# 11 American Recovery and Reinvestment Act 2009 (Pub. L 111-5)

The American Recovery and Reinvestment Act (ARRA) of 2009 authorized the U.S. Department of Health and Human Services to distribute $2 billion in grants to health centers so that they may serve patients who are uninsured and underserved. ARRA federal provisions include:

- A temporary increase in the Federal Medical Assistance Percentage (FMAP) of Medicaid payments to at least 6.2 percent for every state
- A new tax credit of 65 percent to individuals who continue their health insurance through COBRA after losing their job
- Provides $1 billion for proven clinical preventative services and community-based prevention programs through Investing in Evidence-Based Prevention for Americans
- Provides $500 million to support the National Health Services Corps and existing workforce programs, such as Title VII and VIII to educate and train medical professionals
- Invests $10 billion in the National Institutes of Health to move valid research projects backlogged due to funding constraints
- Provides $1.1 billion for Comparative Effectiveness Research to investigate the relative merits of different treatment options
- Invests $2 billion in Community Health Centers
- Provides $500 million to Indian Health Services for HIT and to improve the quality and access to health care services for Native Americans and Alaskan Natives
- Invests $50 million in Health and Human Services IT security

The state of California was allotted $16.9 billion of stimulus funds, which were distributed among community health centers, universities and other institutions through several programs to improve and expand access to health care, establish the infrastructure for health information technology, conduct scientific research, provide fiscal relief and extend other social services to vulnerable populations.

**Exhibit 11-1**
**Hospital Related ARRA Funding in CA**

**Total ARRA funding for CA: $16.9 billion**

- $12.6 billion for increased FMAP for CA Medicaid
- $263.2 million – Community Health Center services
- $124.6 million – Health IT investment
  - $55.5 million - for 4 Regional Extension Centers
  - $38.8 million – CA Health and Human Services Agency for exchanges
- $18.8 million – immunization programs
- $4.6 million – surveillance and prevention of healthcare associated infections

### *Title V: The Healthcare Workforce*

There are a number of provisions and incentives to increase the number of medical professionals. Hospitals rely upon a specially trained workforce to provide their services, workforce shortages can lead to increased costs for the hospital related to noncompliance. Nationally, $250 million was allotted to increase the number of primary care (PC) providers by offering new resources such as the following:

- Creating additional PC residency slots
- Supporting PA training in primary care
- Increasing the number of nurse practitioners trained
- Providing states with resources to address upcoming health care workforce needs
- Expanding tax benefits to health professionals working in underserved areas
- Building primary care capacity through Medicare/ Medicaid
- Making health care education more accessible and provide financial assistance for students

The PPACA included provisions addressing the current and future needs of the health care industry. Title V provides funding to the state and local governments for data collection, education and loan repayment, incentives for primary care and expanded educational and training

opportunities for healthcare professionals that are required by hospitals (Title VI contains workforce provisions pertaining to nursing homes and long-term care). Additionally Title V provides funding for health care construction projects and community health centers.

### *Increased Demand for Services and New Access Points Recovery Act Grant Program*

ARRA funded $263.2 million to Community Health Centers for construction, renovation, health information technology (HIT) investment and needed care services and equipment. Funding was distributed through the Increased Demand for Services and New Access Points Recovery Act Program. There 117 health centers in California who received these grants. All patients seen and attributed to Increased Demand for Services and New Access Point funding in the state totaled 709,623, with 91 percent of those patients from Increased Demand Services.

### *Hospital Price Transparency and Disclosure Act of 2009 (H.R. 2566)*

This legislation amends the Public Health Service Act and requires hospitals to report data to the Secretary of Health and Human Services and disclosure of charges for certain medical services and pharmaceuticals in hospitals to the public. Noncompliance can face a monetary penalty. California posts hospital cost comparisons for services products and procedures on the state website and on the OSHPD website.

### *Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)*

The Health Information Technology for Economic and Clinical Health Act (HITECH) was part of the ARRA legislation enacted in 2009 under President Obama. It provides incentives to states to adopt electronic health records and health information exchanges (HIE) to improve the quality and management of patient health care services. The legislative intent is to reduce federal and private expenditures on health services over the next decade by tens of billions of dollars through increases in efficiency.

Starting in 2011, Medicare or Medicaid healthcare providers will be offered financial incentives for demonstrating the meaningful use of electronic health records (EHR). The incentive money paid is determined by Medicare/Medicaid allowable billings; however, meaningful use involves the entire patient base. Incentives will be offered until 2015, when penalties may be imposed if the conditions of meaningful use have not been met. Each provider must decide whether the Medicare program or the Medicaid program will be most rewarding for his or her practice.

The final rule for meaningful uses a three phased approach, identified as Stage 1, Stage 2, and Stage 3. Stage 1 involves data capture and sharing and is effective 2011. Providers are required to electronically capture health record data in coded format that is reportable and can be used to track clinical conditions. Stage 1 "meaningful use" has detailed set of 15 criteria (core set) that providers must meet in order to prove that they are using their EMR as an effective tool in their practice. There are 10 additional criteria (menu set) from which only five needs to be demonstrated by the provider. In total, each provider must complete 20 Meaningful Use criteria to qualify for stimulus payments during stage one of the EHR incentive program. A detailed description of the criteria of Stage 1 is located in Exhibit 11-2.

Stage 2 involves the advance of the clinical process and is effective 2013. Providers are to guide and support care processes and care coordination. Stage 2 "meaningful use" criteria are expected to be proposed in early 2012 and finalized summer of 2012. Finally, Stage 3 involves improved outcomes and is effective 2015. Providers are to achieve and improve performance and support care processes and key health system outcomes. ❖

**Exhibit 11-2**
**HITECH Stage 1 "Meaningful Use" Criteria**

1. **Computerized Provider Order Entry (CPOE):**
   More than 30% of all unique patients with at least one medication seen by the EP and ordered using CPOE
   Excludes EPs who write fewer than 100 Rx during EHR reporting period
2. **E-Prescribing (eRx):**
   More than 40% of all permissible Rx by EP transmitted electronically using certified EHR technology
   Excludes EPs who write fewer than 100 Rx during EHR reporting period
3. **Report ambulatory clinical quality measures to Centers for Medicare & Medicaid Service (CMS)**
4. **Implement one clinical decision support rule**
5. **Provide patients with an electronic copy of their health information, upon request:**
   More than 50% who request during EHR reporting period are provided it within 3 business days
6. **Provide clinical summaries for patients for each office visit:**
   Provide for more than 50% of all office visits within 3 business days during EHR reporting period
7. **Drug-drug and drug-allergy interaction checks:**
   The EP has enabled this functionality for entire EHR reporting period
8. **Record demographics:**
   More than 50% of all unique patients seen by EP have demographics recorded as structured date
9. **Maintain an up-to-date problem list of current and active diagnoses:**
   More than 80% of all unique patients seen by EP have at least one entry recorded as structured data
10. **Maintain active medication list:**
    More than 80% of all unique patients seen by EP have at least one entry recorded as structured data
11. **Maintain active medication allergy list:**
    More than 80% of all unique patients seen by EP have at least one entry recorded as structured data
12. **Record and chart changes in vital signs:**
    More than 50% of all unique patients ages 2+ seen by EP have height, weight and blood pressure recorded as structured data
13. **Record smoking status for patients 13 years or older:**
    More than 50% of all unique patients 13 years or older seen by EP have status recorded as structured data
14. **Capability to exchange key clinical information among providers of care:**
    Perform at least one test of certified EHR technology's capacity to exchange key clinical information
15. **Protect electronic health information:**
    Perform a security risk analysis per 45 CFR 164.308 (a)(1) implementing security updates as necessary and correct identified security deficiencies as part of its risk management process