

# The Impact of Federal Stimulus Funds on Community Health Centers in California

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## Introduction

California's community health centers are critical components of the health care safety net, providing local, comprehensive primary care services in medically underserved areas regardless of patients' ability to pay. Like many entities that focus on the underserved, the 600-plus federally qualified health centers (FQHCs), FQHC look-alikes,<sup>1</sup> and nonprofit centers in the state can be particularly hard-hit during an economic downturn by a combination of less available funding and more people seeking services.

The American Recovery and Reinvestment Act of 2009 (ARRA), the recently enacted federal stimulus package, recognizes community health centers' crucial role. It allocates significant funds for all types of community health centers, including \$2 billion specifically for FQHCs and community health center-controlled networks. This funding will help meet a variety of needs at community health centers—new sites and services, new and improved infrastructure, adoption of electronic health records (EHRs) and other health information technology, telehealth and broadband, training of primary care professionals, Medicaid coverage assistance, and more.

Although some funding opportunities in ARRA have expired, others are forthcoming; the federal government has yet to announce funding amounts, eligibility, and project specifications. The time between the announcement of a program and awarding of funds is often very short. Therefore, to meet application deadlines, community health centers should diligently monitor events at both the

federal and state levels, and communicate frequently with California officials, as some of the funding will go directly to the state for disbursement.

This issue brief summarizes the many funding opportunities in ARRA that could help bolster and improve California's community health centers during an especially onerous recession. (See the Appendix for a snapshot.)

## Funds for FQHCs

The economic downturn has placed a heavier burden on community health centers that, given their unpredictable funding streams, were already struggling to deliver health care to underserved populations. Some are seeing a 10 percent to 50 percent increase in the number of uninsured patients they serve.<sup>2</sup> In response, ARRA appropriates \$2 billion in grant funding for FQHCs and community health center-controlled networks (support and collaboration systems) in FY2009 and FY2010. Of that amount, \$500 million is for new sites and services, and \$1.5 billion is for infrastructure development. Infrastructure costs have traditionally have been ineligible for federal funding.

## New Sites and Services

In March 2009, the U.S. Department of Health and Human Services (HHS) awarded 126 ARRA grants totaling \$155 million to support new FQHCs and new sites at existing FQHCs. In California, \$15.6 million of that amount will support six new FQHCs and six new sites at existing FQHCs to provide care to an additional 80,890 patients.<sup>3,4</sup>

# ISSUE BRIEF

Also in March 2009, HHS awarded 1,128 ARRA grants totaling \$338 million to expand services at FQHCs and enable them to serve more patients. In California, 118 FQHCs received \$48.1 million.<sup>5</sup> Maximum allocations were based on patient information the health centers submitted in their 2008 Uniform Data System reports; each was eligible for a base amount of \$100,000 plus \$6 per insured patient and \$19 per uninsured patient.

Infrastructure Funding

The \$1.5 billion in ARRA funds targeted to FQHC infrastructure will be awarded in three categories: capital improvements, health information technology (IT)/networks, and facility investments.<sup>6</sup>

Capital Improvements

Maximum allocations were based on patient information the health centers submitted in their 2008 Uniform Data System reports; each was eligible for a base amount of \$250,000 plus \$35 per patient. Funds must support construction, renovation and equipment, and health IT purchases. In addition, grantees must demonstrate improvements in access to health services for the underserved and create health-center and construction-related jobs.

Total: \$850 million

Project period: July 1, 2009–June 30, 2011

Application deadline: June 2, 2009

Award date: July 1, 2009

Health IT Systems/Networks

This funding is for FQHCs and health center-controlled networks in the form of health center network/supplemental grants, 2009 health IT competitions, other health IT adoption support, and new EHR competitions.

Total: ~\$125 million

Project period: FY2009–FY2010

Application deadline: FY2009 (date TBD)

Award date: FY2009 (date TBD)

Facility Investments

This competitive funding is for major capital improvements at FQHCs, with minimum and maximum awards of \$750,000 and \$12 million. Eligible projects, which should address immediate and pressing needs, must involve either:

Total: \$515 million

Project period: FY2010–FY2011

Application deadline: August 6, 2009

Award date: FY2010 (date TBD)

- Alteration/renovation to modernize, improve, and/or change the interior arrangements or other physical characteristics of an existing facility, or to install equipment, without increasing total square footage; or
- Construction—permanently affixing a structure, such as a modular unit or prefabricated building, to real property, or adding a new structure to an existing site, thereby increasing the facility’s total square footage.

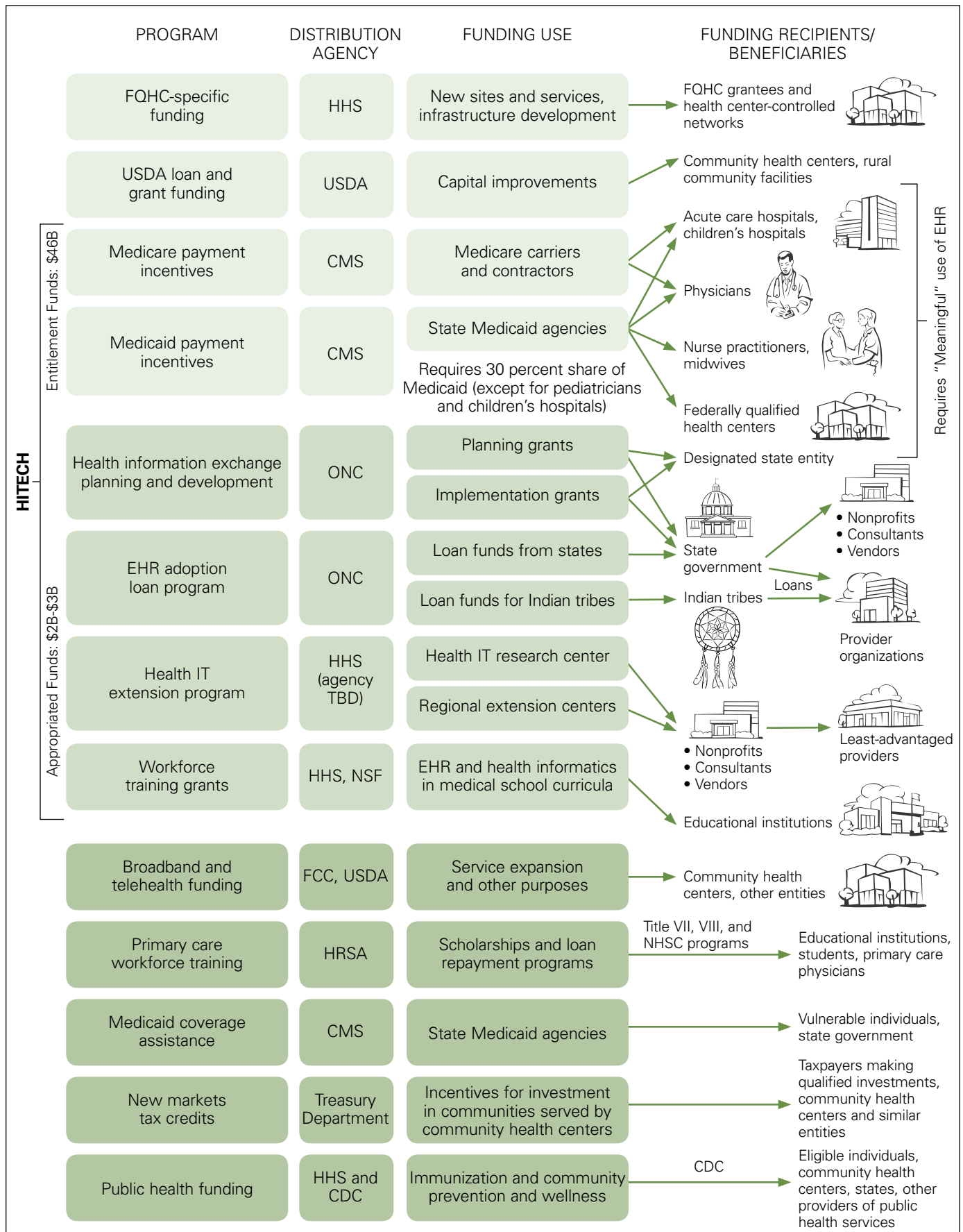
USDA Loans and Grants

Community health centers are often the only health care providers in remote rural areas. ARRA allocates \$1.2 billion to the U.S. Department of Agriculture (USDA) to support its Community Facilities Loans and Grants Program, which pays for the construction, enlargement, or improvement of essential rural community facilities, including community health centers.<sup>7</sup> Eligible entities include municipalities, counties, special-purpose districts (such as health or water districts), nonprofit organizations, and tribal governments serving a rural area—any city, town, or unincorporated area with a population of 20,000 or less.<sup>8</sup> USDA will process applications on a rolling basis until the funds are depleted or until a date in 2010 (to be determined).<sup>9</sup>

Health IT Funding Under HITECH

The Health Information Technology for Economic and Clinical Health Act (HITECH) in ARRA authorizes an estimated \$48 billion in health IT funding to be dispersed over six years. About \$46 billion of that amount will be in the form of Medicaid and Medicare incentives to adopt EHRs.<sup>10</sup> The remaining \$2 billion is for programs such as EHR planning and implementation grants; health IT

**Figure 1. Federal Stimulus Funding Streams**



Source: Manatt Health Solutions.

regional extension centers, which will provide information and technical assistance to clinicians; workforce technology training; a new EHR loan fund; and new technology research and development.<sup>11</sup>

Certain programs, such as the EHR-adoption incentives and EHR loan fund, would directly benefit eligible community health centers. Centers would likely benefit indirectly from HITECH-supported initiatives that enhance the health care industry as a whole. Figure 1 shows the HITECH and other funding streams.

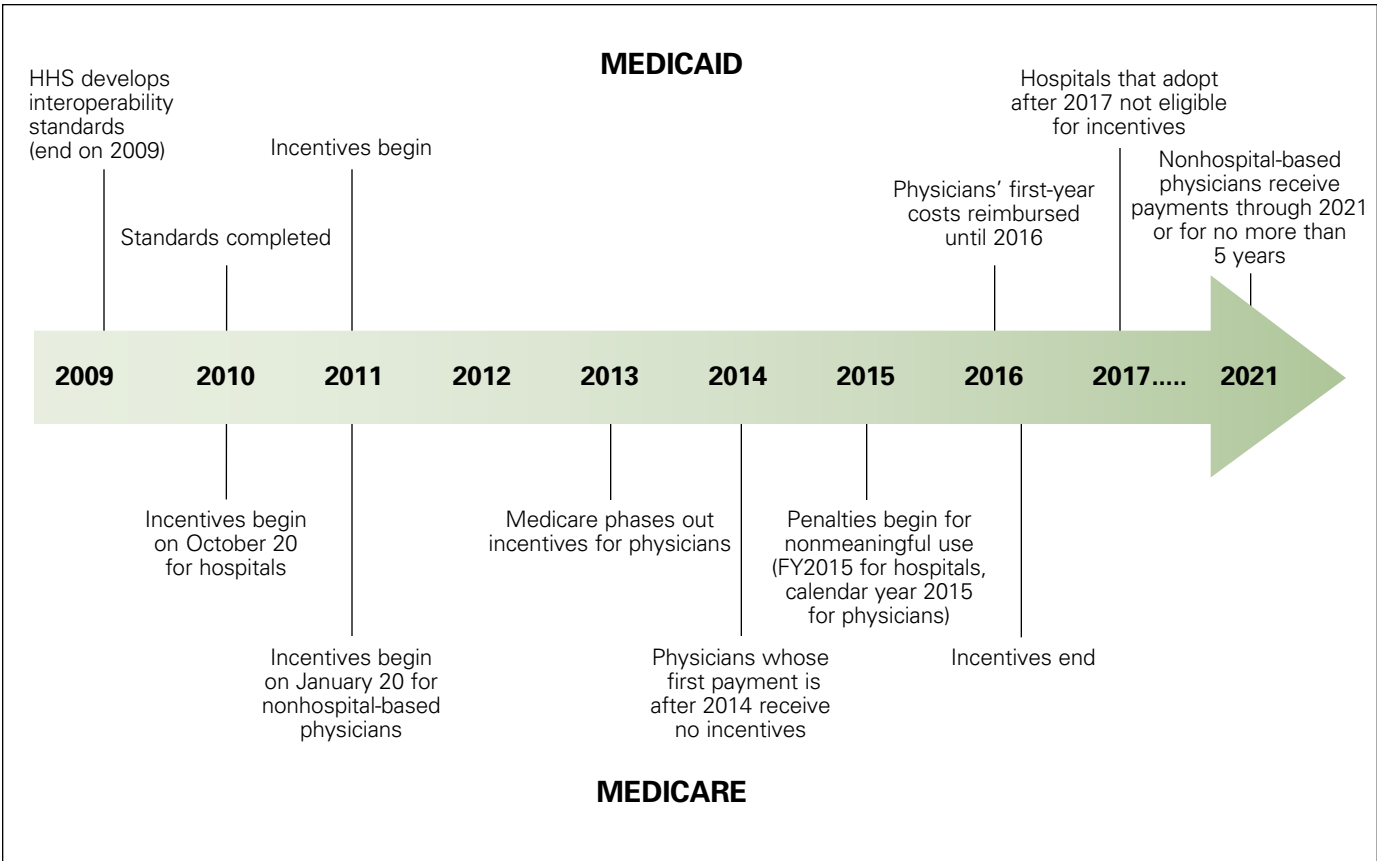
EHR Adoption Incentives

The \$46 billion in EHR adoption incentives will be available to health care providers who can demonstrate “meaningful use” of a “certified EHR.” Under ARRA, meaningful use includes e-prescribing, which does not apply to hospitals; electronic health information exchange to improve the quality of care, such as better care coordination; and use of EHRs to report clinical quality

data. The Centers for Medicare & Medicaid Services (CMS), which will define meaningful use, expects to issue a proposed rule in late 2009.<sup>12</sup> “Certified EHR” refers to systems that can perform particular minimum functions, including the ability to capture demographic and clinical information about patients, provide clinical decision support, enable physician order entry, capture and query quality-related information, and exchange health information with other sources. The EHR certification process and certifying authorities are yet to be determined.

EHR adoption incentives under Medicaid (Medi-Cal in California) will be available to hospitals, physicians who treat adults, pediatricians, dentists, nurse practitioners, nurse midwives, physician assistants, FQHCs, and rural clinics that provide a certain percentage of care to Medicaid patients and, in the case of FQHCs and rural clinics, to uninsured patients. Third-party entities designated by the state Medicaid agency promoting the adoption of certified EHRs may also be eligible for up to

Figure 2. Timeline for Medicaid and Medicare EHR Incentives



Source: Manatt Health Solutions.

5 percent of incentives for eligible professionals, as long as a professional agrees to participate in the entity’s EHR adoption program.

Hospitals can receive reimbursement for EHR adoption under both Medicaid and Medicare. Other health care providers must choose one of the two options. The timeline in Figure 2 shows important milestones between 2009 and 2021 for both options.

**Medicaid Versus Medicare Incentives**

State Medicaid programs have a great deal of discretion in how they implement incentives for physicians and other professionals, but HITECH sets baseline rules. Any time between 2011 and 2016, the programs may make incentives available to eligible recipients who begin meaningful use of EHRs. The payments can continue for a maximum of five years, but cannot extend beyond 2021. They are to be no more than 85 percent of the average allowable cost set by CMS for purchasing, implementing, or upgrading an EHR in the first year, and for operating, maintaining, and using it over the subsequent five years. However, professionals who adopt, implement, or upgrade a certified EHR within the first year need only demonstrate meaningful use of the system in that first year. The total cap on average allowable costs per full-time-equivalent (FTE) provider is \$75,000 (\$25,000 in the first year and \$10,000 in each subsequent year) and the maximum reimbursement \$63,750. The cap for pediatricians is two-thirds of that for other professionals. States may decide whether or not to impose failure-to-adopt penalties.

All eligible nonhospital physicians can start receiving Medicare incentive payments in 2011. Physicians who do not begin meaningful use of their EHR until 2013 receive lower incentive payments. Those who do not begin meaningful use until 2014 or later are not be eligible for any incentives. The maximum reimbursement per FTE provider is \$44,000. Incentive payments end in 2016 and failure-to-adopt penalties start in 2015.

The federal government will soon issue more guidance about the Medicaid and Medicare alternatives. Still unclear is whether providers who acquire EHRs before the first year of incentive payments will be eligible for “purchase” funds, which have a higher dollar cap, or only for “maintenance” funds. Given the potentially higher reimbursements per provider under Medicaid (depending on the average allowable cost limit that CMS sets), most physicians at community health centers in California are likely to select this option. Table 1 shows how the Medicaid incentives apply to each type of provider.

**Table 1. Provider Eligibility for Medicaid EHR Payments**

Eligible Provider	Percent Match/Limit	Medicaid Patient Volumes	Maximum Net Allowable Costs
Independent physician who treats adults	85 percent of net average allowable costs	> 30 percent	\$25,000 for purchase, \$10,000 for operations/maintenance
Pediatrician	85 percent of net average allowable costs	> 20 percent	\$16,667 for purchase, \$6,667 for operations/maintenance
Dentist	85 percent of net average allowable costs	> 30 percent	\$25,000 for purchase, \$10,000 for operations/maintenance
Nurse midwife	85 percent of net average allowable costs	> 30 percent	\$25,000 for purchase, \$10,000 for operations/maintenance
Nurse practitioner	85 percent of net average allowable costs	> 30 percent	\$25,000 for purchase, \$10,000 for operations/maintenance
Acute care hospital	N.A.	> 10 percent	Limited to amount calculated under Medicare, by Medicaid share
Children’s hospital	N.A.	N.A.	Limited to amount calculated under Medicare, by Medicaid share

Source: *What California Stands to Gain: The Impact of the Stimulus Package on Health Care*. California HealthCare Foundation: March 2009 ([www.chcf.org/documents/policy/WhatCAStandsToGainStimulusPackage.pdf](http://www.chcf.org/documents/policy/WhatCAStandsToGainStimulusPackage.pdf)).

## Regional Extension Centers

Community health centers, health center-controlled networks (HCCNs), and consortia will benefit from a new regional extension center program. Regional extension centers (RECs) will provide technical and change-management assistance to all EHR adopters in their areas, giving priority to FQHCs; public, nonprofit, and critical-access hospitals; rural or other health care providers that serve uninsured, underinsured, or medically underserved patients; and solo or small group practices. In May 2009, the Office of the National Coordinator for Health Information Technology (ONC) published preliminary details about the required operations and qualifications of RECs, although these requirements may change significantly in response to public comment.<sup>13</sup> ONC will evaluate applications and award funding.

RECs must be affiliated with a nonprofit organization, which could include a community health center or HCCN, and:

- Define the geographic region and the provider population they would support in that region;
- Describe the levels and types of support;
- Explain how the REC's organization and staffing would give providers ready access to health IT extension agents, and how it would train and support the agents;
- Demonstrate they can facilitate, and support cooperation among, local providers, health systems, communities, and health information exchanges;
- Demonstrate they can meet the needs of providers that have assistance priority<sup>14</sup>; and
- Propose a feasible and efficient strategy for making specialized expertise available to all providers the REC serves regarding organizational development; legal, economic, and financial issues; privacy and security; evaluation of effective EHR use; and other matters. The strategy should also specify how the REC's interdisciplinary extension agents and agents assigned to particular groups of providers would give intensive, individualized, and local assistance.

ONC proposes to give preference to RECs that include collaborations of multiple stakeholders, leverage local resources,<sup>15</sup> and identify viable sources of matching funds, such as grants from states and foundations, and payments from providers.

Under ONC's proposal, providers can use Medicaid and Medicare incentives to pay for RECs' implementation and meaningful-use support services. RECs may choose to assist providers who are not in the safety net, and use those revenues as matching funds for grant-funded activities.

ONC will formally solicit and evaluate REC proposals after it considers public comments on the proposed requirements it published in May 2009. The geographic region and provider population an REC would serve, and its capacity to facilitate and support cooperation among local providers, health systems, communities, and health information exchanges, will be among the evaluation criteria. Depending on the final requirements, two-year awards could be made as early as the first quarter of FY2010, average \$1 million to \$2 million, and be up to a maximum of \$10 million. The FY2010 awards may not require matching funds, due to current economic conditions.

## EHR Loan Program

Loans will be available from HHS to help community health centers and other health care providers purchase certified EHRs, enhance EHR systems (for example, to upgrade them so they qualify for certification), train personnel, and improve the security of electronic information exchange. The loans, which will flow through states and Indian tribes, should be available beginning in January 2010.<sup>16</sup>

## Statewide Planning for Health Information Exchange

California and the California HealthCare Foundation are collaborating on ways to strengthen health information exchange (HIE) in the state and take advantage of federal health IT funding.<sup>17</sup> They will develop a plan that



describes how to make HIE widely available and that promotes the use of such exchange to improve health care and make it more efficient. The plan aims to:

- Maximize California's competitiveness in applying for HIE implementation funding in HITECH;
- Support collaborative and coordinated efforts among diverse health care stakeholders to encourage them to adopt health IT, exchange health information, and develop and comply with statewide information policies, standards, and technical approaches;
- Integrate and synchronize planning for and implementation of HIE, telehealth, and EHR adoption incentives in ARRA;
- Ensure accountability in public fund expenditures; and
- Improve public health through stronger health surveillance and emergency response capabilities.

The state is simultaneously examining other relevant funding aspects of the HITECH Act, including those related to RECs, the EHR loan program, workforce training and development, and research and new technologies. The foundation's and state's parallel efforts are expected to generate strategic plans by the end of August 2009.<sup>18</sup>

### Regulations and Technical Standards

New federal regulations will guide the implementation of many HITECH provisions. Although the release date for these regulations is still unclear, ONC issued a plan in May 2009 describing how and when it intends to execute the provisions.<sup>19</sup> HHS must issue an interim final rule adopting HITECH-related technical standards by December 31, 2009.

### Broadband and Telehealth Funding

California has a long history of support for broadband and telehealth, which can help meet the needs of community health centers in remote areas of the state. In November 2006, California voters approved Proposition 1D, a higher-education bond measure

that included \$200 million for capital improvements to expand and enhance medical education programs at the University of California, with an emphasis on telemedicine. In 2007, a broad coalition established the California Telehealth Network to build a statewide broadband network to improve health care in rural and urban areas. A \$22.1 billion award from the Federal Communications Commission (FCC) will enable the network to connect more than 300 health care providers, including community health centers. These successes put community health centers in a strong position to take advantage of broadband and telehealth funding in ARRA for purposes of health IT and HIE.<sup>20</sup>

Clinical and administrative information technology, such as interoperable EHRs that enable providers in different settings to readily exchange patient information and thus improve access to and the quality of health care, makes telehealth encounters most effective. And secure, reliable broadband connections are crucial in making telehealth and information exchange possible. Broadband and telehealth funding in ARRA will level the playing field for community health centers, especially those in rural areas.

### Broadband Technology Opportunities Program

The Broadband Technology Opportunities Program (BTOP) allocates \$4.7 billion to expand affordable and quality broadband service to underserved populations and to community and public institutions by aggregating demand for service.<sup>21</sup> This ensures community involvement and fosters the development of new applications, thereby creating jobs and stimulating economic growth. BTOP builds on the Department of Commerce's Technology Opportunities Program, which has invested \$233.5 million in state broadband initiatives over the last 10 years.

The National Telecommunications and Information Administration (NTIA) will administer BTOP in consultation with the FCC. The program also seeks to promote broadband awareness, education, training, access,

equipment, and support at community organizations, including health care providers, entities that facilitate more broadband use by or through these organizations, and entities that facilitate vulnerable populations' access to care.

Of the \$4.7 billion in BTOP funding, at least \$250 million is for innovative programs that encourage sustainable adoption of broadband services. The remaining amounts are for expansion of the number of publicly available computers and existing broadband deployment programs, administration and oversight of BTOP, development and maintenance of a broadband inventory map, and development of a national broadband strategy.

### USDA Broadband Program

ARRA appropriates \$2.5 billion to the USDA Rural Utility Service (RUS) for expansion of broadband infrastructure and technical assistance in rural areas through a combination of loans, loan guarantees, and grants. These efforts, part of a new Broadband Initiative Program (BIP), will also facilitate economic development in rural areas, where more than 5 million Californians reside.

Community health centers may benefit from BIP and BTOP either directly, by receiving funds for equipment and training, or indirectly from the services and equipment provided by other program participants. Because BIP and BTOP funding cannot overlap, organizations must carefully consider how best to apply to each of the programs and coordinate their efforts. On July 2, 2009, RUS and NTIA, which will distribute the funds, issued a notice of availability of funding.<sup>22</sup> It tentatively plans to solicit proposals for second- and third-round funding in October and December 2009, and in spring 2010, respectively.

### Indian Health Service Programs

ARRA appropriates \$85 million for Indian Health Service (IHS) health IT activities related to telehealth service development and infrastructure. Funds will also support activities that fit the IHS mission to improve access to and the quality and safety of health care, and to improve the overall health of Native American and Alaska Native patients and populations. In California, 108 federally recognized tribal governments participate in consortia that operate 31 tribal health programs in 57 ambulatory clinics under the authority of the Indian Self Determination Act. These programs had 130,855 registered users and 76,505 active service users in FY2008.<sup>23</sup>

IHS recognizes the critical role that health IT plays in efficient and effective care for patients. Nearly 30 years ago, it developed the Resource and Patient Management System, a clinical information system. Last year, IHS modernized the EHR in this system to incorporate important clinical functions, such as e-prescribing. Most ARRA funding for IHS has been allocated for improving this EHR. IHS and tribal governments are discussing health IT priorities for ARRA funds and recently submitted a report to Congress describing their general expenditure plan.

Because IHS clinics are either FQHCs or FQHC look-alikes and serve many Medicaid patients, some will be able to get HITECH funding through Medicaid incentives for meaningful EHR use, purchase, and implementation. Apart from HITECH, funds will be available to regional IHS offices to pay for health IT hosting and hardware at clinics. These clinics may also seek funding for software.

### Training of Primary Care Professionals

ARRA allocates \$500 million to foster a skilled workforce and boost the service capacity of community health centers and hospitals. Of this amount, \$300 million is for the National Health Services Corps and \$200 million, in Title VII and Title VIII training



program grants from the Health Resources and Services Administration, is for hospitals and medical, nursing, dental, and public health schools.

### National Health Services Corps

The National Health Services Corps (NHSC) recruits clinicians to work in underserved communities by giving scholarships to students and helping health professionals repay education loans. Recipients commit to delivering primary care services in designated high-need areas, often at community health centers.<sup>24</sup>

Of the \$300 million for NHSC, \$200 million is for the corp's Loan Repayment Program.<sup>25</sup> The program awards up to \$50,000 to primary care medical, dental, and mental health clinicians in exchange for service at any site in a NHSC-certified health professional shortage area (HPSA). In certain cases, additional funds may be available for extended service. Sites are ranked based on a HPSA score; NHSC funds go first to the most needy sites. Under ARRA, community health centers stand to benefit because the minimum HPSA score will be lower, thus enabling more centers to take advantage of NHSC's incentives. The application period began June 5, 2009, and ends September 30, 2010, or when all funds have been expended.

The remaining \$100 million of the total \$300 million in NHSC funding is for scholarships through the 2011 school year for medical, dental, nurse practitioner, certified nurse midwife, and physician assistant students.<sup>26</sup> After they graduate, recipients spend two to four years at a NHSC-approved service site. The scholarships will entice students to practice in areas served by community health centers. A center may directly benefit if it is a NHSC-approved site and can arrange school support for a student who has expressed interest in working there after graduation.

Although the FY2009 application period for scholarships has closed, more funds will be available when the application period for the 2010–2011 school year begins in spring 2010.

### Title VII and Title VIII Training Programs

Title VII and VIII training programs in the Health Resources and Services Administration (HRSA) offer grants to educational institutions for scholarships, loan repayment, faculty development, and residency activities. The \$200 million in ARRA for these programs is not likely to benefit community health centers directly. But over the long term, the funds will help ensure the availability of primary care professionals that community health centers need. In addition, some of the \$200 million may ultimately go to area health education centers (AHECs). Community health center consortia and large clinic systems sponsor eight of California's 12 AHECs. Because HRSA has not yet indicated how it will allocate the funds, the extent of this benefit is still unclear.

### Medicaid Coverage Assistance

California's community health centers are likely to benefit indirectly from funding and administrative changes in coverage assistance programs identified in ARRA. In California, some Medi-Cal beneficiaries will receive additional coverage, thereby ensuring that as many patients as possible who receive care at community health centers are insured and reducing the amount of unreimbursed care the centers provide.

### Transitional Med-Cal and Qualifying Individual Programs

ARRA extends, to December 31, 2010, two programs—Transitional Medi-Cal and Qualifying Individual—that help vulnerable people get access to health care.

In Transitional Medi-Cal (TMC), 150,000 Californians moving from welfare to work are eligible for up to a year of coverage; their work income would otherwise disqualify them from receiving benefits. Under ARRA, states must maintain their current level of eligibility for transitional Medicaid assistance because these programs get federal matching funds. ARRA gives states two new options for simplifying and expanding

eligibility criteria: (1) eliminate onerous income-reporting requirements that families must meet to retain coverage, and instead automatically provide 12 months of continuous coverage, or (2) waive the current Medicaid minimum enrollment requirements that families must meet to qualify for transitional coverage.

States can choose one or both options, or neither. Both options would cost California about \$59 million. Given the current budget crisis, the state is unlikely to choose either or both.

About 15,500 Californians in Medi-Cal's Qualifying Individual Program (QI-1), which is funded by a federal block grant, would benefit from an ARRA provision that extends QI-1's end date to December 31, 2010, from December 31, 2009. QI-1 helps low-income elderly people—those whose income is between 120 percent and 135 percent of the federal poverty level and whose assets total no more than \$4,000 (individuals) or \$6,000 (couples)—pay their Medicare Part B premiums.

### Higher Federal Matches for Medicaid

State Medicaid spending is matched by federal funds. The annually adjusted federal match rate is calculated using a formula based on a state's "wealth" relative to the rest of the country. Under ARRA, the match rate increases between October 1, 2008, and December 31, 2010, boosting total federal Medicaid support by \$87 billion. States can access these funds through the standard Medicaid claims process.

California's federal match rate is expected to rise to 61.1 percent from 50.0 percent, yielding an additional \$9 billion to \$10 billion. To receive these funds, the state must pledge to use them to meet the higher demand for Medi-Cal coverage, not to replace lost revenues.

### Other Medicaid Funding Changes

The Bush Administration imposed four regulations, and proposed three others, eliminating certain federal Medicaid reimbursements to hospitals and other health care providers for graduate medical education, intergovernmental transfers, rehabilitation services, provider taxes, school-based administration and transportation services, targeted case management, and outpatient hospital services. These regulations would have cost California an estimated \$10 billion over five years and negatively impacted health care providers and vulnerable patient populations. Some of the regulations have been delayed or rescinded under ARRA or by CMS, and federal action on the others is unlikely. The net effect is that, for now, community health centers that rely on these Medicaid reimbursements can continue to rely on them as a source of revenue.

### New Markets Tax Credit Program

This program is part of the U.S. Treasury Department's Community Financial Institutions Fund, which provides incentives for investment in low-income communities, the kind that community health centers primarily, if not exclusively, serve. Centers can spend the grants on new capital projects or improvements.<sup>27</sup>

The New Markets Tax Credit Program (NMTC) derives its name from the federal income tax credit taxpayers receive for making qualified investments in community development entities—U.S. Treasury-designated intermediary organizations that provide investment capital to low-income persons and communities.<sup>28</sup> ARRA adds \$1.5 billion to the program's \$23 billion. About \$5 billion available in the 2009 funding cycle should be awarded in October. More grants will be awarded in the 2010 cycle.<sup>29</sup>

Some community health centers with poor liquidity have financed the construction or modernization of health care facilities in impoverished areas by combining NMTC grants with loan guarantees from HRSA's Bureau of Primary Health Care.<sup>30</sup> Although restrictions and

eligibility requirements make it very difficult to arrange these transactions, they may be an important source for community health centers and similar entities that cannot otherwise obtain capital financing.

## Public Health

About \$1 billion in ARRA funding will support several public health activities through a prevention and wellness fund. Of this amount, \$300 million will supplement the Section 317 Immunization Grant Program at the Centers for Disease Control and Prevention (CDC), the primary funding source for state immunization efforts. The CDC, states, and territories will spend two-thirds of the \$300 million to purchase vaccines administered by Section 317 grantees. Community health centers stand to benefit indirectly because the immunization program will help ensure the availability of vaccines to their patient populations.

Up to \$650 million in ARRA funds may ultimately become available to various entities for evidence-based clinical and community-based prevention and wellness efforts. HHS has yet to outline this program in detail, but some of the funds may enable community health centers to implement prevention and wellness strategies.

## Conclusion

Billions of dollars in the federal stimulus package could directly or indirectly benefit community health centers. At a time of severe economic hardship, the funding opportunities would help a variety of community health centers in California to construct or improve infrastructure, adopt electronic health records and other health IT, leverage broadband and telehealth, recruit and retain primary care professionals, improve services, stabilize the safety net, and much more. However, to take advantage of these opportunities now and in coming years, community health centers must closely monitor events at the state and federal levels, and communicate with state officials in a timely manner, as California will disburse some of the stimulus funds.

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## ABOUT THE AUTHORS

This report was prepared by Manatt Health Solutions, a division of Manatt, Phelps & Phillips, LLP.

## APPENDIX: ARRA FUNDING RELEVANT TO COMMUNITY HEALTH CENTERS

Program	Funding Amount and Purpose	Distribution Process and Recipients	Award Dates
Funding for federally qualified health centers (FQHCs)	\$2 billion: \$500 million for new sites and services, \$1.5 billion for infrastructure development	From U.S. Department of Health and Human Services (HHS) to FQHC grantees, private institutions, and public, nonprofit institutions	March 2009 through the end of FY2011
Loans and grants from the U.S. Department of Agriculture (USDA)	\$1.2 billion for capital improvements	From USDA to rural municipalities, counties, special-purpose districts, nonprofits, and tribal governments	Rolling, through FY2010
Medicaid and Medicare adoption incentives	Up to \$46 billion for implementation and use of EHRs	From Centers for Medicare & Medicaid Services/state agencies to FQHCs, health care professionals, and hospitals	FY2011–FY2016. Payments continue through FY2021.
Grants for EHR-related adoption	\$2 billion for planning, implementation, regional extension centers (RECs), workforce training, loan fund, and research and development. REC awards will average \$1 million to \$2 million. Up to \$10 million per REC.	From the Office of the National Coordinator for Health Information Technology (ONC) to states and state-designated entities for distribution to health care providers	Beginning in FY2010
Funding for Native American projects	\$85 million for telehealth, related infrastructure, and EHR infrastructure	From ONC to Indian Health Service regional offices	TBD
Broadband and telehealth funding	\$4.7 billion through the Broadband Technology Opportunities Program (BTOP) for service expansion, and \$2.5 billion through the Broadband Initiative Program (BIP) for infrastructure and technical assistance	From the National Telecommunications and Information Administration/Federal Communications Commission (BTOP) and USDA (BIP) to community organizations, including providers and entities that facilitate access to care	December 2009
Grants, scholarships, and loan repayments for training of primary care professionals	\$500 million: \$300 million to the National Health Services Corps (NHSC) and \$200 million to Title VII and Title VIII programs in the Health Resources and Services Administration (HRSA)	Loan repayments and scholarships from NHSC to primary care students. Title VII and VIII grants from HRSA to educational institutions.	FY2009–FY2010
Medicaid coverage assistance	Additional year of coverage for vulnerable individuals. Total increase of \$87 billion in Medicaid support (\$10 billion for California).	Standard Medicaid claims process	Present–FY2010
New Markets Tax Credit Program	\$1.5 billion in incentives for investment in low-income communities served by community health centers	Federal income tax credit for investment in community development entities	FY2009–FY2010
Public health funding	\$1 billion, including \$300 million for immunization grants and up to \$650 million for prevention and wellness.	From HHS to the Centers for Disease Control and Prevention for vaccines, and to community health centers for prevention and wellness.	TBD

Source: Manatt Health Solutions.

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## ENDNOTES

1. Look-alikes do not receive grant support under Section 330 of the Public Health Services Act, but they meet all Section 330 requirements and receive many of the same benefits as Section 330 grantees.
2. Nielson, J. *District Level Impact of Two-Year Suspension of Clinic Programs, Assembly District 2*. California Primary Care Association: June 2009.
3. Ibid.
4. New Access Points Community Health Care Services Grants by State/Territory. U.S. Department of Health and Human Services ([transparency.cit.nih.gov/RecoveryGrants/grant.cfm?grant=nap](http://transparency.cit.nih.gov/RecoveryGrants/grant.cfm?grant=nap)).
5. A complete list of grant awards in California is available at [www.hhs.gov/recovery/programs/hrsa/california.html](http://www.hhs.gov/recovery/programs/hrsa/california.html).
6. More information about funding in these three categories is available at [www.hhs.gov/recovery/reports/plans/healthcenterscapital.pdf](http://www.hhs.gov/recovery/reports/plans/healthcenterscapital.pdf).
7. Essential rural community facilities include dental clinics, nursing homes, assisted living facilities, physician clinics, hospitals, medical rehabilitation centers, psychiatric hospitals, outpatient clinics, police and fire stations, schools, and child care centers. See [www.rurdev.usda.gov/rhs/cf/essent\\_facil.htm](http://www.rurdev.usda.gov/rhs/cf/essent_facil.htm) and [www.rurdev.usda.gov/ca/pdf%20files%20and%20documents/cf%20direct.pdf](http://www.rurdev.usda.gov/ca/pdf%20files%20and%20documents/cf%20direct.pdf).
8. 7 U.S.C. 1991(a)(13)(C).
9. For additional guidance on eligibility and availability of funds, see [www.rurdev.usda.gov/ca/pdf%20files%20and%20documents/cf%20direct.pdf](http://www.rurdev.usda.gov/ca/pdf%20files%20and%20documents/cf%20direct.pdf) and [www.rurdev.usda.gov/ca/cf/index.htm](http://www.rurdev.usda.gov/ca/cf/index.htm).
10. More details about the Medicaid and Medicare incentives for eligible professionals and hospitals are available at [hhs.gov/recovery/reports/plans/hit\\_implementation.pdf](http://hhs.gov/recovery/reports/plans/hit_implementation.pdf).
11. For an analysis of the HITECH Act and recommendations on how California can prepare for, compete for, and use the state's \$3 billion portion of funds, see *An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California* ([www.chcf.org/documents/chronicdisease/AnUnprecedentedOpportunity.pdf](http://www.chcf.org/documents/chronicdisease/AnUnprecedentedOpportunity.pdf)).
12. On June 16, 2009, the Health IT Policy Committee, an HHS advisory committee, issued draft recommendations regarding objectives for "meaningful use." The recommendations are available at [healthit.hhs.gov/portal/server.pt/gateway/PTARGS\\_0\\_11113\\_872720\\_0\\_0\\_18/Meaningful%20Use%20Preamble.pdf](http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_11113_872720_0_0_18/Meaningful%20Use%20Preamble.pdf). However, the committee has tabled them and is expected to issue substantially revised recommendations at its next meeting on July 16, 2009.
13. Notices. *Federal Register* 2009;74(101): 25550–25552 ([edocket.access.gpo.gov/2009/pdf/E9-12419.pdf](http://edocket.access.gpo.gov/2009/pdf/E9-12419.pdf)).
14. Under ARRA, RECs must offer information access and some level of assistance to all health care providers in a designated region. Entities that will receive priority are public and nonprofit hospitals; critical access hospitals; FQHCs; entities for uninsured, underinsured, and medically underserved people; and solo or small group practices whose focus is mostly primary care.
15. Local resources include universities with health-related programs; medical or professional societies; state primary care associations; state or regional hospital organizations; large health centers and networks of rural and/or community health centers; area health education centers; health information exchanges; government entities, such as public health agencies, libraries, and information centers, that have health professional and community outreach programs; and consumer/patient organizations.
16. The California Health & Human Services Agency is hosting workgroups to discuss EHR loan funding availability and other programs. For more information, see [www.chhs.ca.gov/initiatives/HealthInfoEx/Pages/Default.aspx](http://www.chhs.ca.gov/initiatives/HealthInfoEx/Pages/Default.aspx).
17. An advisory board oversees this collaborative effort. The board's co-chairs are Kim Belshe, secretary of the California Health and Human Services Agency, and Paul Tang, MD, vice president and chief medical officer of the Palo Alto Medical Foundation.
18. More information about these efforts is available at [www.chhs.ca.gov/initiatives/HealthInfoEx/Pages/default.aspx](http://www.chhs.ca.gov/initiatives/HealthInfoEx/Pages/default.aspx).
19. ONC's implementation plan is available at [www.hhs.gov/recovery/reports/plans/onc\\_hit.pdf](http://www.hhs.gov/recovery/reports/plans/onc_hit.pdf).
20. For more information on the state's progress to date, see California Telehealth Network—Frequently Asked Questions ([www.caltelehealth.org/documents/faqs.pdf](http://www.caltelehealth.org/documents/faqs.pdf)) and *Connecting California: The Impact of the Stimulus Package on Broadband and Telehealth Expansion*. California HealthCare Foundation: April 2009 ([www.connectedhealthca.org/pdf/CCCH-stimuluspackageIB04022009.pdf](http://www.connectedhealthca.org/pdf/CCCH-stimuluspackageIB04022009.pdf)).
21. More details about BTOP are available at [www.recovery.gov/?q=content/program-plan&program\\_id=7795](http://www.recovery.gov/?q=content/program-plan&program_id=7795).
22. The notice is available at [broadbandusa.sc.egov.usda.gov/files/BB%20NOFA%20FINAL%20with%20disclaimer\\_1.pdf](http://broadbandusa.sc.egov.usda.gov/files/BB%20NOFA%20FINAL%20with%20disclaimer_1.pdf).
23. *Connecting California: The Impact of the Stimulus Package on Broadband and Telehealth Expansion*. California HealthCare Foundation: April 2009 ([www.connectedhealthca.org/pdf/CCCH-stimuluspackageIB04022009.pdf](http://www.connectedhealthca.org/pdf/CCCH-stimuluspackageIB04022009.pdf)).
24. For information on high-need designations, see [www.bhpr.hrsa.gov/shortage](http://www.bhpr.hrsa.gov/shortage) and [nhsc.hrsa.gov/communities](http://nhsc.hrsa.gov/communities).
25. More information about NHSC loans and the types of health care professionals who qualify for them is available at [nhsc.hrsa.gov/loanrepayment](http://nhsc.hrsa.gov/loanrepayment).
26. For scholarship eligibility information, see [nhsc.hrsa.gov/scholarship/apply.htm](http://nhsc.hrsa.gov/scholarship/apply.htm).
27. More information about the Community Financial Institutions Fund is available at [www.cdfifund.gov](http://www.cdfifund.gov).
28. More information about certification of community development entities is available at [www.cdfifund.gov/what\\_we\\_do/programs\\_id.asp?programID=10](http://www.cdfifund.gov/what_we_do/programs_id.asp?programID=10).
29. The application deadline for the 2009 funding cycle was in April. Application, funding, and other dates for 2010, as yet unannounced, may be similar to those in the 2009 cycle.
30. This program provides loan guarantees—up to 80 percent of the principal amount on loans from nonfederal lenders—to FQHCs for constructing, renovating, and modernizing medical facilities. More information about the program is available at [bphc.hrsa.gov/policy/pin9720.htm](http://bphc.hrsa.gov/policy/pin9720.htm).