AAFP
STRONG MEDICINE FOR AMERICA

GOVERNMENT AFFAIRS WEEKLY

AAFP Division of Government Relations — 2021 Massachusetts Avenue, NW — Washington, DC 20036

February 6, 2009

IN THIS REPORT…

1. The Week Ahead in Congress
2. Congress Extends the Children's Health Insurance Program
3. The Senate Leaders Hope to Finish Work on Economic Recovery Bill
4. Advocacy Training E-Mails Sent to Members
5. FamMedPAC Meets with New Legislators
6. House Republicans Announce Health Care Reform Task Force
7. House and Senate Support Health IT in Economic Recovery Legislation

1. THE WEEK AHEAD IN CONGRESS

- If the Senate finishes work on its version of the stimulus bill, House and Senate conferees will attempt to produce a compromise version next week. The leaders in the House and Senate hope to have a final vote before Congress adjourns on Friday for a week-long break.

- The Senate Budget Committee has scheduled a hearing on Tuesday, February 10, to examine how heath care issues affect the federal budget.

2. HOUSE APPROVES CHILDREN'S HEALTH INSURANCE BILL, PRESIDENT SIGNS IT

On Wednesday, February 4, by a vote of 290-135, the House gave final approval to the *Children's Health Insurance Program Reauthorization Act* (HR 2). Later that same day, President Obama signed the measure into law. The White House invited AAFP to send a representative and Dr. Henley, the Executive Vice President, attended the ceremony.

The bill provides $32.8 billion more over the next four and half years to allow coverage for an additional 4.1 million children, most of whom are already eligible but not covered. The program currently covers 7 million children. The bill removes the provision that required legal immigrants to wait 5 years before being eligible for coverage. In addition, the bill allows states to raise the maximum income level for families to be eligible for coverage.

The bill increases the federal tax on cigarettes by 62 cents a pack to pay for the expanded coverage. That means that the federal tax will be $1.01 per pack.

3. SENATE NEARS THE END OF DEBATE ON ECONOMIC RECOVERY LEGISILATION

The Senate has spent the week debating amendments to the *American Recovery and Reinvestment Act* (HR 1) and the leadership hopes to complete the Senate process by later tonight. The bill includes a temporary increase in the Federal Medicaid Assistance Percentage (FMAP), which would help states avoid reducing coverage and benefits for Medicaid recipients. In addition, the legislation would provide the Agency for Healthcare Research and Quality (AHRQ) funding to conduct a comparative effectiveness program that would provide physicians with objective information about the efficacy of commonly prescribed drugs and devices. In addition, the Senate bill includes payments to physician practices that use appropriate Health Information Technology (HIT). The provisions in the House and Senate bill are nearly identical

and are expected to remain in the bill. (For a brief description of the physician-specific HIT provisions, please go to the end of this report.) Finally, the Senate bill includes funding for general grants for health professions, but unlike the House bill does not specify support for family medicine training. If that remains in the bill, the AAFP is working with legislators to keep the House version of this funding.

Action Alerts:
On Tuesday, the AAFP sent a Speak Out alert to all AAFP members urging them to contact their Senators about the *American Recovery and Investment Act* (H.R. 1). AAFP members called Senate offices in support of the bill's HIT provisions and to ask that Title VII funds be included.

4. ADVOCACY TRAINING AVAILABLE TO AAFP MEMBERS
The AAFP published its February grassroots training article on the legislative process. Find it online at http://www.aafp.org/online/en/home/policy/grassroots/training2009.html.

5. AAFP AND FamMedPAC CO-SPONSOR HEALTHCARE CONGRESSIONAL EVENTS
Government Relations staff attended a healthcare meeting with newly elected Representative Walt Minnick (D-ID). Rep. Minnick represents the home district of AAFP President Dr. Ted, Epperly, and FamMedPAC supported Rep. Minnick in his election campaign. Representatives of 13 other medical specialty societies attended the event, including representatives of the Osteopaths and the College of Physicians. Although not on the committees with jurisdiction over healthcare issues, Rep. Minnick is very interested in healthcare reform. As a small businessman, he is very aware of the high cost of health insurance and will work to make it more affordable. He feels that primary care must be the focus of the American healthcare system.

GR also attended a healthcare meeting with Rep. John Fleming (R-LA), a family physician and newly elected Representative. Rep. Fleming represents the home district of FamMedPAC Board Chair Dr. Michael Fleming (no relation) and the PAC supported his campaign. Rep. Fleming was very active in the Louisiana Academy and was named Louisiana Family Physician of the Year in 2007. Along with being a physician, Dr. Fleming is a businessman, owning several UPS and Subway franchises. As such, he is very familiar with healthcare issues facing both providers and employers. He is a strong proponent of “market-based” solutions to the problem of the uninsured and feels the federal government should not be involved in providing health insurance. He supports the medical home model.

6. HOUSE GOP FORMS HEALTH CARE REFORM TASK FORCE
On February 4, House Minority Leader John Boehner (R-OH) announced that Rep. Roy Blunt (R-MO) will chair a Health Care Task Force to develop Republican solutions to increase Americans’ access to quality, affordable health care and highlighting the consequences that a government-run health care system would have for American families. The Task Force which will begin meeting this week includes the following members:

Roy Blunt (R-MO), Chairman; Joe Barton (R-TX); Judy Biggert (R-IL); Charles Boustany (R-LA); Ginny Brown-Waite (R-FL); Michael Burgess (R-TX); Dave Camp (R-MI); Nathan Deal (R-GA); Phil Gingrey (R-GA); Wally Herger (R-CA); Lynn Jenkins (R-KS); Howard P. “Buck” McKeon (R-CA); Tim Murphy (R-PA); Tom Price (R-GA); Paul Ryan (R-WI); and John Shadegg (R-AZ).

7. HEALTH IT INCENTIVES IN ECONOMIC RECOVERY BILLS (as of 2/6/09)
Qualified EHR

- Both bills define a qualified EHR as a comprehensive electronic record of health information that includes patient demographic and clinical health information**,** e.g.,

medical history and problem lists; the capacity to provide clinical decision support; physician order entry; information relevant to health care quality; and the ability to exchange electronic health information and integrate it with other sources. It may or may not be certified.

Certified HIT

- In contrast, a certified HIT is defined as "qualified electronic health records" and is essentially a "subset" of a qualified, comprehensive EHR. The Secretary is required to develop standards. Nevertheless, there is recognition that there is no "one size fits all" certification and both bills are designed to reward a variety of systems, as long as they are certified and appropriate for the type of practice. The incentives do not differentiate between existing systems or new systems.

Medicare Incentive Payments and Incentives for Early Adoption (House and Senate Differences Noted)

- Beginning in 2011, a physician is eligible for 75 percent of their Medicare allowed charges, or no more than the applicable HIT payment cap in that year. Incentive payments are not available to hospital-based professionals.
- In the House bill, the incentive payment limit is $15,000 in the first payment year; $12,000 in the second; $8,000 for the third; $4,000 for the fourth, and $2,000 for the fifth. No incentive payments would be made beyond the fifth year. Physicians could begin using HIT in 2011, 2012 or 2013 on a "rolling admissions" basis. If a physician installed an EHR in 2011, 2012 or 2013, the maximum amount he or she could receive is $41,000 over five years. Payments could be made to providers in a single payment or in periodic installments, according to the Secretary. The following table shows the total amount over five years providers could receive depending on when they began using HIT:

Payment Incentives Schedule for Meaningful Health IT Users -- H.R. 1

Cohort Start year	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*Total*
2011	$15K	12	8	4	2	0	0	$41K
2012		15	12	8	4	2	0	$41K
2013			15	12	8	4	2	$41K
2014				12	8	4	2	$26K
2015					8	4	2	$14K

In thousands of dollars

- In the Senate bill, the incentive payment limit is $15,000 in the first payment year; $12,000 in the second; $8,000 for the third; $4,000 for the fourth, and $2,000 for the fifth. No incentive payments would be paid beyond the fifth year. *However, in an effort to encourage early adoption, providers who first use HIT in 2011 or 2012 are eligible for up to $18,000 in an incentive payment limit, for a maximum amount of $44,000 over five years*. Payments could be made to providers in a single payment or in periodic installments, according to the Secretary of HHS. Finally, providers serving in rural HPSAs will have their incentive payments increased by 25 percent. The following table shows the total amount providers could receive over five years depending on when they began using HIT:

Payment Incentives Schedule for Meaningful Health IT Users -- Senate

Cohort Start year	*2011*	*2012*	*2013*	*2014*	*2015*	*2016*	*2017*	*Total*
2011	$18K	12	8	4	2	0	0	$44K
2012		18	12	8	4	0	0	$42K
2013			15	12	8	0	0	$35K
2014				12	8	0	0	$20K
2015					0	0	0	$0K

In thousands of dollars

"Meaningful Use" of EHRs

- Providers are required to use EHRs "meaningfully." "Meaningful use" will be defined by the Secretary and includes electronic prescribing; certified HIT technology that is connected so that information can be exchanged, e.g., to promote care coordination; and quality reporting of some kind of measures as defined by the Secretary and published in the Federal Register for comment.

Penalties for Providers Not Adopting HIT (House and Senate Differences Noted)

- In the House legislation, for providers who have not shown use of meaningful HIT by the following years, Medicare reimbursement will be cut accordingly: 99 percent for 2016, 98 percent for 2017; and 97 percent for 2018. For 2019 and beyond, if the proportion of providers using meaning HIT is less than 75 percent, than the amount will be decreased -- but to no lower than 95 percent.
- In the Senate bill, for providers who have not shown use of meaningful HIT by the following years, Medicare reimbursement will be cut *one year earlier*: 99 percent for 2015, 98 percent for 2016; 97 percent for 2017. For 2018 and beyond, if the proportion of eligible professionals using meaning HIT is less than 75 percent than the amount will be decreased –but again to no lower than 95 percent.

Hardship Exemption

- The Secretary is permitted to exempt providers if compliance with the law would "result in a significant hardship, e.g., someone in a rural area without sufficient Internet access."

Medicaid Incentive Payments – for "High Volume" Providers Only

- Medicaid will contribute 85 percent up to $75,000 of allowable costs to providers for adoption and implementation of HIT, which is $63,750 over five years. However, providers cannot be hospital-based and must see at least 30 percent Medicaid patients.
- Purchase and initial implementation of certified HIT cannot exceed 85 percent of $25,000. Operation, maintenance or use of HIT may not exceed 85 percent of $10,000 in any year or last longer than five years.
- Providers must decide whether they will receive either Medicare of Medicaid incentive payments. Eligible providers include physicians, as well as nurse midwives and nurse practitioners.
- Certified EHR technology means a qualified electronic health record that is certified by the secretary, as above.
- Payments must be given directly to the providers without deductions.

Incentives for Providers in MA Organizations

- Similar provisions apply to providers if their MA organization attests that they are meaningful EHR users. Eligible providers are described as employed by the MA

organization or employed by/partner of an entity that furnishes at least 80 percent of the patient care services to MA enrollees *and* provides at least 80 percent (the Senate figure is 75 percent) of the professional services to enrollees of the organization *and* furnishes at least 20 hours per week of patient services. Regarding the specific incentive payments, the Secretary may substitute an amount that is similar to what providers would receive if they were being paid under Part B rather than under MA.

- For eligible professionals not using EHRs, payments also are decreased but using a different formula.
- In addition, in the Senate bill, incentive payments to MA organizations can be to no more than 5,000 eligible professionals in the organization. Further, the Secretary will post on the website a list of MA organizations receiving incentive payments. Finally, the Secretary will provide assistance to eligible professionals located in rural or other medical underserved areas to choose, implement and use certified EHR technology.

State Grants

- The Secretary may award grant to states (or a state-designated entity) for expanding the use of health information among organizations according to standards such as secure use and exchange; complementing Federal grants; strategies for underserved communities, use of EHRs for quality improvement, etc.
- Any plans for these grants should be consistent with the National Coordinator's strategic plan. Grant seekers are required to consult with health care providers (including those who provide services to low-income and underserved populations), health plans, patients, etc.).
- Loans are provided to states and eligible entities to establish loans to providers. States and eligible entities must meet a significant number of goals to secure these funds. Providers must use the funding to facilitate the purchase of certified EHRs; enhance utilization; train personnel; and improve secure electronic exchange. Interest rates cannot exceed the market interest rate; payments will begin no later than 1 year after the loans is awarded; and should be amortized within 10 years.

E-Prescribing

- Eligible professionals must decide whether to accept EHR *or* e-prescribing incentives. If a provider has a complete EHR system, which includes e-prescribing, they may receive only the EHR incentive. However, if the provider has an e-prescribing system, and not a full EHR, they may continue to receive the E-prescribing incentive. Ultimately, the E-prescribing incentive will continue but the penalties will be subsumed into the EHR program.