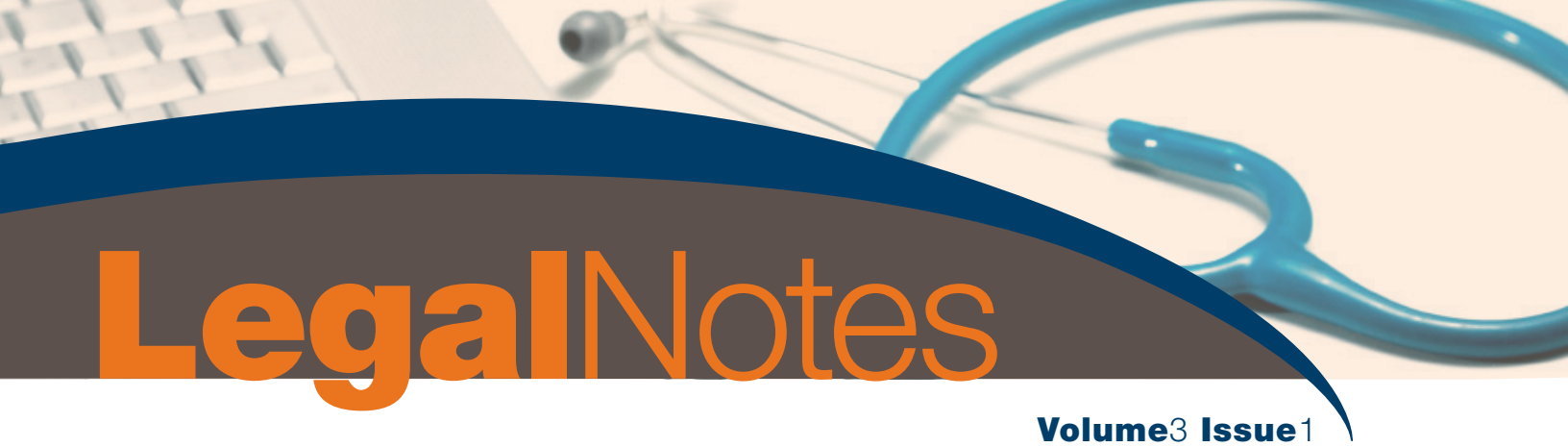




LegalNotes

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LegalNotes is a regular online *Aligning Forces for Quality* (AF4Q) publication that provides readers with short, readable summaries of developments in the law that collectively shape the broader legal environment for efforts to improve quality, reduce health care disparities, and improve the transparency of price and quality information.

Disparities Reduction and Minority Health Improvement under the ACA

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Introduction

Given the relationship between health insurance coverage and access to necessary health care,¹ health insurance reforms contained in the Patient Protection and Affordable Care Act (hereinafter referred to as the Affordable Care Act (ACA))² can be expected to have a significant effect on the health of low income and minority populations.³ However, substantial evidence underscores that health insurance alone cannot reduce disparities in access, quality, and patient care outcomes. Therefore, the ACA also contains a number of provisions that directly address the goal of reducing disparities in health and health care among minority populations. The ACA brings new emphasis to quality and value in public and private health insurance, directs federal funding toward programs that strengthen access and the health care workforce, and advances the collection and reporting of data on race, ethnicity, sex, primary language and disability status in federally supported health care programs, imposing national standards in order to ensure uniformity in collection and reporting.

Aligning Forces for Quality leaders are familiar with the issue of disparities reduction, since improving equity and collecting race, ethnicity, and language data represent core program goals. This brief reviews ACA provisions that address these matters.

Highlights

- A comprehensive data collection provision will require collection of race, ethnicity, language, and other demographic factors in all federally supported health care programs, as long as funds are appropriated for that purpose.
- The goals of reducing disparities and improving minority health are integrated into the National Health Care Strategy and the directive of the Office of Minority Health.
- Use of stratified quality data will be built into Medicaid, CHIP, and specific projects within Medicare, such as the Physician Feedback Program.
- Various federal grants authorized by the ACA will be distributed for the purpose of increasing the number of underrepresented minorities in the health care workforce, or will direct funds to recipients with a specific focus on underserved and minority populations.

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Data Collection

Section 3101 of the Public Health Service Act (as added by Section 4302 of the ACA) requires that the Department of Health and Human Services (HHS) Secretary ensure that, by March 30, 2012, any “federally conducted or supported health care or public health program, activity, or survey ... collects and reports data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants,” as well as any other demographic data regarding health disparities.⁴ The statute does not define “federally conducted or supported health care or public health program, activity or survey,” but by its plain language, the provision is broad in scope and could encompass health insurance coverage purchased by individuals through health insurance exchanges with the assistance of advance premium tax credits.⁵ However, the statute also states that the data collection is required “to the extent practicable” which gives HHS leeway to exclude certain programs from its data collection efforts.

For the data collection, ACA requires that Office of Management and Budget (OMB) standards be used to measure race and ethnicity, and also provides for the development of standards for the collection of data on sex, primary language, disability status, and other demographic data by the applicant or participant of a federally funded program.⁶ The National Coordinator for Health Information Technology is directed to develop national standards for the management of the collected data and to develop interoperable and secure systems for data management.⁷ Collected data must be analyzed to detect and monitor health disparities; data must be made available for additional research and analysis by other agencies, non-governmental agencies, and the public.⁸ The ACA also puts in place privacy protections similar to the HIPAA Privacy Rule that will govern collected data. The law calls for information security safeguards to be established for data collection, analysis and sharing, and protects against “all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses” (to be defined by the Secretary).⁹ One unusual requirement is that any data collected regarding racial and ethnic minorities must also be collected regarding underserved rural and frontier populations.¹⁰

Implementation of these requirements may depend on the appropriation of funding. The ACA prevents data from being collected as required unless specific funding is appropriated for this purpose.¹¹ The current continuing budget resolution does not identify specific data collection activities as authorized under this section of the ACA.¹² However, many data collection activities are funded as components of larger programs or as discretionary funding. In addition, demographic data collection is

a requirement for providers who want to demonstrate meaningful use of electronic health records under the HITECH Act (part of the American Recovery and Reinvestment Act (ARRA));¹³ as a result, it appears that data will be collected for a majority of Medicare-participating providers.¹⁴ HHS has continued to incorporate demographic data into requirements for demonstrating meaningful use.¹⁵ In addition, as discussed below, other ACA provisions direct agencies to collect data within federal programs in order to reduce disparities.

Patient Centered Outcomes Research Institute

In establishing the Patient Centered Outcomes Research Institute,¹⁶ the ACA focuses on both quality improvement and data collection. The data collection clause gives the Institute access to data collected by the Centers for Medicare and Medicaid Services (CMS) while empowering the Institute to request data from federal, state or private entities.¹⁷ The Institute must use the data it obtains to conduct research into high-priority areas, including disparities in health care delivery and patient outcomes.¹⁸ The ACA requires that the Institute’s research findings be broadly disseminated and used as a tool for physicians, health care providers, patients, payers, and policy makers.¹⁹

Changes to Federal Health Insurance Programs

Addressing Health Disparities in Medicaid and the Children’s Health Insurance Program (CHIP)

Section 4302(b) of the ACA amends Medicaid and CHIP to require that any data collected under a state Medicaid or CHIP plan must meet the new requirements of Section 3101 of the Public Health Service Act, which, as noted above, governs data collection, analysis, and quality.²⁰

The ACA directs the Secretary to evaluate and implement approaches for the collection of Medicaid and CHIP disparities data²¹ related to race, ethnicity, sex, primary language, and disability status. In conducting her evaluation, the Secretary must promote the goals of: (1) protecting patient privacy; (2) reducing administrative burdens related to data collection and reporting; and (3) improving quality of data on race, ethnicity, sex, primary language, and disability status.²² Within 18 months of enactment, the Secretary must submit a report outlining proposed methodologies to be used for data collection and evaluation as well as recommendations for improving health disparities data collection under Medicaid and CHIP.²³

Improvements to the Physician Feedback Program

The ACA also amends the Medicare and Medicaid Physician Feedback Program to allow the Secretary to use claims data to generate physician reports that measure physician resource use in furnishing care to Medicare and Medicaid patients.²⁴ The law requires the Secretary to make adjustments that take into account individual differences related to socioeconomic and demographic characteristics, ethnicity, and health status, “such as to recognize that less healthy individuals may require more intensive interventions.”²⁵ After holding listening sessions in the summer and fall of 2010 and considering comments on the need to adjust for socioeconomic and cultural differences, HHS announced that for Phase 2 of the Physician Feedback Program, it would use the same risk adjustment methodology as for Medicare Advantage, which does not consider socioeconomic or cultural factors.²⁶

Quality Improvement

Office of Minority Health

The ACA moves the Office of Minority Health from the Office of Public Health and Science to the Office of the HHS Secretary. The law reclassifies the head of the Office as the Deputy Assistant Secretary for Minority Health and empowers the Office to award grants to public and private nonprofit entities in communities of color; the goal of the grants is to improve health and the quality of health care that minorities receive and to eliminate racial disparities.²⁷ The law also directs HHS to develop measures to evaluate the effectiveness of activities to reduce health disparities. The Office has been moved and key personnel have been named, including Deputy Assistant Secretary Garth Graham.²⁸ The Office has already awarded \$16.2 million in grants to states, territories, national and community health organizations, tribal organizations, and educational entities for demonstration projects aimed at eliminating health disparities among racial and ethnic groups.²⁹ The law also redesignated the National Center on Minority Health and Health Disparities as the National Institute on Minority Health and Health Disparities, which received over \$218 million in funding under the current continuing budget resolution³⁰ to fund the Centers of Excellence and related programs.

National Health Care Quality Strategy

The ACA requires the adoption of a national strategy by March 2011, the goal of which is to improve health care delivery, patient outcomes, and population. The law establishes nine objectives that the Secretary’s priorities must meet:

- improving health outcomes;
- efficiency and patient-centered care for all groups;
- identifying practice areas with the capability to improve the quality and efficiency of patient care in the delivery of health care;
- addressing gaps in quality, efficiency, comparative effectiveness information, health outcomes measures, and data aggregation techniques;
- improving payment policy;
- enhancing the use of health care data;
- assessing the care provided to patients with chronic diseases;
- improved research and dissemination methods;
- reducing health disparities; and
- other areas as determined by the Secretary.³¹

The ACA requires the national strategy to incorporate quality improvement and measurement, and a plan for health information technology, as required by the American Recovery and Reinvestment Act of 2009.³² Comments were solicited on the National Health Care Quality Strategy in the fall of 2010,³³ and it was released by the Secretary on March 21, 2011.

Community Transformation Grants

The ACA establishes a new grant program whose purpose is the improvement of health. The program will award grants to state and local agencies and community-based organizations to implement, evaluate and disseminate preventative activities to reduce chronic disease rates; prevent secondary conditions from occurring; address health disparities; and develop an evidence-based approach to prevention programs.³⁴ Eligible entities include state or local government agencies, a national network of community-based organizations, state or local nonprofit organizations, and Indian tribes.³⁵ The grant program contemplates a wide variety of fundable activities, but prohibits the use of funds for the creation of video games or other activities that may increase the rate of obesity.³⁶ For 2012, the President has requested \$221 million for the Centers for Disease Control (CDC) to allocate toward the Community Transformation Grants.³⁷

Prevention and Public Health Trust Fund

The ACA establishes a Prevention and Public Health Trust Fund within the Department of Health and Human Services (HHS).³⁸ The law authorizes \$500 million for the Fund for fiscal year 2010, with an increase slated for each year until 2015; the fund will remain at \$2 billion for each fiscal year thereafter.³⁹ While the Office of the Secretary of HHS administers the Fund, Congress is authorized to transfer monies in the Fund to eligible activities.⁴⁰ The Fund may be used for activities authorized by the Public Health Service Act, including prevention, wellness, public health, and screening activities, such as the Community Transformation Grant program.⁴¹ To date, the Department of Health and Human Services has awarded a total of \$100 million in grants to a number of communities in states across the country to support public health efforts to curb smoking and obesity, increase physical activity, and improve nutrition.⁴² Awards went to local health departments to increase HIV testing, to communities to reduce tobacco use, to all 50 states to increase epidemiological, laboratory, and health information systems capacity, and to behavioral health agencies to integrate primary care into their practices.⁴³ The President's budget for fiscal year 2012 allocates \$1 billion of mandatory spending to the Prevention Fund.⁴⁴

Workforce Training and Access

The Affordable Care Act creates a number of training and educational opportunities for underrepresented minorities, rural populations, and underserved groups. Many of these programs give priority in the distribution of grants to entities that provide training in the care of vulnerable populations or training to individuals from underrepresented minorities.⁴⁵ However, it is important to note that in some cases, funding for these programs has been authorized but not appropriated or disbursed. In the current economic and political climate, funding that has not yet been appropriated may not materialize.

Primary Care Training

A provision of the ACA entitled "Support and Development of Primary Care Training Programs" requires the Secretary of HHS to give priority in awarding grants to entities that have a record of training individuals from underrepresented or minority groups.⁴⁶ The ACA authorizes \$125 million for fiscal year 2011; however, of that sum there is no evidence that any funding has been distributed.⁴⁷ The ACA also directs the National Health Care Workforce Commission to coordinate with the Departments of Health and Human Services, Labor, Veterans' Affairs, Homeland Security, and Education.⁴⁸ The ACA outlines specific topics that the Commission must review, including the health care workforce needs of minority and underserved populations and loan programs that require low-income, minority students to serve in their

home communities if they are designated as medically underserved areas.⁴⁹ The law authorizes Commission funding to be appropriated as needed.⁵⁰

Minority Representation in Workforce

Increasing the participation of underrepresented minorities in the health care workforce was a goal of the American Recovery and Reinvestment Act as well as the Affordable Care Act. The following ACA provisions direct funding to improve the representation of minorities in the health profession.

- **Grants for Area Health Education Centers:** the ACA authorizes grants to eligible educational entities to increase minority faculty members.⁵¹ Funding for the Area Health Education Centers has been increased by the President in the budget authorization for the Area Health Education Centers for fiscal year 2012.⁵² It is expected that approximately 56 grant awards will be disbursed in fiscal year 2012,⁵³ but funds have not been given to eligible entities at this time.⁵⁴
- **Preference in funding for Centers of Excellence:** the ACA amends the grant provisions for the Centers of Excellence, and allocates additional funding on top of the funds allocated through ARRA.⁵⁵ The modifications include a provision making an additional \$12 million available for grants to health profession schools at historically black colleges if the programs of excellence have less than \$24 million allocated for underrepresented minorities. Of the remaining amount available, 60 percent must be made available for grants to health profession schools with Hispanic or Native American centers of excellence. HHS has already issued grants to a number of entities under this program.⁵⁶ For fiscal year 2012, the President has requested \$24 million to fund the Centers.⁵⁷
- **Preference in mental and behavioral health education funding:** the ACA provides that historically black colleges must receive preference for Mental and Behavioral Health Education and Training Grants.⁵⁸ For fiscal year 2012, the President has requested \$18 million for the Training Grants. It is expected, according to the budget request, that 45 grants will be awarded within this program.⁵⁹ However, HHS has not yet issued grants to eligible entities.⁶⁰
- **Expanded uses for Workforce Diversity Grants:** the ACA also modifies Workforce Diversity Grants by expanding their uses to include stipends for diploma or associate's degree nurses and scholarships, in order to increase nursing education opportunities among individuals from disadvantaged backgrounds.⁶¹ A number of these grants have already been awarded to Nursing Training entities.⁶² The President's budget for 2012 also includes a total of \$20 million for the entire program.⁶³

Reducing Disparities in Access to Care

The provisions of the ACA relating to improved access and delivery of health care pay particular attention to the needs of underserved and minority populations in the requirements for gathering comprehensive data, increasing the supply of qualified health care workers, and enhancing health care workforce education and training.⁶⁴ The ACA authorizes the Secretary to award grants to entities for the development, evaluation and dissemination of research or other projects that demonstrate cultural competency, prevention, public health proficiency and reducing health disparities,⁶⁵ although no grants have been awarded to date. Finally, the ACA establishes a program under which states will issue grants to health care providers who treat a high percentage of medically underserved or other special populations, as defined by the state.⁶⁶ The state grants have not yet been issued.

Implications for *Aligning Forces for Quality*

As with many other aspects of health reform, *Aligning Forces for Quality* is ahead of the curve on the issue of quality improvement and disparities reduction. The ACA will make the collection of race, ethnicity, language, and gender data alongside quality data a routine task throughout the health care system. Alliances will want to monitor the development of data reporting requirements for federal programs, which will be coordinated through the Office of the National Coordinator for Health Information Technology.⁶⁷ Regulations for individual programs, such as Medicaid, will likely have revised reporting requirements. In addition, alliances may wish to comment on the HIT Policy Committee's preliminary recommendations for Stage 2 of meaningful use⁶⁸ and subsequent regulations.

Beyond data collection, the ACA's emphasis on overall quality improvement, preventive care, and workforce development will help promote greater access to high quality care for those who are currently underserved. The National Quality Strategy includes methods to reduce disparities, which will be implemented across federal programs.

As *Aligning Forces for Quality* progresses, alliances that want to expand their efforts to improve equity beyond health care quality improvement and data collection should be aware of the other incentives created by the ACA to improve the health of minority populations. The provisions related to workforce development may be a source of funding for teaching hospitals and academic institutions with an interest in improving culturally competent care. Although many more provisions of health reform address community health resources and improving access to care for the medically underserved than are covered in this brief, some specifically cite the reduction of disparities as a goal, such as the Community Transformation Grants. These grants have yet to be made available, but they could represent an opportunity for *Aligning Forces* communities to leverage federal funding.

¹Institute of Medicine. *Unequal Treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press; 2002.

²Patient Protection and Affordable Care Act (H.R. 3590), as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872), Pub. L. 111-1522 (signed into law March 30, 2010).

³"Health Reform and Communities of Color: Implications for Racial and Ethnic Health Disparities," Kaiser Family Foundation, September, 2010, <http://www.kff.org/healthreform/upload/8016-02.pdf>; (accessed, September 29, 2010).

⁴Public Health Service Act §3101(a)(1) [42 U.S.C. § 300kk] (as added by ACA §4302(a)). The law states: "The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey by the Bureau of Labor Statistics and the Bureau of the Census collects and reports, to the extent practicable (A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants; (B) data at the smallest geographic level such as State, local, or institutional levels if such data can be aggregated; (C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients or participants using, if needed, statistical oversamples of these subpopulations; and (D) any other demographic data as deemed appropriate by the Secretary regarding health disparities."

⁵Such credits are classified as federal financial assistance under ACA §1557. The Secretary of HHS has not yet clarified how this classification of advance tax credits might relate to the data collection provisions.

⁶Public Health Service Act §3101(a)(2) [42 U.S.C. § 300kk] (as added by ACA §4302(a)).

⁷Public Health Service Act §3101(a)(3) [42 U.S.C. § 300kk] (as added by ACA §4302(a)).

⁸Public Health Service Act §3101(b)(1) §3101(c)(3) [42 U.S.C. § 300kk] (as added by ACA §4302(a)).

⁹Public Health Service Act §3101(e)(1); (c)(1) [42 U.S.C. § 300kk] (as added by ACA §4302(a)).

¹⁰Public Health Service Act §3101(f) [42 U.S.C. § 300kk] (as added by ACA §4302(a)).

¹¹Public Health Service Act §3101(h) [42 U.S.C. § 300kk] (as added by ACA §4302(a)) ("Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.")

¹²For up-to-date budget information, see Status of Appropriations Legislation for Fiscal Year 2011 at <http://thomas.loc.gov/home/prop/app/11.html>.

¹³ARRA, Sec. 3000(13).

¹⁴Mosquera M. "Providers strongly commit to signing up for EHR incentive program." *Government Health IT*, Jan. 13, 2011, <http://govhealthit.com/newsitem.aspx?nid=75912> (accessed Jan. 24, 2011).

¹⁵HIT Policy Committee: *Meaningful Use Workgroup Request for Comments Regarding Meaningful Use Stage 2*. Jan. 12, 2011, http://healthit.hhs.gov/media/facil/MU_RFC%20_2011-01-12_final.pdf (accessed Jan. 19, 2011).

¹⁶U.S. Government Accountability Office Press Release. "GAO Announces Appointments to new Patient Centered Outcomes Research Institute Board of Governors." Sept. 23, 2010, <http://www.gao.gov/press/pcori2010sep23.html> (accessed Feb. 28, 2011). The b has held several meetings on budget and public affairs issues. "Draft Agenda March 7-8, 2011." <http://www.pcori.org/> (accessed Feb. 25, 2011).

¹⁷Social Security Act §1181(d)(3) [42 U.S.C. 1301 et. seq.] (as added by ACA §6301(a)).

¹⁸Social Security Act §1181(d)(1)(A) [42 U.S.C. 1301 et. seq.] (as added by ACA §6301(a)).

¹⁹Social Security Act §1181(d)(8)(A) [42 U.S.C. 1301 et. seq.] (as added by ACA §6301(a)).

²⁰Social Security Act §2108(e)(7) [42 U.S.C. 1397hh(e)] (as added by ACA §4302(b)(1)).

²¹Social Security Act §1902(a)(76) [42 U.S.C. 1396 et. seq.] (as added by ACA §4302(b)(1)).

²²Social Security Act §1946(a) [42 U.S.C. 1396 et. seq.] (ACA §4302(b)(2)).

²³Social Security Act §1946(b)(1) [42 U.S.C. 1396 et. seq.] (ACA §4302(b)(2)).

²⁴Social Security Act §1848(n) [42 U.S.C. 1395w-4(n)] (as amended by ACA §3003(a)).

²⁵Social Security Act §1890(b) [42 U.S.C. 1395w-4(n)] (as amended by ACA §3003(a)).

²⁶CY2011 Medicare Physician Fee Schedule Final Rule (CMS-1503-FC), 75 Fed. Reg. 73185, et seq. Feb. 28, 2011, <http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf>. See also <https://www.cms.gov/PhysicianFeedbackProgram/>.

²⁷Public Health Service Act §1707(a) [42 U.S.C. 300u-6] (as amended by ACA §10334(a)(1)).

²⁸Office of Minority Health Key Personnel. 2009, <http://minorityhealth.hhs.gov/templates/content.aspx?ID=7406&tl=1&tlID=7>. (Accessed Mar.1, 2011).

²⁹Office of Minority Health Press Release "HHS' Office of Minority Health Awards \$16.2 Million to Help Eliminate Health Disparities Among Racial and Ethnic Minorities." Oct. 2010, <http://minorityhealth.hhs.gov/templates/content.aspx?ID=8632&tl=1&tlID=10> (accessed Feb. 28, 2010).

³⁰Senate Report 111-243 - Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2011. [http://thomas.loc.gov/cgi-bin/cpquery/R?cp111:FLD010:@1\(sr243\)](http://thomas.loc.gov/cgi-bin/cpquery/R?cp111:FLD010:@1(sr243)) (accessed Mar. 1, 2011).

³¹Public Health Service §399HH(a) [42 U.S.C. 241 et. seq.] (as added by ACA §3011).

³²Public Health Service Act §399HH(b)(2)(F) [42 U.S.C. 241 et. seq.] (as added by ACA §3011).

³³Department of Health and Human Services. "National Health Care Quality Strategy and Plan," September 9, 2010, <http://www.hhs.gov/news/reports/quality/nhcqsap.html> (accessed on Mar. 1, 2011). Plan available at <http://www.hhs.gov/news/reports/quality/nationalhealthcarequalitystrategy.pdf>.

³⁴ACA §4201(a).

³⁵ACA §4201(b)(1).

³⁶ACA §4201(e).

³⁷Centers for Disease Control and Prevention Fiscal Year 2012 Budget Justification, p. 17, http://www.cdc.gov/fmo/topic/Budget%20Information/appropriations_budget_form_pdf/FY2012_CDC_CJ_Final.pdf (accessed Feb. 28, 2011)

³⁸ACA §4002(a).

³⁹ACA §4002(b).

⁴⁰ACA §4002(a), (d)

⁴¹ACA §4002(c); §4201.

⁴²Department of Health and Human Services Press Release, "HHS Awards Nearly \$100 Million In Grants For Public Health and Prevention Priorities," September 24, 2010, <http://www.hhs.gov/news/press/2010pres/09/20100924a.html> (accessed Mar. 1, 2011).

⁴³Id.

⁴⁴Office of the President. FY 2012 Budget for the U.S. Government, p. 83 <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2012/assets/budget.pdf> (accessed Feb. 28, 2011)

⁴⁵See Public Health Service Act §747(a)(1)(A-F) [42 U.S.C. 293k] (as added by ACA §5301); ACA §5101

⁴⁶Public Health Service Act §747(a)(1)(A-F) [42 U.S.C. 293k] (as added by ACA §5301)

⁴⁷Public Health Service Act §747(a)(1)(A-F) [42 U.S.C. 293k] (as added by ACA §5301); Health Resources and Services Administration Fiscal Year 2011 Budget Justification, p. 83-88. <http://www.hrsa.gov/about/budgetjustification/budgetjustification11.pdf> (accessed Jan. 18, 2011)

⁴⁸ACA §5101(a)(2)

⁴⁹ACA §5101(d)(3)

⁵⁰ACA §5101(h)(2); Health Resources and Services Administration Fiscal Year 2011 Budget Justification, <http://www.hrsa.gov/about/budgetjustification/budgetjustification11.pdf> (accessed Jan. 18, 2011)

⁵¹See ACA §4101; Public Health Service Act §752 [42 U.S.C. 294 et seq.] (as added by ACA §5403).

⁵²Health Resources and Services Administration Fiscal Year 2012 Budget Justification, p. 130 <http://www.hrsa.gov/about/budget/budgetjustification2012.pdf> (accessed Feb. 28, 2011).

⁵³Health Resources and Services Administration Fiscal Year 2012 Budget Justification, p. 133 <http://www.hrsa.gov/about/budget/budgetjustification2012.pdf> (accessed Feb. 28, 2011).

⁵⁴Health Resources and Services Administration Fiscal Year 2011 Budget Justification, p. 108-111. <http://www.hrsa.gov/about/budgetjustification/budgetjustification11.pdf> (accessed Jan. 18, 2011)

⁵⁵Public Health Service Act §736(h)(1)(B) [42 U.S.C. 293] (as added by ACA §5401).

⁵⁶Department of Health and Human Services Press Release, "HHS Awards \$159.1 Million to Support Healthcare Workforce Training," August 5, 2010, <http://www.hhs.gov/news/press/2010pres/08/20100805a.html>, (accessed Jan. 6, 2011).

⁵⁷Health Resources and Services Administration Fiscal Year 2012 Budget Justification, p. 103 <http://www.hrsa.gov/about/budget/budgetjustification2012.pdf> (accessed Feb. 28, 2011).

⁵⁸Public Health Service Act §756(b) [42 U.S.C. 294] (as added by ACA §5306(a)).

⁵⁹Health Resources and Services Administration Fiscal Year 2012 Budget Justification, p. 143-146 <http://www.hrsa.gov/about/budget/budgetjustification2012.pdf> (accessed Feb. 28, 2011).

⁶⁰Substance Abuse and Mental Health Services Administration Fiscal Year 2011 Budget Justification, http://www.samhsa.gov/Budget/FY2011/SAMHSA_FY11CJ.pdf (accessed Jan. 18, 2011)

⁶¹Public Health Service Act §821(a) and (b) [42 U.S.C. 296m] (as amended by ACA §5404).

⁶²"HHS Awards \$159.1 Million to Support Healthcare Workforce Training," <http://www.hhs.gov/news/press/2010pres/08/20100805a.html>, (accessed Jan. 6, 2011).

⁶³Health Resources and Services Administration Fiscal Year 2012 Budget Justification, p. 162 <http://www.hrsa.gov/about/budget/budgetjustification2012.pdf> (accessed Feb. 28, 2011).

⁶⁴ACA §5001 ("The purpose of this title is to improve access to and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations . . .")

⁶⁵Public Health Service Act §741(a) [42 U.S.C. 293e] (as added by ACA §5307(a)).

⁶⁶ACA §10501(k)

⁶⁷Public Health Service Act §3101(a)(3) [42 U.S.C. 201 et seq.] (as added by ACA §4302(a)).

⁶⁸HIT Policy Committee: *Meaningful Use Workgroup Request for Comments Regarding Meaningful Use Stage 2*. Jan. 12, 2011, http://healthit.hhs.gov/media/facil/MU_RFC%20_2011-01-12_final.pdf (accessed Jan. 19, 2011).