going		<ul style="list-style-type: none"> • Revision of the Business Associate Agreement • Section 13406 explains that external programs which provide services that benefit Wyoming citizens and have marketing and potential legal impacts to the agency will now be considered requirements for a business associates agreement. • DOH will be required to contact the client and get an authorization for participation and including an electronic method for the client to opt out at any time. 	Dependent upon EHR Completion
			<p>Following are 11 sections of the ARRA affecting the overall compliance with both HITECH and HIPAA:</p> <ul style="list-style-type: none"> • Section 13400 establishes new defines for the terms “breach,” “electronic health record,” (EHR) and “personal health record” (PHR) 						

			<ul style="list-style-type: none"> • Section 13401 refers to the application of security provisions and penalties to Business Associates of covered entities and annual guidance on security provisions. • Section 13402 outlines the requirements for notification to each individual whose unsecured protected health information (PHI) may have been accessed, acquired, or disclosed, during an alleged breach. • Section 13404 refers to the application of privacy provisions and penalties to Business Associates of covered entities. • Section 13405 outlines the restrictions on certain disclosures and sales of health information, accounting of certain protected health information disclosures, and access to information in electronic format. • Section 13406 imposes stricter provisions on marketing communications. • Section 13407 outlines requirements for temporary breach notification for vendors of personal health records and other non-HIPAA covered entities. • Section 13408 requires business associate contracts for health information exchanges, regional health information organizations and PHR vendors. • Section 13409 and 13410 provides clarification of applicants of wrongful disclosures, criminal penalties, and improved enforcement. • Section 13411 audit requirements. • Section 13421 outlines the relationship of HITECH to other laws. 						
		<p>IDEA Part C</p> <p>White Paper: Wyoming Department of Health – ARRA IDEA Part C Part 2 Wyoming Department of Health – ARRA IDEA Part C</p> <p>Individuals with Disabilities Education Act (IDEA) Part C Grants for Infants and Families Program Description: The Wyoming Early Intervention and Education Program receives federal funds from the U.S. Department of Education, Office of Special Education Programs (OSEP) for this program. These funds are distributed to the states on a formula basis to provide services to infants and toddlers with disabilities and their families. The Wyoming Department of Health (WDH) administers the IDEA Part C Program through the Developmental Disabilities Division, Early Intervention and Education Program. Wyoming receives an annual funding allocation of approximately \$2.2 million, which is distributed to fourteen (14) regional child development centers (CDC).and/or developmental delays.</p>	2,139,843	1,069,922		2 year period.			
		<p>PCO ARRA Initiative</p> <p>White Paper: PCO ARRA</p> <p>The National health Service Corps recently awarded the State Primary Care Office Program \$6 million of ARRA Funds.</p>	\$6 million in increments of \$2 million for each FY.	\$28,655	Based on the Current NHSC Vacancies. Funds are to be used to support NHSC outreach, efforts, hire additional staff, ect. With ARRA funds, States will have to quantify how these funds contributed to	Fys 2009-2011			

					retention of jobs, etc.				
		Communities Putting Prevention to Work – State Supplemental Funding White Paper: ARRA Impact: State Supplemental Funding	\$125 Million	\$353,267 for Component 1, \$442,973 in Component III Funding Certainty – Estimate	Application Date: 11/24/09. Note: The State of Wyoming will not be applying for Component II. This grant is competitive and the WDH is not interested in applying for these funds at this time.				
		Communities Putting Prevention to Work – Community Funding White Paper: ARRA Impact: Community Funding	\$373 Million	\$3-8 million per community under each category.	Application Date: 12/1/09 Note: Letter of intent is due 10/31/09				