What California Stands to Gain:
The Impact of the Stimulus Package on Health Care

California HealthCare Foundation

ISSUE BRIEF

March 2009

Introduction

Since the enactment of the American Recovery and Reinvestment Act of 2009[1] (ARRA) on February 17, 2009, the federal government has been moving rapidly to implement its various provisions. Commonly referred to as "the stimulus package," the ARRA is intended to jumpstart the economy, as well as to provide support to individuals who have lost jobs and health coverage, and to offer fiscal relief to state governments facing gaping budget deficits and sagging revenues. Federal agencies face tight statutory deadlines to effectuate policy changes and disburse large amounts of ARRA funding—generally only available for two years—to states, various entities, and individuals. State administrators and policymakers, industry leaders, and individuals all have a role to play in maximizing the benefits offered to California by the ARRA. In particular, they need to understand and act upon the prerequisites that must be met to qualify for or trigger the disbursement of stimulus funds.

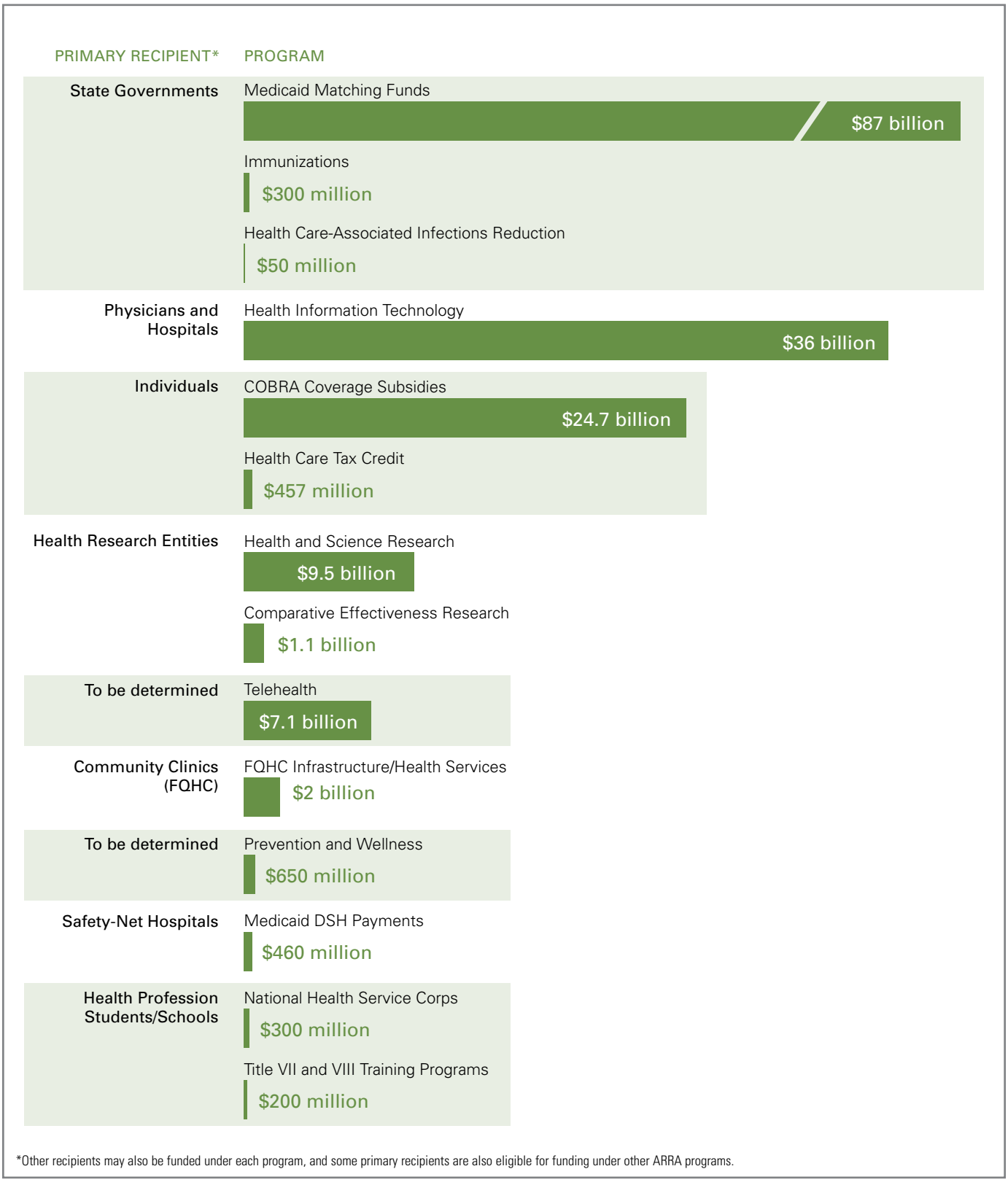
Health care provisions in the stimulus package include addressing immediate health services needs, providing assistance to individuals whose access to health care or coverage is diminished by the recession, and increasing both the quality of health care and its long-term economic efficiency through investments in health-related science and technology.

This issue brief is the second in a series of analyses on the ARRA conducted by the California HealthCare Foundation in collaboration with Manatt Health Solutions. This brief describes the major ARRA health care provisions, examines the federal funds made available, and highlights whether state or other stakeholder actions need to be taken. Among the specific ARRA-related health care programs and issues discussed in the brief are:

- **Medi-Cal support.** Increases in federal matching payments, increased Disproportionate Share Hospital funding, a moratorium on federal Medicaid policy changes that would have affected provider reimbursement, and extension of Transitional Medi-Cal and Indian health care programs.
- **Assistance with health coverage.** Subsidies for and extensions of COBRA coverage and expansion of the federal Health Care Tax Credit.
- **Investments in primary care.** Grant opportunities and enhanced reimbursement for community health centers and additional support for primary health care workforce programs.
- **Elevated status for comparative effectiveness research.** Establishment of a federal advisory board regarding comparative effectiveness research, and dedication of substantial funding.

The brief also examines ARRA provisions relating to support for public health activities, health and science research and facility modernization, and health information technology, including telehealth and broadband programs.

Figure 1. American Recovery and Reinvestment Act of 2009: Estimated National Funding, by Primary Recipient and Program



*Other recipients may also be funded under each program, and some primary recipients are also eligible for funding under other ARRA programs.

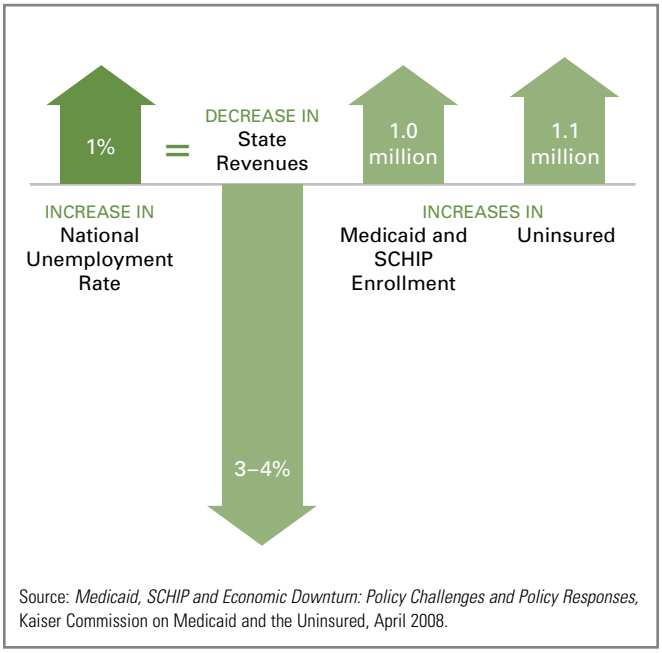
Medi-Cal

Medi-Cal, California's Medicaid program, provides health care coverage to 6.7 million low-income individuals.[4] Annual Medi-Cal spending is approximately $40 billion, which is jointly financed by the federal government, the state, and localities.[5] Medi-Cal is the nation's largest Medicaid program in terms of people served and the second largest in terms of expenditures.

Increased Federal Matching Payments for Medi-Cal

Under current law, state Medi-Cal spending is matched by federal funds at the Federal Medical Assistance Percentage (FMAP, or match rate), which is calculated annually through a statutorily established formula based on the state's "wealth" relative to the rest of the country. California's share is financed primarily by the state through its General Fund, but local governments and public hospitals also contribute a portion.[6] California's current federal match rate is at the minimum level, 50 percent.

Figure 2. Effect of 1 Percent Increase in Unemployment



Source: *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses,* Kaiser Commission on Medicaid and the Uninsured, April 2008.

As more individuals come to rely on Medicaid and other safety-net programs during the economic downturn, and state revenues are also constrained, the ARRA increases the match rate from October 1, 2008 through December 31, 2010, thereby boosting total federal Medicaid support by $87 billion. States will be able to access these funds under the standard Medicaid claiming process, on a quarterly prospective basis. California's match rate is projected to increase from 50 percent to an estimated 61.6 percent, yielding the state, and other governmental entities that share in Medi-Cal costs, an additional $10 to $11 billion.[7,8] This increase is to be achieved through three mechanisms:

- **Hold harmless.** Any reductions that would have been required under the standard annual calculation are suspended. However, any increases under the current formula may be retained.
- **Base increase.** After application of the hold-harmless mechanism, the state's match rate is to increase by 6.2 percent. This would bring California's current 50 percent match rate up to 56.2 percent.
- **Economic condition increase.** If the state experiences higher unemployment, the state's contributions to Medi-Cal would be reduced, in addition to changes from the hold-harmless and base increase mechanisms. This adjustment could add an additional 5.4 percent to the match rate.[9]

To receive the increased Medicaid match rate, California must comply with certain conditions—partly to ensure that the federal funds are targeted to the increased demand for health coverage and not used simply to replace state funds. The ARRA specifies the following requirements:

- **No eligibility decreases or new enrollment hurdles.** The state must maintain Medi-Cal eligibility levels at least as high as the levels in place as of July 2008, and may not impose new procedural hurdles in enrollment.

- **No payment delays.** The state must comply with current rules to promptly pay provider Medi-Cal claims and must apply prompt payment rules to hospitals and nursing home Medi-Cal claims as well. Prompt payment rules specify that the state must pay 90 percent of "clean" claims within 30 days of receipt and 99 percent of "clean" claims within 90 days of receipt. The rule applies to provider, hospital, and nursing home Medi-Cal claims dated after the enactment of the ARRA. The state is given until June 1, 2009 to comply with the new prompt payment requirements.
- **No increases in local financial responsibilities.** The state may not increase localities' required shares of Medi-Cal contributions above the levels in place as of September 30, 2008.
- **No stockpiling of federal Medicaid funds.** The state may not redirect the increased federal Medicaid payments into state reserves or "rainy day" funds.

At the present time, California is not in compliance with all of these conditions. Specifically, the state must eliminate a mid-year reporting requirement for children enrolled in Medi-Cal. Legislation to eliminate this requirement was passed in emergency session and forwarded to the Governor for signature on March 26, 2009. This modification is estimated to increase state Medi-Cal spending by $70 million.[10] In addition, the state must remain in compliance with the prompt pay provisions, regardless of state budget disputes and cash flow considerations.

Table 1. Supplemental Medi-Cal Funding

Key Resources	HHS Recovery, Medicaid FMAP: www.hhs.gov/recovery/programs/medicaidfmap.html
Funding Mechanism	Entitlement
Funding Entity	Centers for Medicare & Medicaid Services (CMS) and the state
Allocation Process	Reimbursement
Matching Funds Requirement	State and local matching funds are required; local matching funds must be in the same proportion as is currently required
Timing	October 1, 2008 through December 31, 2010; CMS recently made $15 billion available for increased payments for October 1, 2008 through March 31, 2009
Funds Flow Through	California Department of Health Care Services (DHCS)
Eligible Recipients	Governmental entities that share in Medi-Cal costs (e.g., state agencies, local governments, public hospitals)
Level of Federal Funding	Congress estimated this provision would increase federal Medicaid spending by approximately $87 billion over the 27-month period
Expected California Share	California estimated to receive total of $10 to $11 billion in increased match rate funds over the 27-month period
Requirements for Funding	State must comply with conditions to receive increased match rate funds, partly to assure that federal funds are targeted to the increased demand for health coverage and not used simply to replace state funds

Increased Disproportionate Share Hospital Funding for Medi-Cal

Medi-Cal Disproportionate Share Hospital (DSH) payments are made to assist with unreimbursed care costs of hospitals that serve a high volume of Medi-Cal or uninsured patients. Federal funds for these Medi-Cal payments are capped at a statutorily defined annual state allotment. California's DSH allotment is approximately $1.1 billion for federal fiscal year 2009. While the ARRA does not increase the matching rate for DSH payments, the stimulus legislation does temporarily increase federal funds available by raising the state allotment levels for federal fiscal years 2009 and 2010. In federal fiscal year 2009, California's allotment will increase by 2.5 percent over its statutorily defined level. In federal fiscal year 2010, the ARRA increases each state's allotment by 2.5 percent over its recession-adjusted federal fiscal year 2009 level, or allows a state to maintain its federal fiscal year 2010 statutorily defined allotment if that level is higher.

California's qualifying public hospitals could receive up to a total of $54 million in additional federal funds over the 2009–2010 period, provided the state and hospitals can meet their own share obligations.[11] Accessing additional DSH payments will depend on the ability to incur qualified costs for public (including University of California) hospitals. The ability to claim DSH funds for all county, district, and most University of California, public hospitals would remain capped at 175 percent of unreimbursed, uncompensated care costs for each hospital.

California also has authority under its State Plan to provide DSH-like payments to private hospitals through a "virtual" DSH program. That program's funding level is linked in state law and the State Plan to the amount of federal DSH funds available; thus the ARRA change would also impact the level of payments available to qualifying private hospitals. Under related state law and State Plan provisions, participating private hospitals

Table 2. Supplemental DSH Funding

Key Resources	HHS Recovery, DSH Allotments: www.hhs.gov/recovery/cms/dshstates.html
Funding Mechanism	Entitlement
Funding Entity	Centers for Medicare & Medicaid Services (CMS), state, counties, and UC
Allocation Process	Reimbursement
Matching Funds Requirement	50 percent match by state or public hospitals (including UC hospitals)
Timing	October 1, 2008 through September 30, 2010
Funds Flow Through	California Department of Health Care Services (DHCS)
Eligible Recipients	Hospitals that serve a "disproportionate share" of Medi-Cal and uninsured patients and are designated by the state to receive DSH payments
Level of Federal Funding	Congress estimated this provision would increase federal DSH payments by $460 million over the two-year period
Expected California Share	• California's qualifying public hospitals could receive $54 million over the two-year period; DSH payments vary by hospital • CMS recently made $269 million available in additional federal fiscal year 2009 allotments; of this amount, California's qualifying public hospitals could be eligible to receive $27 million • Due to an interaction between ARRA and California state law, California's qualifying private hospitals could receive $18 million in "virtual" DSH funds over the two-year period
Requirements for Funding	Hospitals receiving DSH funds must comply with current federal rules

would receive an additional $18 million, divided between state and federal payments. Total DSH payments to qualifying private hospitals would remain constrained by current hospital-specific limits, set at 100 percent of unreimbursed, uncompensated care costs.

Moratorium on Federal Medicaid Policy Changes

The ARRA delays certain federal regulatory changes that would have negatively impacted California's providers and its health care safety net at large. During the past two years, the Bush Administration promulgated seven regulations that would have eliminated federal reimbursement to hospitals and other providers for a variety of Medicaid services. The California Department of Health Care Services estimated the fiscal impact of these regulations at $10 billion over five years. These regulations relate to:

- Graduate medical education;
- Intergovernmental transfers;
- Rehabilitation services;
- Provider taxes;
- School-based administration and transportation services;
- Targeted case management; and
- Outpatient hospital services.

Last year, Congress enacted a moratorium on implementing six of the seven regulations through March 31, 2009 (the regulation relating to outpatient hospital services was not included).

The ARRA extends the moratorium on these six regulations through June 30, 2009, and applies the moratorium to the regulation relating to outpatient hospital services reimbursement. The ARRA extension provides the Obama Administration with additional time to review and evaluate these policies and to decide on further action. The ARRA also includes language discouraging the Obama Administration from permitting the proposed regulations to take effect.

Moratorium on Federal Medicare Policy Changes

Current federal Medicare regulations phase out certain adjustment factors used in determining Medicare payments to hospices and acute care hospitals, starting in federal fiscal year 2009 (October 1, 2008). The phase-out of these factors — the hospice budget neutrality adjustment factor included in the hospice prospective payment system, plus the indirect medical education adjustment factor included in the inpatient prospective payment system — would likely reduce Medicare reimbursement for these providers. The ARRA prevents these regulatory changes from taking effect in federal fiscal year 2009, but notes that Congress does not anticipate extending the moratorium and instead expects the hospice and hospital communities to seek a permanent solution through the annual rulemaking process.

Finally, the ARRA makes technical corrections to a three-year delay of Medicare policy changes related to reimbursement to long-term care hospitals. The delay was originally imposed under the Medicare, Medicaid, and SCHIP Extension Act of 2007.

Transitional Medi-Cal and Qualifying Individuals Programs

The ARRA extends, through December 31, 2010, two programs that help vulnerable individuals gain access to health care.

The Transitional Medi-Cal (TMC) program currently provides up to a year of Medi-Cal coverage to 150,000 individuals who are moving from welfare to work, and who would otherwise become ineligible for Medi-Cal due to work income.[12] The ARRA presents two new options to simplify eligibility criteria and to lessen administrative

burdens. Under the ARRA, at an estimated state cost of $59 million, Medi-Cal officials could:

- Eliminate onerous income-reporting requirements that families must meet in order to retain TMC coverage, and instead automatically provide 12 months of continuous coverage; or
- Waive the current Medi-Cal minimum enrollment requirements that families must meet to qualify for TMC coverage.[13]

The ARRA also extends the Qualifying Individual program. This program pays Medicare Part B premiums for individuals whose income is between 120 percent and 135 percent of the Federal Poverty Level (FPL), and who are eligible for both Medicare and Medi-Cal coverage. Approximately 15,500 Californians are covered by this program.

Indian Healthcare

Several provisions in the ARRA relate to Medicaid and Children's Health Insurance Program (CHIP) services provided to American Indians/Native Americans, generally extending protections to those who are Medicaid/CHIP-eligible and assuring certain Medicaid/CHIP payment levels for providers with or facilities operated by the Indian Health Program or an Urban Indian Organization. Across California, eight urban health programs and 31 tribal health programs currently operate 57 ambulatory clinics.[14]

Assistance with Health Coverage

COBRA Health Insurance Coverage Subsidies

Under federal law, individuals who lose eligibility for group health coverage (for example, due to loss of employment) may temporarily extend their coverage; generally, they become personally responsible for up to 102 percent of the premium cost. This is commonly referred to as COBRA coverage. Many people who are eligible for it do not opt for COBRA coverage, however, because premiums can be prohibitively expensive. The ARRA mitigates this financial barrier by providing a 65 percent premium subsidy for up to nine months of COBRA coverage to individuals who become involuntarily unemployed between September 1, 2008 and December 31, 2009 and have an annual income below $125,000 ($250,000 for families). Because some individuals declined COBRA coverage due to cost when initially eligible, the ARRA also provides a special "second chance" election period for those who failed to enroll in COBRA coverage between September 1, 2008 and the enactment of the ARRA. In addition, the ARRA permits, but does not require, employers to offer recently unemployed workers the option of switching to a less expensive health plan than the one they had while working.

The ARRA also extends this premium subsidy to individuals in comparable continuation of coverage programs, such as California's Cal-COBRA program. Under Cal-COBRA, small employer group plans are required to offer COBRA-like continuation of coverage. Under the ARRA, individuals who enroll in Cal-COBRA and meet the requirements noted above will also be able to access the premium subsidy. It is unclear, however, whether the recently unemployed who refused Cal-COBRA coverage prior to the enactment of the ARRA will be able to take advantage of the premium subsidy since the ARRA permits, but does not mandate, the state to apply the special "second chance" enrollment period to those on Cal-COBRA coverage. The state has

yet to make its intention clear on this matter. However, legislation is being developed that would require the special enrollment period.

Mechanics of the COBRA Subsidy

Individuals may access the COBRA premium subsidy through their former employers, or in some instances, their insurers. Plan administrators must notify individuals who are potentially eligible for the premium subsidy and provide them with an application for it. Individuals who access the subsidy pay 35 percent of the premium; the federal government pays the remaining 65 percent of the premium by offsetting payroll taxes.

The California Budget Project has estimated that 800,000 Californians could qualify for this subsidy.[15] However, the number of Californians who actually enroll in and maintain coverage will ultimately depend on how affordable they find their 35 percent share.[16]

Health Care Tax Credit

The Health Care Tax Credit (HCTC) makes health care coverage more affordable for certain workers, retirees, and their families by subsidizing a large portion of qualified health insurance costs. Under current law, the credit is available to Trade Adjustment Assistance, Alternative Trade Adjustment Assistance, or Pension Benefit Guaranty Corporation recipients and their families, paying for 65 percent of qualified health plan premiums through either a monthly subsidy or an annual refundable tax credit. Through December 31, 2010, the ARRA boosts the subsidy to 80 percent and eases eligibility requirements. Congress estimated this provision would increase federal spending on the HCTC by $457 million. These changes are not expected to substantially impact the state since fewer than 10,000 Californians are likely to qualify for the tax credit and historically participation has been low.[17]

Table 3. COBRA Subsidy

Key Resources	Employee Benefits Security Administration, COBRA: www.dol.gov/ebsa/COBRA.html Internal Revenue Services (IRS), COBRA: www.irs.gov/newsroom/article/0,,id=204505,00.html
Funding Mechanism	Entitlement
Funding Entity	IRS
Allocation Process	Monthly subsidy
Matching Funds Requirement	35 percent of premium paid by individual
Timing	February 17, 2009 through September 30, 2010
Funds Flow Through	IRS to group health plans, insurers
Eligible Recipients	Individuals who become involuntarily unemployed between September 1, 2008 and December 31, 2009, with same-year income less than $125,000 ($250,000 for married couples) are eligible for full 65 percent subsidy; smaller subsidy available for individuals with incomes up to $145,000 ($290,000 for couples)
Level of Federal Funding	Congress estimated this provision at $24.7 billion
Expected California Share	Dependent upon the number of individuals taking advantage of the subsidy
Requirements for Funding	Funds must be used for COBRA or Cal-COBRA continuation of coverage

Primary Care

The ARRA makes significant investments in primary care, providing substantial support for both the delivery of primary care services and workforce development.

Community Health Centers

Community health centers are critical components of the health care safety net, providing community-based, comprehensive primary care services in medically underserved areas regardless of an individual's ability to pay. One source of federal support for community health centers is the Federally Qualified Health Center (FQHC) grant programs. (See the California HealthCare Foundation's recent report, *California's Safety-Net Clinics: A Primer,* for additional details; www.chcf.org/topics/chronicdisease/index.cfm?itemID=115960.) In California, more than 100 community health centers access FQHC support, and may now qualify for additional funds under the ARRA.[18] Home to more than 10 percent of all community health centers in the country, California could benefit greatly from the $2 billion in various community health center grant opportunities provided by the legislation.[19] In addition, California's community health centers are eligible under the ARRA for enhanced Medi-Cal reimbursement for adoption and use of electronic health records. ARRA funding for health information technology is discussed in the California HealthCare Foundation's recent issue brief, *An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California* (www.chcf.org/topics/view.cfm?itemid=133864).

The Federal Health Resources and Services Administration (HRSA) is moving rapidly to make these funds available. In fact, $500 million of ARRA funds already have been disbursed. HRSA has provided:

- $155 million to fund newly designated FQHCs and new sites of existing FQHCs. A total of $15.6 million was awarded to 12 community health centers in California, estimated to serve 80,890 patients and to

Table 4. Community Health Services

Key Resources	HRSA Bureau of Primary Health Care: www.bphc.hrsa.gov HRSA Open Grant Opportunities: www.hrsa.gov/grants/default.htm#primary
Funding Mechanism	Federal appropriations
Funding Entity	HRSA
Allocation Process	Formula allocation and competitive grants
Matching Funds Requirement	To be determined
Timing	Funds available upon delivery of HRSA's operating plan for these funds to Congress, due by mid-May 2009
Funds Flow Through	HRSA, likely through several grant opportunities
Eligible Recipients	FQHCs and FQHC-controlled networks currently receiving operating grants
Level of Federal Funding	• Congress appropriated $1.5 billion • HRSA indicated funds to be available through several grant opportunities, with awards ranging from defined formula allocations to several million dollars for larger capital project needs
Expected California Share	To be determined
Requirements for Funding	FQHCs must use funds for specified infrastructure purposes: • Construction and renovation • Equipment • Acquisition of health information technology systems

create 600 jobs.[20] (For the list of community health centers awarded funds, see www.hhs.gov/recovery/hrsa/applicant.html.)

- $338 million to augment health services at existing FQHCs; newly designated FQHCs also qualify for these funds. A total of $48.1 million was awarded to 117 community health centers in California, estimated to serve 303,474 new patients (148,376 of whom are uninsured) and to create or retain 896 jobs. (For the list of community health centers awarded funds, see www.hhs.gov/recovery/programs/hrsa/california.html.)[21]

Given the quick disbursement pace, it is critically important that qualified health centers in California rapidly assess their needs and ready themselves to respond to funding opportunities. Existing FQHCs and FQHC-controlled networks still have the opportunity to compete for the $1.5 billion designated for infrastructure improvements, funds that can be used to support capital costs traditionally ineligible for federal funding. In addition, the ARRA allows community health centers to use these funds to purchase health information technology systems. Preliminarily, HRSA has indicated that it will dedicate $120 million to health information technology acquisition grants, and direct the remaining funds broadly to construction, renovation, and equipment grants (which may also include health information techonology needs).

Primary Health Care Workforce

California's health care safety net has benefited greatly from federally funded primary care workforce programs that provide $24 million (federal fiscal year 2008) in support of scholarships, student loan repayment, and training for a variety of the state's health professionals.[22] These workforce programs currently engage 292 providers who deliver care to California's underserved communities.[23]

The ARRA offers an additional $500 million to foster a skilled workforce and boost the capacity of hospitals, health centers, and clinics to deliver services. Health professionals will have access to $300 million through the National Health Service Corps (NHSC) program and $200 million will be available to hospitals and to medical, nursing, dental, and public health schools through Title VII and Title VIII training program grants. The ARRA also makes workforce training grants available to health professional schools to increase health information technology literacy (see the California HealthCare Foundation's recent issue brief, *An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California*; www.chcf.org/topics/view.cfm?itemid=133864).

The NHSC program helps to recruit clinicians to underserved communities by providing scholarships to students in health professional training programs and loan repayment aid for current health professionals. Recipients of these funds commit to delivering primary care services in designated high-need areas, often in community health centers. (For additional details on high-need designations, see the HRSA Web site at www.bhpr.hrsa.gov/shortage.)

Title VII and Title VIII training programs also provide assistance for primary care workforce development through grants that target educational institutions. Health professional schools may use these funds to provide scholarships and loan repayment for students or to develop educational infrastructure, such as funding faculty or residency program activities.

Comparative Effectiveness Research

The ARRA elevates comparative effectiveness research (CER)—including funding for rigorous evaluation of different options for treating a given medical condition—as a priority for HHS and dedicates $1.1 billion to accelerate, advance, and disseminate such research. The legislation establishes an advisory body, the Federal Coordinating Council for Comparative

Table 5. Primary Health Care Workforce: National Health Service Corps and Titles VII and VIII Training Programs

	NATIONAL HEALTH SERVICE CORPS	TITLES VII AND VIII TRAINING PROGRAMS
Key Resources	HRSA NHSC: www.nhsc.hrsa.gov	HRSA Bureau of Health Professions: www.bhpr.hrsa.gov HRSA Grants: www.hrsa.gov/grants
Funding Mechanism	Federal appropriations	Federal appropriations
Funding Entity	HRSA	HRSA
Allocation Process	Competitive process through existing National Health Service Corps programs	Competitive process through existing Title VII Health Professions and Title VIII Nurse Training scholarship and loan repayment programs, and training programs
Matching Funds Requirement	None	None
Timing	Funds available upon delivery of HRSA's operating plan for these funds to Congress, due by mid-May 2009	Funds available through existing grants opportunities
Funds Flow Through	HRSA	HRSA
Eligible Recipients	Students in health professional training programs and health professionals (primary care physicians, nurse practitioners, dentists, mental and behavioral health professionals, physician assistants, certified nurse-midwives, dental hygienists)	Entities operating health professional training programs (e.g., hospitals, and schools of medicine, dentistry, public health)
Level of Federal Funding	Congress appropriated $300 million, $75 million of which is available through September 30, 2011	Congress appropriated $200 million
Expected California Share	To be determined	To be determined
Requirements for Funding	Funds must be used for National Health Service Corps recruitment and field activities	Funds must be used for scholarship and loan repayment, training programs for health professionals, and grants to training programs for equipment; also to foster cross-state licensing agreements for healthcare specialists

Effectiveness Research, and commissions an Institute of Medicine (IOM) study, due to Congress by June 30, 2009, to set priorities and make funding recommendations for $400 million of the available funds.

The remaining $700 million is allocated under broad authority to the Agency For Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH)—agencies currently pursuing CER—to support research efforts and demonstration projects as well as other grants. As the ARRA specifies that no more than 1 percent of the AHRQ funds may be used for internal staff work, most of these CER funds will likely become grant opportunities available to external organizations.

Comparative effectiveness studies may compare similar treatments, such as competing therapies or drugs, or it may assess the benefits of very different approaches, such as surgery compared to drug therapy. As a result, findings from CER have the potential to generate cost savings for the health care system, to influence coverage decisions by payors, to inform provider decisionmaking, and to improve health outcomes for patients. California's research institutions (public and private) are eligible to compete for this funding.

Table 6. Comparative Effectiveness Research: HHS, NIH, and AHRQ

	HHS	NIH	AHRQ
Key Resources	HHS Recovery, FCC biographies: www.hhs.gov/recovery/programs/os/cerbios.html	NIH Recovery Act Grants: www.grants.nih.gov/recovery	AHRQ CER: www.effectivehealthcare.ahrq.gov
Funding Mechanism	Federal appropriations	Federal appropriations	Federal appropriations
Funding Entity	HHS	NIH	AHRQ
Allocation Process	Grant or contracting process; HHS must consider recommendations from the Federal Coordinating Council and the IOM Report to Congress	To be determined	To be determined
Matching Funds Requirement	To be determined	To be determined	To be determined
Timing	Funds available upon delivery of HHS's operating plan for these funds to Congress, due by July 30, 2009 and November 1, 2009 for fiscal years 2009 and 2010, respectively	Funds available upon delivery of NIH's operating plan for these funds to Congress, due by July 30, 2009 and November 1, 2009 for fiscal years 2009 and 2010, respectively	Funds available upon delivery of AHRQ's operating plan for these funds to Congress, due by July 30, 2009 and November 1, 2009 for fiscal years 2009 and 2010, respectively
Funds Flow Through	HHS, possibly HHS agencies	NIH	AHRQ
Eligible Recipients	Entities that have demonstrated experience and capacity; includes HHS agencies, other governmental agencies, and private sector entities	Broad array of entities, including NIH national research institutes, NIH national centers, external scientific institutions and scientists	Broad array of entities, including AHRQ training programs, providers, and researchers
Level of Federal Funding	Congress appropriated $400 million; $1.5 million directed towards HHS and the Institute of Medicine to report to Congress recommending national priorities for comparative effectiveness research to be conducted or supported with these ARRA funds	Congress appropriated $400 million	Congress appropriated $300 million
Expected California Share	To be determined	To be determined	To be determined
Requirements for Funding	Funds must be used to accelerate development and dissemination of research assessing comparative effectiveness of health care treatments and strategies; recipients of funds must offer, to the extent feasible, opportunity for public comment on the research	Funds must be used to conduct or support comparative effectiveness research	Funds must be used for comparative effectiveness research

Other Provisions

Public Health

The ARRA provides over $1 billion to support several public health activities under the rubric of a Prevention and Wellness Fund. Of this total, $300 million will be directed specifically to supplement an existing immunization grant program for states, and significant other amounts will be available—under broad terms, the details of which are as yet unspecified—for prevention and wellness strategies. Fifty million dollars is directed to states to develop strategies to reduce health care-associated infections (HAI), while $650 million could be available to a variety of entities for evidence-based clinical and community-based prevention and wellness strategies.

The ARRA also provides $50 million to the Public Health and Social Service Emergency Fund (PHSSEF), but this funding appears to be dedicated to improving information technology security at HHS and thus is inaccessible to the states or other entities.

Table 7. Public Health: Immunizations, HAI Reduction, and Clinical and Community Prevention and Wellness

	IMMUNIZATIONS	HAI REDUCTION	CLINICAL AND COMMUNITY PREVENTION AND WELLNESS
Key Resources	HHS Recovery: www.hhs.gov/recovery	HHS Recovery: www.hhs.gov/recovery	HHS Recovery: www.hhs.gov/recovery
Funding Mechanism	Federal appropriations	Federal appropriations	Federal appropriations
Funding Entity	Centers for Disease Control and Prevention (CDC)	HHS	HHS
Allocation Process	Competitive grant process	To be determined	To be determined; details likely to emerge from a regulatory process
Matching Funds Requirement	None	To be determined	To be determined; details likely to emerge from a regulatory process
Timing	To be determined, though funds likely available through existing grants process	Funds available upon delivery of HHS's operating plan for these funds to Congress, due by mid-May 2009	Funds available upon delivery of HHS's operating plan for these funds to Congress, due by mid-May 2009
Funds Flow Through	Existing CDC Section 317 Immunization Grant Program	HHS	HHS
Eligible Recipients	State health departments	States	To be determined; details likely to emerge from a regulatory process
Level of Federal Funding	$300 million	$50 million	$650 million
Expected California Share	To be determined	To be determined	To be determined
Requirements for Funding	Funds may be used for surveillance, immunization registries, training, education, public information and outreach, provider quality assurance, vaccine management, and purchase of vaccines for adults and children who do not qualify for the Vaccine for Children program	States must use funds to carry out activities to implement "health care-associated infections (HAI) reduction strategies"	Funds must be used to carry out evidence-based clinical and community-based prevention and wellness strategies authorized under the Public Health Service Act that deliver specific, measurable health outcomes that address chronic disease rates

Health and Science Research

California's many research institutions could be well-positioned to pursue the nearly $10 billion that the ARRA provides for health and science research, and for research facility modernization. Although NIH has broad discretion on the use of these funds, the agency has indicated that it will devote ARRA funding to "projects that will stimulate the economy, create or retain jobs, and have the potential for making scientific progress in two years."

NIH recently made $1.5 billion of initial grant funding available as follows:

- At least $200 million in challenge grants to support research that addresses specific challenges in biomedical and behavioral research that would benefit from significant two-year jumpstart funds;
- $1 billion in construction grants to help build new or to improve existing research facilities, and to help grow the economy; and
- $300 million in shared instrumentation grants to facilitate the purchase of research equipment that will enable scientists and researchers to complete critical projects.

Health Information Technology

The health information technology provisions in the ARRA, known as the Health Information Technology for Economic and Clinical Health (HITECH) Act, authorize roughly $36 billion in outlays between 2011 and 2016 for health information technology. Approximately $34 billion dollars are targeted as provider-adoption incentives for the use of electronic health records (EHRs) through Medicare and Medicaid. The remaining $2 billion will be distributed through a variety of competitive grant

Table 8. Health and Science Research

Key Resources	NIH Recovery Act Grants: www.grants.nih.gov/recovery
Funding Mechanism	Federal appropriations
Funding Entity	HHS
Allocation Process	To be determined, though likely under NIH's existing grant mechanisms
Matching Funds Requirement	To be determined
Timing	NIH recently made initial funding available
Funds Flow Through	NIH
Eligible Recipients	To be determined, though likely the broad array of entities currently eligible for NIH grants, including institutions of higher education, state and local governments, and nonprofit and for-profit organizations
Level of Federal Funding	Congress appropriated: • $8.2 billion for scientific research • $1.0 billion in grants or contracts for construction, repairs, and alterations of existing non-federal research facilities • $300 million for instrumentation and other capital research equipment to recipients of grants and contracts as well as other appropriate entities
Expected California Share	To be determined
Requirements for Funding	Funds may be used for scientific research, construction, repairs, alterations, and capital equipment

programs for planning and development of state and/or regional health information exchange services and for training and support for health information technology adoption, as well as through EHR and other loan funds. (See the California HealthCare Foundation's recent issue brief, *An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California*, for an analysis of the Act and recommendations on how California should prepare and compete for, and ultimately use, the state's $3 billion share of funds; www.chcf.org/topics/view.cfm?itemid=133864.)

Telehealth and Broadband Technologies

The ARRA includes a number of new funding commitments to encourage the adoption and use of broadband and telehealth technologies to improve the quality of and access to healthcare. Major funding opportunities include: $4.7 billion for the Broadband Technology Opportunities Program (BTOP); $2.5 billion for the Distance Learning, Telemedicine, and Broadband Program; and $85 million for Indian Health Service (IHS) health information technology activities. In addition, the ARRA includes numerous other funding opportunities to advance California's existing broadband and telehealth efforts.

California has experienced rapid growth in the adoption and use of broadband and telehealth technologies. Investments at state, regional and local levels have helped demonstrate the state's commitment to and national leadership in broadband and telehealth as tools to improve quality of care. Leveraging these existing investments, California is well positioned to access ARRA funds and thereby expand access to care for its residents. (See the issue brief soon to be released from the Center for Connected Health, *Connecting California: The Impact of the Stimulus Package on Telehealth and Broadband Expansion,* which provides a more detailed overview of broadband and telehealth provisions within the ARRA, of implications to California's telehealth and broadband efforts, and of opportunities for the state to influence policy development in these areas.)

Conclusion

The considerable health care-related funding available under the stimulus package presents California with two different paths of opportunity. Some ARRA funds, such as those for COBRA health insurance subsidies, are intended to directly assist individuals to cope with economic hardship. But a large share of ARRA health care-related funds are more broadly directed at allowing the state to stabilize its health care safety net, such as increased federal matching payments for Medi-Cal and increased DSH funding for hospitals serving a high volume of low-income patients. Capitalizing on these stabilization funds will require California to finance its share of certain program costs through state or local matching funds. To the extent current budget constraints lead the state not to match such funds, California risks leaving substantial federal stimulus resources untapped. California also must take the administrative steps necessary to ensure the receipt of funding and to communicate effectively with eligible residents about how they can benefit directly from the stimulus package.

Other opportunities offered by the stimulus bill go well beyond stabilization of the state's existing health care system and present California with opportunities to strengthen and advance that system. The ARRA makes investments to develop workforce and infrastructure for the primary care delivery system, to facilitate health information technology, to extend its broadband network to vulnerable populations, and to expand health and science research. California's policymakers should evaluate how these opportunities can be leveraged to foster a transformation of the state's health care system. Since funds will be distributed through competitive grants directly to public and private actors, the funds that come to California will depend on both the volume and quality of proposals emanating from the state. Seizing this opportunity will require that eligible entities work

collaboratively and creatively to maximize funding opportunities for the state.

The present economic crisis place enormous strains on the state's health care system. But the federal stimulus package fashioned to respond to the crisis may create opportunities for significant positive change in the health care system by supporting programs and ideas that might otherwise be neglected or passed over. The health care opportunities presented by the stimulus package are considerable, and California public administrators, policymakers, and other stakeholders would do well to maximize the benefits the ARRA offers the state and its residents.

About the Authors

Manatt Health Solutions, which collaborated with the California HealthCare Foundation in developing this brief, is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, a law and consulting firm with offices in California, New York, and Washington, D.C. Contributing to this project on behalf of Manatt Health Solutions were William Bernstein, J.D., Melinda Dutton, J.D., Alice Lam, M.P.A., and Leah Griggs Pauly, J.D.

About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

Endnotes

1. Public Law 111-5
2. Budget Act of 2009, SBX3 1 Chapter 1, §§ 8.25 – 8.30, Statutes of 2009; ABX3 16 Chapter 5, Statutes of 2009.
3. Implementing AB3x 16 (Trigger Bill), March 17, 2009 Public Hearing, Treasurer's Office Staff Report, www.treasurer.ca.gov/10B_BudgetTrigger/staff.pdf.
4. Department of Health Services (DHS), Fiscal Forecasting and Data Management Branch, Management Summary, Medi-Cal November 2006, Local Assistance Estimate for FY2006 – 07 and FY2007 – 08; includes DHS estimate of Medi-Cal spending by other departments.
5. See note 4.
6. California Department of Health Services (CDHS), November 2006 Medi-Cal Local Assistance Estimate for FY2006 – 07; includes CDHS estimate of Medi-Cal spending by other departments.
7. *Federal Economic Stimulus Package: Fiscal Effect on California*. Legislative Analyst's Office, March 10, 2009.
8. *The American Recovery and Reinvestment Act Becomes Law, Budget Brief 09-04*. Federal Funds Information for States, February 23, 2009.
9. The economic condition adjustment is performed through a complex formula: The amount by which the state's quarterly unemployment rate exceeds a "base rate," or exceeds the lowest three-month average state unemployment rate since January 2006, determines the amount of reduction in the state's Medi-Cal contributions (5.5 percent, 8.5 percent, or 11.5 percent). This adjustment is applied after taking into account the hold-harmless provision and half of the base increase provision.
10. *Federal Economic Stimulus Package: Fiscal Effect on California*. Legislative Analyst's Office, March 10, 2009.
11. See note 8.
12. See note 7.
13. See note 7.

14. California Area Indian Health Service.

15. *What Does the American Recovery and Reinvestment Act of 2009 Mean for California?* The California Budget Project, March 9, 2009.

16. Schwartz, Karyn, "The COBRA Subsidy and Health Insurance for the Unemployed," Kaiser Commission on Medicaid and the Uninsured, Policy Brief, March 2009, www.kff.org/uninsured/7875.cfm; Dorn, Stan, "Can Economic Recovery Legislation Be Most Effective in Helping Laid-off Workers Obtain Health Coverage?" Robert Wood Johnson Foundation/ Urban Institute, February 2009.

17. Stone-Axelrad, J. and B. Lyke. *Health Coverage Tax Credit Authorized by the Trade Act.* Congressional Research Service, February 8, 2005.

18. Saviano, E.C. *California's Safety-Net Clinics: A Primer.* California HealthCare Foundation, March 2009, www.chcf.org/topics/chronicdisease/index.cfm?itemID=115960.

19. *State Health Facts: Number of Federally Qualified Health Centers, 2007*. Kaiser Family Foundation.

20. *Recovery Act (ARRA): Community Health Center Grants by State.* United States Department of Health and Human Services.

21. *Recovery Act (ARRA): Increased Demand for Services Grants by States.* United States Department of Health and Human Services.

22. HRSA Geospatial Data Warehouse, Federal Fiscal Year 2008 data.

23. HRSA Geospatial Data Warehouse, as of March 21, 2009.