
NATIONAL RURAL HEALTH ASSOCIATION


# Rural Health and the American Recovery and Reinvestment Act of 2009

## National Rural Health Association

The NRHA is a national nonprofit membership organization with more than 18,000 members. The association's mission is to provide leadership on rural health issues. The NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of an interest in rural health.

## Letter from the President

Dear Rural Health Stakeholder,

The American Recovery and Reinvestment Act of 2009 was, dollar-for-dollar, the largest investment in rural health in our country's history. In order to help you better access this investment for your community's health, the NRHA has developed this booklet to help guide you. This is an incredible opportunity for all of us to utilize new resources to improve the health of the 62 million who call rural America home.

Thank you for your commitment to rural health!

Sincerely,

Beth Landon

Beth Landon

President

## Contact the National Rural Health Association


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## Rural Health Provisions in the American Recovery and Reinvestment Act

### Medicaid Federal Matching Assistance Percentage (FMAP)

*Increase $87 billion was included for the Medicaid program. States will be required to maintain at least current eligibility for the Medicaid program in order to receive this funding.*

**Agency:** Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

**Description:** Provides each state with an increase in federal matching funds for state Medicaid expenditures in order to assist states with budget shortfalls avoid cutting back Medicaid assistance.

### Community Health Center Infrastructure Grants

*$1.5 billion was included for Community Health Centers.*

**Agency:** U.S. Department of Health and Human Services

**Description:** To renovate clinics and make health information technology improvements. These funds will be distributed through a competitive grants process and are to be used for construction, renovation, and equipment, and for the acquisition of health information technology systems for community health centers, including health center controlled networks receiving operating grants under section 330 of the Public Health Service Act.

**Website:** http://bphc.hrsa.gov/about/apply.htm; http://www.hrsa.gov/grants/default.htm

**Contact:** (877) 464-4772 (HRSA Call Center)

### Community Health Center Services Grants

*$500 million was included for Community Health Centers.*

**Agency:** U.S. Department of Health and Human Services

**Description:** To increase the number of uninsured Americans who receive quality healthcare. These funds will be dispersed through a competitive grants process and are to be used to support new sites and service areas, to increase services at existing sites, and to provide supplemental payments for spikes in uninsured populations.

**Website:** http://bphc.hrsa.gov/about/apply.htm; http://www.hrsa.gov/grants/default.htm; http://dhhs.nv.gov/Grants/Sitemap_Grants.htm

**Contact:** 1-877-464-4772 (HRSA Call Center)

### National Health Service Corps

*$300 million was included for the National Health Service Corps.*

**Agency:** National Health Service Corps, Health Resources and Services Administration

**Description:** To address shortages of primary healthcare providers in specific health professional shortage areas. These competitive grants, scholarships, and loan repayment programs will be used for training primary healthcare providers including doctors, dentists, and nurses as well as helping to pay medical school expenses for students who agree to practice in underserved communities through the National Health Service Corps.
**Website:** http://nhsc.hrsa.gov/applications/
**Contact:** (877) 464-4772 (HRSA Call Center)

## Health Care Workforce

*$200 million was included for programs under Title VII and Title VIII of the Public Health Service Act.*
**Agency:** Bureau of Health Professions, Health Resources and Services Administration
**Description:** To provide for training of health professions. These competitive grants, scholarships, and loan repayment programs will be used for all the disciplines trained through the primary care medicine and dentistry program, the public health and preventive medicine program, and the scholarship and loan repayment programs for nurses and health professions.
**Website:** http://www.hrsa.gov/help/healthprofessions.htm; http://www.hrsa.gov/grants/default.htm
**Contact:** (877) 464-4772 (HRSA Call Center)

## Training and Employment Services

*$250 million for grants.*
**Agency:** U.S. Department of Labor, Employment and Training Administration
**Description:** Grants for worker training and placement in high growth and emerging industry sectors, including health care. Eligibility has not yet been established
**Website:** http://www.dol.gov/recovery

## Biomedical Research

*$8.2 billion was included for expanding biomedical research funded by National Institute of Health.*
**Agency:** National Institutes of Health
**Description:** To expand jobs in biomedical research to study diseases. $7.4 million will be distributed to specific Institutes and Centers and to the Common Fund for biomedical research grants. $800 million will be used by the Office of the Director for purposes that can be completed within two years, including short-term grants focused on specific scientific challenges, new research that expands the scope of ongoing projects, research on public and international health priorities, and to enhance central research support activities, centralized information support systems.

**Website:** http://www.nih.gov/

**Contact:** (301) 435-0714 (General Grant Information), grantsinfo@od.nih.gov

## University Research Facilities

*$1.3 billion was included for the National Institute of Health to renovate and equip university research facilities.*

**Agency:** National Center for Research Resources, National Institutes of Health

**Description:** To renovate and equip university research facilities. These funds will be distributed using the competitive grants process and will be used for the construction and renovation of extramural research facilities and for the acquisition of shared instrumentation and other capital research equipment.

**Website:** http://www.ncrr.nih.gov/

**Contact:** (301) 435-0888 (National Center for Research Resources)

## Prevention and Wellness Program

*$1 billion was included for the Center for Disease Control for evidence based clinical and community prevention and wellness programs.*

**Agency:** U.S. Department of Health and Human Services

**Description:** To support state and local efforts to fight preventable chronic diseases and infectious diseases. Funds will dispersed through a competitive grants process to carry out evidenced based clinical and community-based prevention and wellness strategies and public health workforce development activities, including immunization programs and state efforts to reduce healthcare-related infections. The Department has not decided which agencies will take the lead but the CDC is likely to be central to these efforts.

**Website:** http://www.cdc.gov/; http://www.hhs.gov/

## Comparative Effectiveness Health Research

*$1.1 billion was included for HHS, the Agency on Healthcare Research and Quality (AHRQ), and NIH*

**Agency:** Agency on Healthcare Research and Quality (AHRQ) and National Institutes of Health (NIH), U.S. Department of Health and Human Services

**Description:** To compare the effectiveness of different medical treatments This funding, dispersed through a competitive grants process, will be used to conduct or support research to evaluate and compare clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition. This research will not be used to mandate coverage decisions or impose "one-size-fits-all" medicine on patients. It will be designed to enable medical professionals and patients improve treatment. $300 million will be administered by AHRQ, $400 million will be transferred to NIH, and $400

million will be allocated at the discretion of the Secretary of HHS.

**Website:** http://www.ahrq.gov/; http://www.nih.gov/

**Contact:** (301) 427-1364 (AHRQ)

## Health Information Technology Grants

*$2 billion was included for discretionary grants to promote the adoption and use of interoperable health information technology (HIT).*

**Agency:** Office of the National Coordinator of Health Information Technology, Agency for Healthcare Research and Quality, CDC, and Indian Health Service/States or State- Designated Entities U.S. Department of Health and Human Services

**Description:** To promote the use and exchange of electronic health information in a manner consistent with the Office of the National Coordinator of Health Information Technology's strategic plan. To award planning and implementation grants to states or qualified state-designated entities to facilitate and expand electronic health information exchange. To award grants to states or Indian tribes to establish loan programs for health care providers to purchase certified electronic health record technology, train personnel in the use of such technology, and improve the secure electronic exchange of health information. To provide financial assistance to universities to establish or expand medical informatics programs.

**Website:** http://www.hhs.gov/healthit/

**Contact:** (877) 696-6775 (HHS)

## Health Information Technology Improvements

*$17 billion was included to improve investments and incentives through Medicare and Medicaid to ensure widespread adoption and use of interoperable health information technology (HIT).*

**Agency:** Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS)

**Description:** Provides incentives for the early adoption and use of interoperable HIT to Medicare and Medicaid providers and penalties in future years for providers not demonstrating meaningful use of Electronic Health Records. Provides eligible professionals who show meaningful use of an Electronic Health Record (EHR) in 2011 or 2012 with incentive payments of $18,000 in the first year. Payment adjustments for eligible professionals not demonstrating meaningful use of an EHR would begin in 2015. Provides eligible hospitals (including Critical Access Hospitals) with incentive payments starting in Fiscal Year 2011 and payments adjustments for hospitals not demonstrating meaningful use of an EHR in Fiscal Year 2015.

**Contact:** (800) MEDICARE

## Broadband Technology Opportunities Act

*$4.35 billion for grants and other initiatives.*

**Agency:** U.S. Department of Commerce, National Telecommunications and Information Administration

**Description:** Grants for broadband education, awareness, training, access, equipment and support to medical and health care providers to facilitate greater use of broadband services to enhance health care delivery. Grantees may be non-profit foundations, corporations, institutions or associations. Other eligible grantees may be identified by the Commerce Department by rule at a later time.

**Website:** http://www.commerce.gov/Recovery/index.htm.

## COBRA Continuation Coverage

*$24.7 billion was included for COBRA Continuation Coverage.*

**Agency:** Group Health Plan, US Department of Labor

**Description:** To provide individuals and their families with a premium subsidy of 65 percent of the COBRA continuation premiums for a maximum of 9 months of coverage only with respect to involuntary terminations that occurs on or after September 1, 2008, and before January 1, 2010. The full premium subsidy is limited by a taxpayer's adjusted gross income (AGI), $125,000 for individuals and $250,000 for joint filers and is phased out for individuals with an AGI between $125,000 and $145,000 and families with an AGI between $250,000 and $290,000. It provides a special 60-day election period for a qualified beneficiary who is eligible for a subsidized premium and who has not elected COBRA continuation coverage as of the date of enactment or who is no longer enrolled on the date of enactment, for example, because the beneficiary was unable to continue paying the premium. Recession-related job loss threatens health coverage for many families. This provision is intended to provide targeted assistance to individuals and families who have been involuntarily terminated to enable them to afford premium payments for health insurance coverage under COBRA. The Joint Committee on Taxation estimates that this provision would help 7 million people maintain their health insurance by providing a vital bridge for workers who have been forced out of their jobs in this recession.

**Website:** http://www.dol.gov/dol/topic/health-plans/cobra.htm

**Contact:** (866) 4-USA-DOL

## Facilities Construction

*$415 million included for facilities construction, to be distributed as follows: $227 million for 2 new facilities on the Indian Priority Facilities List, $100 million for Maintenance and improvements, $68 million for construction, repair and maintenance*

*of Sanitation Facilities, and $20 million for purchase of Medical Equipment.*

**Agency:** U.S. Department of Labor

**Description:** The objectives of the Indian Health Service (IHS) health facilities management, health care facilities construction, sanitation facilities construction, and environmental health services programs are: (1) to provide optimum availability of functional, well-maintained IHS and tribally-operated health care facilities and adequate staff housing at health care delivery locations where no suitable housing alternative is available; and (2) to reduce the incidence of environmentally-related illness and injury by: (a) determining and addressing factors contributing to injuries; (b) working with the tribes to improve environmental conditions; and (c) constructing sanitation facilities and ensuring the availability of safe water supply and adequate waste disposal facilities in American Indian and Alaska Native (AI/ AN) homes and communities. Funding will be used for facilities construction projects, deferred maintenance and improvement projects, the backlog of sanitation projects, and the purchase of equipment.

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**Website:** www.hhs.gov/recovery

## Rural Community Facilities Program Account

*$130 million was included for loans and grants for construction, enlargement or improvement of "essential community facilities," including health care facilities, in rural areas.*

**Agency:** U.S. Department of Agriculture (USDA)

**Description:** Provides loans and grants for non-profit corporations in rural areas (fewer than 20,000 people) providing essential community services for construction, enlargement or improvement of "essential community facilities," including health care facilities. Funds to acquire land, pay professional fees and purchase equipment.

**Website:** http://www.rurdev.usda.gov/rhs/cf/cp.htm.

## Medicare HIT Incentive Payments

**PPS Hospitals:** PPS hospitals that are meaningful users of EHR are eligible for incentives beginning in fiscal year (FY) 2011 and can receive payments for up to four years. The Recovery Act details the formula that the Centers for Medicare & Medicaid Services must use to pay the incentives. An MS Excel spreadsheet with a Hospital Payment Incentive Calculator to help your hospital estimate its potential health IT incentive payments can be accessed at http://www.aha.org/aha/content/2009/spreadsheet/090220-it-hospben-calculator2.xls.

To use the calculator, you will need the following information for your hospital:

1. Total Discharges
2. Total Gross Revenue
3. Total Charity Care Charges
4. Medicare Inpatient Days (Part A Fee-for-Service and Part C Medicare Advantage)
5. Total Inpatient Days

Payment for a qualified PPS hospital is calculated as Medicare's share of the sum of $2 million plus an additional discharge-related amount. A hospital receives $200 for each discharge for discharges starting with its 1,150th and continuing through its 23,000th discharge. There is no additional payment for discharges outside of this range – which means that the largest *discharge-related amount* available to any hospital equals $4,370,200. The largest total amount available would be $6,370,200 ($2 million plus $4,370,200). The calculation is updated each year with current data.

*($2 million + (23,000-1,149)*200)) * Medicare share*

However, the incentive payment will only cover the Medicare share of the incentive amount. The Medicare share consists of total Medicare Part A and C inpatient days, divided by the product of total inpatient days and hospital charges excluding charity care divided by total charges:

$$\frac{\text{Medicare inpatient days}}{\text{(total inpatient days*((gross revenue - charity) / gross revenue))}}$$

Payments phase out over a four-year period in 25 percent increments. A hospital that is a meaningful EHR user starting in FYs 2011-2013 receives the full amount in the first year, 75 percent of the full amount in the second year, 50 percent in the third year, 25 percent in the fourth year and no payments in the fifth year. If a hospital first qualifies as a meaningful user in 2014, three years of payments will be made, starting at the 75 percent level. Consequently, 50 percent will be paid in the second year and 25 percent in the third year.

**Penalties for PPS Hospitals**: Unless significant hardship is demonstrated, hospitals that are not meaningful users by FY 2015 will see their market basket update reduced. In FY 2015, three-quarters of their applicable market basket update will be reduced by 33.33 percent; the market basket update will be reduced in FY 2016

by 66.66 percent, and in FY 2017 and beyond by 100 percent. Adoption in later years can prevent the update reductions, but no incentive payments would be available.

**Timeline of Eligible Payment Incentives and Update Reductions**

| Year of Adoption | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|
| Payment for adopting in FY 2011 or before | 100% | 75% | 50% | 25% | | | |
| If first adopting in FY 2012: | | 100% | 75% | 50% | 25% | | |
| If first adopting in FY 2013: | | | 100% | 75% | 50% | 25% | |
| If first adopting in FY 2014: | | | | 75% | 50% | 25% | |
| If first adopting in FY 2015: | | | | | 50% | 25% | |
| | | | | | | | |
| Penalties begin if not adopting by FY 2015: Three-quarters of the applicable market basket update is reduced by: | | | | | 33.33% | 66.66% | 100% |

**Critical Access Hospitals:** The Recovery Act creates a different payment incentive for CAHs. These payments build off of the current cost-based payment system that pays CAHs 101 percent of their Medicare allowed costs. Under the incentive, a CAH that is determined to be a meaningful user can fully depreciate certified EHR costs beginning in FY 2011. This allows CAHs to load multiple years of depreciation into a single year. In addition, the method of determining Medicare cost is modified for the purposes of determining Medicare's share of certified EHR costs. First, for EHR costs, the Medicare allocation methodology is changed to mirror the calculation using inpatient days, total charges and total charity care charges, as described above in the formula for inpatient PPS hospitals. In addition, for EHR costs the Medicare share is increased by 20 percentage points (not to exceed 100 percent of costs). Additional payments can be made to CAHs using this methodology from FYs 2011-2015 if a CAH incurs additional EHR charges; however, a CAH can only receive additional payments for four years.

**Total EHR Costs x (Medicare Share + 20% )**

**Penalties for CAHs:** Unless significant hardship is demonstrated, CAHs that have not implemented EHRs by FY 2015 are subject to payment reductions, with payment reduced to 100.66 percent of cost in FY 2015; 100.33 percent of cost in FY 2016; and 100 percent of cost in FY 2017 and beyond. CAHs may only receive a hardship exemption for a maximum of five years.

**EHR Adoption Timeline Incentives and Penalties for Meaningful Users of EHR at CAHs**

| Year | CAH EHR Adoption Incentive for Meaningful Use | CAH EHR Non-Meaningful User Penalty |
|---|---|---|
| 2011 | Above incentive formula for 2011-2014 | None |
| 2012 | Above incentive formula for 2012-2014 | None |
| 2013 | Above incentive formula for 2013-2014 | None |
| 2014 | Above incentive formula for 2014 only | None |
| 2015 | If CAH adopts Meaningful EHR Use after 2014:<br>▪ Normal cost-based reimbursement applies, no incentive formula | 2015: 0.33% reduction in Medicare reimbursement |
| 2016 | | 2016: 0.66% reduction in Medicare reimbursement |
| 2017 | | 2017 and beyond: 1.0% reduction in Medicare reimbursement |

**Eligible Professionals:** An eligible professional (physician) will receive incentive payments as specified in the legislation, for the first five years (2011 –2015), for demonstrating a meaningful use of EHR technology and demonstrated performance during the reporting period for each payment year. If an eligible professional does not demonstrate meaningful use by 2015, his/her reimbursement payments under Medicare will begin to be reduced. No incentive payment will be made after 2016.

A meaningful user is an eligible professional (physician) that:

1) Demonstrates to the satisfaction of the Secretary that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary;
2) Demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; and
3) Submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary.

Certified EHR technology means an EHR that is certified to meeting standards pursuant to this Act. To be qualified as a certified EHR technology, the certified technology must include patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources.

If the eligible physician is practicing in a **Health Professional Shortage Area**, then they can receive a 10% increase in incentive payments

If eligible professionals have not become meaningful users of EHRs by 2015, they will not receive full Medicare payments beginning in 2015. The reduction in the fee schedule is as follows:

2015 - 99%;

2016 - 98%

2017 and each subsequent year - 97%

| Payment Year | Incentive |
|---|---|
| First Payment Year | • $18,000 if the first payment year is 2011 or 2012<br>• $15,000 if the first payment year is 2013<br>• $12,000 if the first payment year is 2014 |
| Second Payment Year | $12,000 |
| Third Payment Year | $8,000 |
| Fourth Payment Year | $4,000 |
| Fifth Payment Year | $2,000 |
| *For eligible professionals in a health professional shortage area (HPSA), the incentive payment amounts will be increased by 10%<br>*Payments are not available to hospital-based professionals (such as a pathologist, emergency room physician, or anesthesiologist). | |

## Medicaid Incentives for Meaningful Use of Certified HER Technology

Provides incentive payments for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology) by Medicaid providers. Though legislative language does not specify a start date, written Senate sources lead us to think 2011 is likely. The definition of "meaningful use" must be established through a means that is approved by the State and acceptable to the Secretary. As a further step, the definition must be in alignment with the one used for Medicare.

Certified EHR technology means a qualified EHR that is certified to meeting standards pursuant to this Act and includes patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources.

The State is authorized to make payments to Medicaid providers totaling no more than 85% percent of net average allowable costs for certified EHR technology (and support services including maintenance and training that is for, or is necessary for the adoption and operation of, such technology).

Under this section Medicaid providers eligible for funding are defined as:

- An non-hospital-based professional who has at least 30 percent of the professional's patient volume attributable to individuals who are receiving medical assistance under this title;
- A non-hospital-based pediatrician who has at least 20 percent of his/her patient volume attributable

to individuals who are receiving medical assistance under this title; and

- An eligible professional who practices predominately in a Federally-qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume attributable to needy individuals.
- Children's hospitals – or an acute care hospital that is not a children's hospital – and that have at least 10 percent of the hospital's patient volume attributable to individuals who are receiving medical assistance under this title may receive not in excess of the maximum amount permitted for the provider involved.

No reductions in Medicaid payments are to be made if a provider does not adopt certified EHR technology. The legislation instructs the Secretary to ensure the coordination of incentive payments to eligible professionals through Medicare and Medicaid. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. To carry-out these activities, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.