

February 13, 2009

## IN THIS REPORT...

1. AAFP Priorities Included in Final Economic Stimulus Measure
2. Senate Committee Holds Hearing on Health Issues in the Budget
3. Freshman Democratic House Members Learn about AAFP
4. FamMedPAC Reaches Out to New and Senior Legislators
5. Virginia House of Delegates Passes Bill to Limit Smoking

Next week both the House and Senate will stand in recess for the President's Day break. They are scheduled to reconvene on February 23.

## 1. ECONOMIC RECOVERY BILL INCLUDES KEY AAFP PRIORITIES

The House-Senate Conference Committee finalized an agreement on the economic recovery bill, known as the *American Recovery and Reinvestment Act* (HR 1). This afternoon, the House gave final approval to the legislation on a vote of 246 to 183. The vote was along party lines, with no Republicans supporting the bill and 7 Democrats opposing it. The Senate will likely pass the final measure later today or tomorrow. Attached to this report is a summary that highlights AAFP's priorities in the final version of the legislation which the President could sign as early as Monday, February 16.

## 2. CBO CHIEF TESTIFIES ON EXPANDING HEALTH INSURANCE COVERAGE

On Tuesday, February 10, Senate Budget Committee Chairman, Senator Kent Conrad (D-ND) opened the committee's hearing on "Expanding Health Insurance Coverage and Controlling Costs for Health Care" by indicating that health care reform would not be possible if it requires billions of dollars. He said that the federal government faces a deficit that is "dramatic and serious" and in his view health care spending is already growing too rapidly as a percent of GDP. According to Sen. Conrad, the reasons for the spiraling costs of health care include a lack of care coordination and too little evidence on best practices along with too much unexplained geographic variation in practice costs.

The written testimony of the hearing's only witness, Congressional Budget Office (CBO) Director, Douglas Elmendorf, Ph.D. can be found at <http://cbo.gov/doc.cfm?index=9982>.

In response to comments by Senator Jeff Sessions (R-AL) on the need to fix Medicare physician payment, Dr. Elmendorf testified that eliminating the deficit created by the Congress has patched the physician payment rate would cost \$556 billion over ten years, if the premiums that beneficiaries pay are not allowed to increase.

Senator Ron Wyden (D-OR) talked about his bill (S. 391) to reform the US health insurance market radically by ending the tax break for employer-paid premiums.

Senator Lamar Alexander (R-TN) said that he wants the federal government to take over Medicaid because of the budget hardship on states. He acknowledged the increased FMAP in

the stimulus bill, and he said he was pleased that OMB Director Peter Orzag supported health care reform to control costs. Dr. Elmendorf replied that there is a risk of undermining good health care if the federal government just mechanically ratchets down spending.

### **3. AAFP REACHS OUT TO NEW DEMOCRATIC HOUSE MEMBERS**

AAFP staff met Thursday, February 12, with a number of freshman Democrat House members at an event cohosted by AAFP and held at the AMA GR office.

The members and/or staff we met with included:

- Rep. Alan Grayson (D-FL)
- Rep. Frank Kratovil (D-MD)
- Rep. Michael McMahon (D-NY)
- Rep. Mary Jo Kilroy (D-OH)
- Rep. Walt Minnick (D-ID) who mentioned a close friend, Dr. David Peterman, a family physician in Boise.
- Rep. Travis Childers (D-MS)
- Rep. John Barrow (D-GA) who is a member of the Health Subcommittee of the Energy and Commerce Committee
- Rep Kathy Dahlkemper (D-PA), who is a former dietitian and quite interested in primary care and prevention. Her district is rural and she understands the value of primary care and family physicians.
- Rep. Harry Teague (D-NM)
- Rep. John Yarmuth (D-KY) who is in his second term also attended. He is on the Ways and Means Committee.

Staff met with each of the legislators and their staff to discuss family medicine's priority issues including Medicare payment, the patient-centered medical home, family medicine workforce, health information and health coverage for all.

### **4. FamMedPAC MEETINGS HIGHLIGHT AAFP'S ISSUES**

Newly elected Senator Kay Hagan (D-NC) invited PACs that helped to retire her campaign debt to attend a "thank-you" breakfast this week. AAFP staff attended. The American Hospital Association and Blue Cross-Blue Shield were the only other healthcare groups in attendance. Senator Hagan said she is interested in healthcare and plans to be involved in the upcoming debate. Her son just started medical school in North Carolina so she is learning more about medical education issues, as well as the issues physicians face once they enter practice.

She expects healthcare to be taken up by the Senate soon after work is done on the economic recovery legislation. She supported the SCHIP legislation, which included an increase in cigarette taxes to pay for the expanded coverage, but she said it was a very difficult vote for her due to the importance of the tobacco industry to North Carolina. However, she felt it was in the country's best interest to expand the availability of health insurance, so she decided to support the bill. She is interested in learning more about the medical home and AAFP's efforts on HIT.

On Friday, February 13, staff attended a healthcare breakfast for Rep. Xavier Becerra (D-CA), who serves on the Health Subcommittee of the Ways and Means Committee and is the Democratic Caucus Vice Chair. Rep. Becerra specifically singled out family medicine in his remarks on healthcare, saying that AAFP members would be "very happy" with the direction of healthcare reform that the House is contemplating. He also said the Medicare reimbursement system is a complete disaster and must be redesigned. Rep. Becerra discussed the HIT provisions in the economic recovery bill. He said that physicians needed to act quickly to capture the benefits offered for HIT adoption, before the "carrot" turns into a "stick."

## **5. WEAKENED CLEAN AIR ACT ADVANCES IN OLD DOMINION**

The Virginia House of Delegates approved this week an act to curtail smoking in most of the state's bars and restaurants. The bill is a compromise measure—hammered out between Governor Tim Kaine (D) and House Speaker William Howell (R)—that is under fire from both sides. The bill originally sought to eliminate smoking in all bars and restaurants, except for those that constructed separately ventilated, enclosed smoking rooms for patrons or that are private clubs. Additional amendments weakened the bill to permit smoking in rooms separated by doors, even if there is no separate ventilation system; in outdoor patio areas; at restaurants during private functions when the function takes up the entire restaurant; and, at clubs or bars at times when under-age patrons are not admitted.

The Senate passed stricter clean air acts in recent sessions, only to see them die in House subcommittees. That this bill, though weakened, passed the House in a state dependent on the tobacco industry, is significant.

# HIGHLIGHTS OF AAFP PRIORITIES IN THE AMERICAN REINVESTMENT AND RECOVERY ACT (ARRA)

## TITLE VII – HEALTH PROFESSIONS TRAINING

The conference agreement on the American Reinvestment and Recovery Act (ARRA) includes \$500 million for health workforce.

- \$300 million for the National Health Service Corps.
- \$200 million for all the disciplines trained through the primary care medicine and dentistry program, the public health and preventive medicine program, the scholarship and loan repayment programs authorized in Title VII and Title VIII of the PHS Act, and grants to training programs for equipment. The funds may also be used to foster cross-State licensing agreements for healthcare specialists.

The conference report gives HRSA discretion over the \$200 million. It does not specify how much will be allocated to Section 747 Primary Care Medicine and Dentistry Training. HRSA is required to provide an operating plan to the House and Senate Appropriations Committee within 90 days of enactment of this Act describing activities to be supported and timelines.

## HEALTH INFORMATION TECHNOLOGY FOR PHYSICIANS

ARRA provides \$19 billion for HIT: \$17 for Medicare and Medicaid incentive grants and \$2 billion for HIT grants.

- Establishes Office of National Coordinator for HIT by law and begins a process to develop standards by 2010.

## Medicare Incentive Payments and Incentives for Early Adoption

- 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.
- 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 amount providers could receive over five years depending on when they began using HIT:

**Payment Incentives Schedule for Meaningful Health IT Users -- Senate \$ in thousands**

<i>Cohort Start year</i>	<i>2011</i>	<i>2012</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>	<i>2016</i>	<i>2017</i>	<i>Total</i>
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

## Penalties

- For providers who first adopt after 2014, Medicare reimbursement will be cut as follows: 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.

## “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.*

## 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 or 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, 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.

### **COBRA PREMIUM ASSISTANCE**

ARRA includes \$24.7 billion for a premium assistance program for unemployed workers eligible to continue group health coverage under provisions in the Consolidated Omnibus Budget Reconciliation Act (COBRA).

- The program will cover up to 65% of COBRA premiums for workers involuntarily terminated between September 1, 2008 and December 31, 2009 and earning less than \$125,000 individually or \$250,000 as a family.

### **MEDICAID**

ARRA provides an estimated \$86.6 billion over two years in additional federal matching funds to help states maintain their Medicaid programs in the face of massive state budget shortfalls.

- Funding distributed through 12/31/2010
- Across-the-board increase to all states and territories
  - 6.2% for states
  - "Similar increase" for territories
- In addition to across-the-board increase, the State share will decrease should an increase in the State's unemployment rate occur
- Maintenance of effort on eligibility is required to qualify
  - If a state reduces eligibility for its program to contain its size/scope, the state could lose its qualification for the FMAP increase and unemployment increase safety net
- Extends the moratorium through June 30, 2009 on six Medicaid regulations
  - Adds a seventh regulation to the moratorium
  - Regulations would otherwise restrict Medicaid funding for
    - outpatient hospital payments,
    - graduate medical education,
    - targeted case management,
    - cost limits on public providers,
    - rehabilitation services,
    - provider taxes, and
    - school administration and transportation services.

- Extends Transition Medical Assistance (TMA) until December 31, 2010.
  - TMA allows states to extend Medicaid coverage to individuals as they reenter the workforce after receiving welfare.
    - Given that many low-wage jobs, if offering health insurance at all, require a waiting period before a new worker may enroll in their employer-sponsored insurance, this program helps individuals gain a job without worrying about losing their health care.
- Extends the Qualified Individual (QI) Program through December 31, 2010.
  - QI assists certain low-income individuals with Medicare Part B premiums.
- Prohibits states from imposing cost-sharing on Medicaid-eligible American Indians receiving services from an Indian health care provider or from a Contract Health Services (CHS) provider.

### **COMPARATIVE EFFECTIVENESS RESEARCH**

ARRA provides \$1.1 billion for comparative clinical comparative effectiveness research to help patients and doctors determine the effectiveness of different treatments.

- \$300 million to the Agency for Healthcare Research and Quality.
- \$400 million will go to the NIH to support or conduct this research.
- \$400 million will go to the Secretary of HHS “conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders and other health conditions and encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generated or obtain outcomes date.”
- Directs the Institute of Medicine to report no later than June 30, 2009 on recommendations for national CER priorities.
- Establishes a Federal Coordinating Council for Comparative Clinical Effectiveness Research to coordinate these efforts.