



Monday, February 23 2009

American Recovery And Reinvestment Act of 2009 (ARRA)

H.R. 1 (Conference Agreement enacted on 2/17/09)

Summary of Major Health Care Provisions

Status

The House of Representatives and Senate passed ARRA on February 13th (House vote of 246-183, with no Republican support and 7 Democrats voting no; Senate vote of 60-38, with 3 Republicans voting yes (Senators Collins, Snowe, and Specter). President Obama signed the bill on February 17, 2009.

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 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 would receive an additional FMAP increase. It is estimated that the conference agreement would 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 would 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 current Medicaid prompt pay requirements 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 DSH allotments for FY 2009 and 2010.

Health Information Technology (HIT)

Provides approximately \$19 billion for Medicare and Medicaid HIT incentives over five years.

- Officially establishes the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS to promote the development of a nationwide interoperable HIT infrastructure; President Bush already 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 would adopt through the rule-making process an initial set of standards, implementation specifications, and certification criteria by December 31, 2009.
- ONCHIT would 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 would 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, after 2015. Physicians who report using an EHR that is also capable of e-prescribing would be eligible for EHR incentives only.
- Early adopters, whose first payment year is 2011 or 2012, would be eligible for an initial incentive payment up to \$18,000. In 2014, the payment limit would equal \$12,000. Adopters, whose first payment year is 2015, would receive \$0 payment for 2015 and any subsequent year.
- For eligible professionals in a rural health professional shortage area, the incentive payment amounts would be increased by 10 percent.
- Incentives under the Medicaid program are also available for physicians, hospitals, federally-qualified health centers, rural health clinics, and other providers; however, physicians cannot take advantage of the incentive payment programs under both the Medicare and Medicaid programs. Eligible pediatricians (non-hospital based), with at least 20 percent Medicaid patient volume, could receive up to \$42,500, and other physicians (non-hospital based), with at least 30 percent Medicaid patient volume, could receive up to \$63,750, over a six-year period.
- Physicians who do not adopt/use a certified HIT system would face reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. E-prescribing penalties would sunset after 2014.
- Allows HHS to increase penalties beginning in 2019, but penalties cannot exceed -5%. Exceptions would be made on a case-by-case basis for significant hardships (e.g., rural areas without sufficient Internet access).

Privacy

- Federal privacy/security laws (HIPAA) are expanded to protect patient health information.
- HIPAA privacy and security laws would apply directly to business associates of covered entities.
- Defines actions that constitute a breach of patient health information (including inadvertent disclosures) and requires notification to patients if their health information is breached.
- Allows patients to pay out of pocket for a health care item or service in full and to request that the claim not be submitted to the health plan.
- Requires physicians to provide patients, upon request, an accounting of disclosures of health information made through the use of an EHR.
- Prohibits the sale of a patient's health information without the patient's written authorization, except in limited circumstances involving research or public health activities.
- Prohibits covered entities from being paid to use patients' health information for marketing purposes without patient authorization, except limited communication to a patient about a drug or biologic that the patient is currently being prescribed.
- Requires personal health record (PHR) vendors to notify individuals of a breach of patient health information.
- Non-covered HIPAA entities such as Health Information Exchanges, Regional Health Information Organizations, e-Prescribing Gateways, and PHR vendors are required to have business associate agreements with covered entities for the electronic exchange of patient health information.
- Authorizes increased civil monetary penalties for HIPAA violations.
- Grants enforcement authority to state attorneys general to enforce HIPAA.

Comparative Effectiveness Research (CER)

The government will increase funding for CER by \$1.1 billion.

- Establishes the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER), an advisory board that will be comprised of up to 15 representatives of federal agencies—at least half will 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 that actual ARRA language 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 as ARRA incorporates by reference the provisions in the Medicare Modernization Act of 2003 that explicitly preclude this.
- 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 of HHS will have the discretion to allocate the remaining \$400 million for CER to accelerate the

development and dissemination of research assessing the comparative effectiveness of health care treatments and strategies.

The Secretary of HHS will also be obligated to meet several requirements, including: contract with the 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 for such grants and contracts 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 December 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 and the AMA has been working actively in a coalition effort to promote its repeal.

Medicare Improvement Fund Modifications

The conference agreement clarifies that the Medicare Improvement Fund can be used to increase the physician conversion factor to address any projected shortfall in 2014 relative to the 2008 conversion factor and to adjust Medicare payments for Parts A and B items and services. It would also require, in 2020 and beyond, that any savings from HIT penalties be applied to the Medicare Improvement Fund.

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.
- **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.

More details on the health care provisions in the American Recovery and Reinvestment Act of 2009 (ARRA):

[Explanation of CER Provisions \(PDF\)](#)

[Explanation of HIT Provisions \(PDF\)](#)

[Explanation of Privacy Provisions \(PDF\)](#)

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