ADVOCACY UPDATE

February 16, 2009

Special Report:
H.R. 1, the "American Recovery and Reinvestment Act of 2009"

This week, President Obama is expected to sign H.R. 1, the "American Recovery and Reinvestment Act of 2009," into law. The House of Representatives passed the bill on February 13 by a vote of 246-183, with no Republican support; 7 Democrats voted against the bill. Later that evening, the Senate passed the bill 60-38, with only 3 Republicans voting in support [Senators Susan Collins (R-ME), Olympia Snowe (R-ME), and Arlen Specter (R-PA)].

Provisions in the final bill pertaining to health information technology (HIT) mirror those passed earlier last week by the Senate, with a larger ($18,000) bonus in the first year for the earliest physician users of HIT. The maximum amount a physician can collect in HIT bonuses is $44,000 over a five-year period. Penalties for not adopting HIT begin in 2015 (for those who failed to report in 2014), with a -1% reduction in Medicare physician payments that phases to -3% in 2017 and beyond. The final comparative effectiveness research (CER) provisions include clarifying language intended to address concerns about the duties of the new Federal Coordinating Council for CER. This advisory council would be prohibited from mandating coverage, reimbursement, or other policies for any public or private payer.

Additionally, the bill provides states with increased Medicaid funding to address budget shortfalls, and expands COBRA eligibility and subsidization to address the health needs of unemployed individuals and their families. The bill also includes a long list of public health investments, including $1 billion for health and wellness promotion, $500 million to support the training of primary care providers, and $500 million to modernize Indian Health Service facilities.

Attached is a more detailed summary of the health provisions in the Stimulus Conference Agreement. Additional information on some of the more complex provisions of the bill will be posted on the AMA web site later this week.

AMA Position: The AMA supports the goal of enabling millions of Americans to maintain health insurance coverage during the economic crisis. This final legislation takes a significant step toward the development of a nationwide HIT infrastructure by establishing interoperability standards and providing considerable financial resources to physicians

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who use HIT systems. The CER provisions of the bill are consistent with principles adopted by the House of Delegates at the Interim Meeting in November 2008. The AMA also supports providing additional resources to state Medicaid programs and expanding COBRA benefits. The AMA will continue to work with policy makers and the new Administration to ensure that these elements are implemented in a manner that benefits patients and is practical for physician practices.

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H.R. 1, THE "AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009"

Summary of Major Health Care Provisions

Status

- The House of Representatives passed the Conference Agreement on 2/13/09 by a vote of 246-183.
- The Senate passed the Conference Agreement on 2/13/09 by a vote of 60-38.

COBRA

- Sixty-five percent temporary COBRA premium subsidy for workers who have been involuntarily terminated between Sept. 1, 2008, and Dec. 31, 2009.
- Subsidy available for up to 9 months.
- Subsidy would not be considered income for purposes of other federal/state program eligibility.
- To be eligible for the subsidy, an individual must have a modified adjusted gross income below $145,000 (or $290,000 for joint filers); if the taxpayer's income exceeds this threshold, then the premium subsidy must be repaid. For taxpayers with AGI between $125,000 and $145,000 ($250,000 and $290,000 for joint filers), the amount of the premium subsidy that must be repaid is reduced proportionately.

Medicaid

$87 billion in additional federal matching funds is provided (from Oct. 1, 2008-Dec. 31, 2010).

- Increases Federal Medical Assistance Percentages (FMAP) for all states by 6.2%.
- Holds states harmless against a drop in their FMAPs for FYs 2009, 2010, and first quarter of FY 2011 (e.g., if 2008 FMAP is higher than 2009, the state gets the higher 2008 rate).
- States with large increases in unemployment will receive an additional FMAP increase. It is estimated that the conference agreement will provide about 65% of its spending via the hold harmless agreement and across-the-board increases, and about 35% via the unemployment-related increase.
- FMAP increases will not apply to other parts of state Medicaid programs that are based on enhanced FMAP (e.g., DSH, TANF, SCHIP, child/family services, etc.).
- States cannot use FMAP/high unemployment increases for rainy day/reserve fund.
- States must maintain the same eligibility standards, methodologies, and procedures that were in effect on July 1, 2008, in order to receive FMAP increase.
- States must comply with prompt pay laws in order to receive FMAP increase.
- Extends through June 30, 2009, the current moratorium on 4 Medicaid regulations relating to provider taxes, targeted case management services, school-based services, and outpatient hospital services; states the sense of the Congress that the HHS Secretary should not promulgate as final the proposed regulations relating to cost limits on public providers, GME payments, and rehabilitative services.
- Provides for a temporary increase in state Disproportionate Share Hospital (DSH) allotments for FY 2009 and 2010.

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Health information technology (HIT)

Provides approximately $19 billion for Medicare and Medicaid Health Information Technology (HIT) incentives over five years.

- Creates statutory authority for the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS; President Bush created ONCHIT by Executive Order in 2004.
- Establishes HIT Policy and Standards Committees that are comprised of public and private stakeholders (e.g., physicians) to provide recommendations on the HIT policy framework, standards, implementation specifications, and certification criteria for electronic exchange and use of health information.
- HHS to adopt through the rule-making process an initial set of standards, implementation specifications, and certification criteria by Dec. 31, 2009.
- ONCHIT will be authorized to make available an HIT system to providers for a nominal fee.
- Provides financial incentives through the Medicare program to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) in a meaningful way (as defined by the Secretary and may include reporting quality measures). Authorizes ONCHIT to provide competitive grants to states for loans to providers.
- Medicare incentive payments will be based on an amount equal to 75% of the Secretary's estimate of allowable charges, up to $15,000 for the first payment year. Incentive payments would be reduced in subsequent years: $12,000, $8,000, $4,000, and $2000, ending in 2015. Physicians who report using an EHR that is also capable of e-prescribing will no longer be eligible for the e-prescribing bonuses established by the Medicare Improvements for Patients and Providers Act (MIPPA); they will be eligible for HIT incentives only to avoid "double-dipping."
- Early adopters (including those who have already implemented HIT systems) whose first payment year is 2011 or 2012 will be eligible for an initial, larger incentive payment up to $18,000. In 2014, the payment limit for new adopters will be $12,000.
- For eligible professionals in a rural health professional shortage area, the incentive payment amounts will be increased by 10 percent.
- Also provides incentives for eligible physicians, hospitals, Federally-qualified health centers, rural health clinics, and other providers under Medicaid.
- Physicians who do not adopt/use a certified HIT system will face reduction in their Medicare fee schedule payments of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. E-prescribing penalties sunset after 2014.
- Both bills allow HHS to increase penalties beginning in 2019, but penalties cannot exceed -5%. Exceptions will be made on a case-by-case basis for significant hardships (e.g., rural areas without sufficient Internet access).
- Federal privacy and security laws (HIPAA) were expanded to protect patient health information, including: defining which actions constitute a breach (including some inadvertent disclosures), imposing restrictions on certain disclosures, sales, and marketing of protected health information, requiring an accounting of disclosures to a patient upon request, authorizing increased civil monetary penalties for HIPAA violations, and granting authority to state attorneys general to enforce HIPAA.

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Comparative effectiveness research

The Conference Agreement provides $1.1 billion in funding for comparative effectiveness research (CER).

- Establishes the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER), to be comprised of up to 15 representatives of federal agencies—at least half must be physicians or other experts with clinical expertise.
- The FCC-CER will coordinate CER to reduce duplication of efforts and encourage coordinated and complementary uses of resources, coordinate related health services research, and make recommendations to the President and Congress on CER infrastructure needs.
- Both the Report on the Conference Agreement and bill provide that the FCC-CER will not mandate coverage, reimbursement, or other policies of public or private payers.
- CER will not include national clinical guidelines or coverage determinations.
- The Agency for Healthcare Research and Quality (AHRQ) will receive $700 million for CER; AHRQ must transfer $400 million to NIH to conduct or support CER.
- The Secretary will have the discretion to allocate $400 million for CER to accelerate the development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies.
- The Secretary will also be obligated to meet several requirements, including: contract with the Institute of Medicine (IOM) to produce and submit a report to Congress and the Secretary by June 30, 2009, that includes recommendations on the national priorities for CER; consider any recommendations of the FCC-CER; publish information on grants and contracts awarded with the funds within a reasonable time of the obligation of funds and disseminate research findings from such grants and contracts to clinicians, patients, and the general public, as appropriate; ensure that the recipients of the funds offer an opportunity for public comment on the research; and annually report on the research conducted or supported through the funds.

Repeal of the 3 percent withholding tax

The conference agreement delays, from Dec. 31, 2010, to December 31, 2011, implementation of the 3% withholding tax on government contractors (including Medicare providers) that was enacted under section 511 of the Tax Prevention and Reconciliation Act of 2005. Section 511, which was intended to ensure that government contractors file their tax returns properly and promptly, would be tremendously burdensome on physician practices with their relatively small operating margins and the AMA has been working actively in a coalition effort to promote its repeal.

Other appropriations

- **Prevention and Wellness**: $1 billion in funding for wellness and prevention programs, including $300 million for the section 317 immunization program; $50 million for state health-associated infections reduction strategies; and $650 million for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes addressing chronic disease rates.
- **Community Health Centers**: $1.5 billion for construction, renovation, and equipment, and for the acquisition of HIT systems, for community health centers, and $500 million for services.

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- **Training Primary Care Providers**: $500 million to address shortages by training primary health care providers, under Titles VII and VIII of the Public Health Service Act, including physicians, dentists, and nurses as well as helping pay medical school expenses for students who agree to practice in underserved communities through the National Health Service Corps.
- **Indian Health Service Facilities**: $415 million to modernize aging hospitals and clinics and make health care technology upgrades to improve care.
- **NIH Research and Facilities**: $10 billion in funding for NIH for new research grants and renovations and construction at the NIH's campuses.

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