

health reform matters



Ropes & Gray Analysis of Selected Health-Related Provisions of the Final American Recovery and Reinvestment Act of 2009 — February 18, 2009

Provision	H.R.1 Conference Report/Public Law No. 111-5
Health Information Technology (HIT) Funding	<p>Grants Provides \$2 billion in funds¹ to the Office of the National Coordinator for Health Information Technology (building from the NCHIT created by April 2004 executive order) to invest in HIT architecture supporting the nationwide electronic exchange of health information.</p> <p>Programs include:</p> <ul style="list-style-type: none">• Grants to states, including state-designated entities to facilitate expanded use of HIT.• Grants to states to develop loan programs for providers to acquire and implement HIT.• Grants for demonstration projects to integrate electronic health records (EHR) into clinical education programs.• Grants to universities to establish multidisciplinary Centers for Health Care Information Enterprise Integration to research system challenges to health care delivery and develop health information technologies.• Assistance to universities for medical health informatics education programs. <p>Medicare and Medicaid Incentive Payments: \$17.2 billion through 2019² Creates incentive payments for professionals and hospitals qualifying as “meaningful EHR users.”</p> <ul style="list-style-type: none">• Meaningful EHR users must be using certified EHR technology, must be able to electronically exchange information to improve quality and must participate in quality reporting using certified EHR technology. <p>Medicare Payments begin in FY2011.</p> <p>Eligible hospitals may receive an annual payment amount based on a formula that calculates the hospital’s Medicare share (using inpatient days except charity care days) of a base amount of</p>

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**Health
Information
Technology (HIT)
Funding**
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\$2 million plus \$200 per-discharge, for discharges 1,500 through 23,000. Incentive payments are phased down by 25% per year over 4 years.

Eligible professionals may receive an amount equal to 75% of allowed charges for Part B services, subject to maximum limits starting at \$18,000 for the first payment year and phasing out over five years (for a total maximum amount of \$44,000 per professional).

Hospital-based professionals are not eligible.

Incentive payments to eligible professionals practicing primarily in health professional shortage areas (HPSAs) are increased by 10%.

Medicare Advantage organizations may be eligible for payments for professionals employed by, or providing over 80% of Medicare patient care services to enrollees of, the MA plan. Contains provisions to prevent duplication of payments.

Critical access hospitals are paid the Medicare share plus 20 percentage points of their reasonable costs of purchasing EHR technology. Such costs may be expensed in a single year and are not required to be depreciated.

Providers first eligible after 2013 receive less payments and after 2014 receive no payments. Beginning in 2015, providers who are not certified EHR users will receive reductions in their market basket update or fee schedule payments.

Medicaid

Eligible hospitals may receive up to the same aggregate amount as would be calculated under the Medicare formula, but substituting Medicaid days for Medicare days in the formula. Payments may be made over 6 years, but may not equal more than 50% of the total amount calculated in any one year or more than 90% of the total in any two-year period. Payments are in addition to Medicare incentive payments. To be eligible, hospitals must have at least 10% Medicaid volume or be a children's hospital. Hospitals will not be eligible for payments after 2016 if they have not previously qualified.

Eligible professionals may receive, for no more than 5 years, payments in the amount of 85% of net

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<p>Health Information Technology (HIT) Funding <i>continued</i></p>	<p>average allowable EHR costs. These costs are subject to an aggregate limit of \$75,000 (including a limit of \$25,000 for initial purchase and implementation of EHR and annual limits of \$10,000 for other costs). The first year of payment may not be after 2016, and no payments may be made after 2021.</p> <p>To be eligible, professionals must provide at least 30% of their volume to Medicaid patients, must not be hospital-based and must waive their right to Medicare incentive payments. Pediatricians with between 20% and 30% Medicaid volume are eligible for reduced payments</p> <p>To qualify for the first year of payment, a provider must demonstrate efforts to adopt, implement, or upgrade certified EHR technology. For any subsequent years, the provider must be a “meaningful EHR user” to qualify for payments.</p> <p>Medicaid EHR incentive payments to providers are treated as administrative expenses for states and are matched at 100% matching rate. States must provide assurances that federal matching funds are paid directly to providers without any deduction or rebate.</p>
<p>HIT Interoperability and Privacy Standards</p>	<p>Creates HIT Policy Committee and HIT Standards Committee within the Office of the National Coordinator to develop standards, implementation specifications, and certification criteria, as well as a rulemaking process by which the Secretary of HHS must adopt standards by Dec. 31, 2009.</p> <p>Requires all business associates to comply with the security provisions of HIPAA, requires all business associate agreements to specifically incorporate these provisions, and subjects business associates to the same civil and criminal penalties to which covered entities are subject.</p> <p>Restricts the types of marketing communications that are considered health care operations and limits the conditions under which covered entities and business associates may receive payment for such communications.</p> <p>Fundraising communications are permitted but recipients of such communications must be given opportunity to opt out of receiving future communications.</p> <p>Permits state attorneys general to bring civil actions in federal court to enforce federal privacy standards.</p> <p>Requires notification of a security breach within 60 days, including notification of HHS, the individuals affected, and local media outlets (if more than 500 individuals are impacted).</p>

Comparative Effectiveness Research	<p>Provides \$1.1 billion for comparative effectiveness research to the Agency for Healthcare Research and Quality (\$400 million to be transferred to NIH, and another \$400 million to be distributed at HHS Secretary's discretion).</p> <p>Joint Explanatory Statement accompanying final bill states that the conferees "do not intend for the ... funding ... to be used to mandate coverage, reimbursement, or other policies for any public or private payor."</p> <p>Creates Federal Coordinating Council for Comparative Effectiveness to assist the agencies and advise the President and Congress.</p>
Support for National Institutes of Health (NIH)	<p>Provides \$8.2 billion to NIH for scientific research.³</p> <p>Additional \$1.3 billion to the National Center for Research Resources for renovation of existing nonfederal research facilities.⁴</p> <p>Additional \$500 million for NIH buildings and facilities.⁵</p>
COBRA Extension	<p>65% subsidy available to individuals who lose health coverage because of involuntary termination of employment between Sep. 1, 2008 and Dec. 31, 2009. Subsidy effective for periods of coverage beginning on or after enactment date.</p> <p>Coverage lasts for 9 subsidized months, and up to 9, 20 or 27 more unsubsidized months, as applicable.</p> <p>Subsidy is only available for continuation of health coverage in which individual was enrolled as an employee, or, if employer permits, employee may elect different coverage, provided the premium does not exceed the premium for the previously held coverage.</p> <p>Special election period of 60 days required for subsidy-eligible individuals who did not previously elect COBRA.</p> <p>Employer may claim cost of premium as a credit against wage withholding and payroll taxes, and will be reimbursed by Treasury for amounts employer pays in COBRA premiums that exceed the withholding and taxes.</p> <p>COBRA extension is estimated to cost \$24.7 billion.⁶</p>

<p>FMAP Increase</p>	<p>Provides a 6.2% across-the board increase from Oct. 1, 2008 through Dec. 31, 2010 (and prevents any scheduled decrease in FMAP under current formulas) plus an unemployment-related increase depending upon the state's unemployment rate. These increases are estimated to cost \$86.6 billion.⁷ Unemployment-related increases reflect 35% of the overall amount.</p> <p>Does not apply to:</p> <ul style="list-style-type: none"> • Disproportionate share hospital (DSH) payments • Cost of eligibility expansions • Children's Health Insurance Program (CHIP) expenditures <p>States receiving the FMAP increase:</p> <ul style="list-style-type: none"> • May not require political subdivisions to pay a greater percentage of non-federal share than before the recovery period. This provision also applies separately to DSH payments. • Must meet maintenance of effort (MOE) requirement under which Medicaid eligibility levels may not be reduced. (There is no MOE requirement for provider reimbursement or benefits.) • Must meet prompt pay requirements, including new requirements for nursing facilities and hospitals.
<p>Medicaid Disproportionate Share (DSH) Funding</p>	<p>Provides temporary across-the-board allotment increase for FY2009 and 2010, equal to 2.5% of the FY2009 allotment, and 2.5% of that enhanced allotment for FY2010 (unless the increase due to inflation would be higher for FY2010). \$460 million.⁸</p>
<p>Transitional Medical Assistance</p>	<p>Expands the Medicaid Temporary Medical Assistance (TMA) program, which provides transitional medical assistance for families that no longer qualify for Medicaid because of income. Through December 2010, states could opt to extend coverage from 6 months to 1 year and to waive the requirement of previous enrollment for 3 of the previous 6 months. \$1.3 billion.⁹</p>
<p>Other Medicaid</p>	<p>Extends Qualified Individual program (for certain dual eligibles) through December 31, 2010. \$550 million.¹⁰</p> <p>Provides \$31.25 million to HHS Office of Inspector General for oversight and audit of programs, grants, and projects funded and separately provides \$5 million to CMS for implementation and oversight of the FMAP increase.¹¹</p> <p>Includes Indian Health provisions that eliminate cost sharing and resource determination requirements for Medicaid or CHIP coverage. Effective date for cost sharing provisions is July 1, 2009. \$134 million.¹²</p>

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<p>Other Medicaid <i>continued</i></p>	<p>Directs Government Accounting Office to assess the impact of increasing FMAP rates in an economic downturn, to make recommendations for modifying FMAP rates in an economic downturn, and to assess the impact of recessions on health insurance coverage.</p>
<p>Medicare and Medicaid Regulations</p>	<p>Medicaid Regulations</p> <p>Extends moratoria on the following final Medicaid regulations until July 1, 2009:</p> <ul style="list-style-type: none"> • Portions of rule restricting allowable provider taxes • Rule restricting federal reimbursement for school administration and transportation services • Portions of rule restricting federal reimbursement for case management services <p>Imposes a moratorium on the final outpatient hospital services rule from December 8, 2008 until July 1, 2009.</p> <p>Expresses the Sense of Congress that the Secretary of HHS should not promulgate regulations concerning intergovernmental transfers, Graduate Medical Education, and rehabilitative services.</p> <p>Total cost of provisions relating to Medicaid regulations is \$105 million.¹³</p> <p>Medicare Regulations</p> <p>Prevents Medicare capital indirect medical education (IME) cuts until October 1, 2009. \$191 million.¹⁴</p> <p>Delay phase-out of Medicare hospice budget neutrality adjustment through October 1, 2009. \$134 million.¹⁵</p> <p>Applies the three-year delay in the implementation of the 25% rule to all long term care hospitals (LTCHs) and to bed expansions that were approved between April 1, 2005 and Dec. 29, 2007. 13 million.¹⁶</p>
<p>Funding for Community Health Centers (CHCs)</p>	<p>\$1.5 billion in capital funding for renovation and repair of health centers and for the acquisition by such centers of HIT systems. Grants must be awarded within 180 days of enactment.¹⁷</p> <p>\$500 million in operating funding for grants to CHCs.¹⁸</p>
<p>Capital Funding</p>	<p>Generally expands marketability of tax-exempt bonds, including to commercial banks.</p>
<p>Workforce</p>	<p>Creates a \$1 billion¹⁹ fund administered by HHS for activities including immunization, chronic disease, HIV/AIDS, environmental health, injury prevention, and public health workforce development.</p> <ul style="list-style-type: none"> • Includes \$30 million for CDC immunization efforts; \$650 million for evidence-based clinical and community-based prevention and wellness strategies; and \$50 million in state grants to reduce healthcare-associated infections.

Workforce
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Additional \$500 million to address workforce shortages. \$300 million is allocated to the National Health Service Corps for recruitment and field activities. The remaining \$200 million is for grants and scholarships (including the Public Health Service Act Title VII and Title VIII scholarship and loan repayment programs) at the discretion of HRSA.20

Footnotes

¹Amount appropriated in Conference Report.

²Senate Finance Committee Summary of Conference Report.

³Amounts appropriated in Conference Report.

⁴Amounts appropriated in Conference Report.

⁵Amounts appropriated in Conference Report.

⁶Senate Finance Committee Summary of Conference Report.

⁷Senate Finance Committee Summary of Conference Report.

⁸Senate Finance Committee Summary of Conference Report.

⁹Senate Finance Committee Summary of Conference Report.

¹⁰Senate Finance Committee Summary of Conference Report.

¹¹Amount appropriated in Conference Report.

¹²Senate Finance Committee Summary of Conference Report.

¹³Conference Report Summary from U.S. House of Representatives.

¹⁴Conference Report Summary from U.S. House of Representatives.

¹⁵Senate Finance Committee Summary of Conference Report.

¹⁶Senate Finance Committee Summary of Conference Report.

¹⁷Amount appropriated in Conference Report.

¹⁸Amount appropriated in Conference Report.

¹⁹Amount appropriated in Conference Report.

²⁰Amount appropriated in Conference Report.