The Legislative Bulletin

A publication of the Vermont Medical Society

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

On February 17th, President Obama signed H.R. 1, the "American Recovery and Reinvestment Act of 2009," into law. Below, is a summary of the health provisions in the legislation prepared by the American Medical Association (AMA). The VMS will provide additional information as it becomes available.

Summary of Major Health Care Provisions According to the AMA

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 nine 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 percent.
- 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 percent of its spending via the hold harmless agreement and across-the-board increases, and about 35 percent 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.

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• Extends through June 30, 2009, the current moratorium on four 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.

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 percent 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 percent in 2015, -2 percent in 2016, and -3 percent 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 percent. 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 percent 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.

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.

- **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.

- **NIH Research and Facilities**: $10 billion in funding for NIH for new research grants and renovations and construction at the NIH's campuses.

Governor proposes to cut Medicaid reimbursement to physicians by Eight percent

Governor Douglas' state fiscal year 2010 (SFY10) budget proposes to cut physician Medicaid reimbursement in three areas by a total of $6.6 million, effective July 1st. This represents an eight-percent cut, based on $81.7 million in projected physician payments in SFY10.

Since Medicaid is paid for jointly by the federal government and state government, any reduction in payments to physicians would be significantly less than the savings to the state. The $6.6 million cut in reimbursement to physicians would only save the state $2.2 million in expenditures.

4-percent cut in physicain reimbursement for all non-evaluation and management procedures. Total reduction impact $1.7 million ($0.6 million state savings) - This four-percent reduction is on top of the 7.5-percent reduction for the same procedures that took place on July 1, 2005 (there has not been an increase for these procedures since that date).

Reduce Primary Care and Case Management fees. Total reduction impact $2.6 million ($0.9 million state savings) - OVHA has recommended that the Primary Care and Case Management fees paid to primary care physicians be cut from five dollars per month to $2.50 per month.

20-percent cut in reimbursement for most procedures for Medicare/Medicaid eligible patients. Total reduction impact $2.3 million ($0.8 million state savings) - OVHA has recommended paying crossover-claims at the Medicaid rate in instances where the patient is covered under both Medicare and Medicaid. Under this proposal, the state's Medicare 20 percent beneficiary co-insurance payment on behalf of the patient would be limited to the Medicaid amount. For procedures where the Medicaid fee schedule is less than 80 percent of Medicare, physicians would receive no payment for the 20 percent co-insurance amounts paid by patients under Medicare Part B.

In order to help ensure that Vermonters covered by the Medicaid program have continued access to medical services, VMS urges physicians to contact members of the House and Senate Appropriations Committees by:

- Calling them at home or leaving a message at the Statehouse at (802) 828-2228;
- Writing a letter to their home address, (go to the VMS website for home addresses and phone numbers - *www.vtmd.org*) or to their attention at 115 State Street, Montpelier, VT 05633

Appropriations Committee

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