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EXTERNAL MEMORANDUM

To: **American Society of Transplant Surgeons**

From: Peter Thomas, Adam Chrisney and Theresa Morgan

Date: February 23, 2009

Re: **The American Recovery and Reinvestment Act (ARRA)**

After over a month of fierce negotiations, Congress has passed an economic recovery package, the American Recovery and Reinvestment Act ("ARRA"), which the President signed yesterday, February 17. To gain support from three Republicans in the Senate in order to secure passage, the bill had to be pared down to a price of $787 billion; during the debate in the Senate, the cost of the legislation breached $900 billion.

Congress worked on the economic stimulus legislation for all of January and much of February. President Barack Obama worked for bi-partisan support of the plan, but the vast majority of Republicans voted against the bill and remain skeptical that the new spending will stimulate the economy. Last Friday, February 13, the House passed ARRA along partisan lines, 246-183, with no Republicans voting in favor and 11 Democrats voting against.

In the Senate, a group of moderate Democrats and Republicans worked behind the scenes to engineer a compromise that would receive broad support, but when the compromise was completed only three Republican Senators (Olympia Snowe (R-ME), Susan Collins (R-ME) and Arlen Specter (R-PA)) would back it.

That compromise, known as the Nelson-Collins amendment, became the underlying Senate bill. A brief, behind-the-scenes conference process resulted in a compromise package that closely mirrored the Senate version of the bill. The Senate voted to pass the conference report 60-38, without a vote to spare in order to break a filibuster.

The bill includes funding for a number of health programs integral to the provider community serving individuals with disabilities, including a large boost for Medicaid, an extension of the moratoria on four controversial Medicaid regulations, and a $10 billion boost for the National Institutes of Health. The following memorandum is a detailed outline of significant provisions.

MEDICAID:

Federal Medical Assistance Percentage (FMAP) Increase

The FMAP is the rate at which states are reimbursed by the federal government for most Medicaid service expenditures. The stimulus bill includes nearly $90 billion in FMAP funding to help states sustain Medicaid services during the recession.

The bill increases FMAP funding for a 27-month period beginning October 1, 2008 with an across-the-board increase to all states of 6.2%. In addition, the legislation provides for reductions in states' shares by 5.5, 8.5 or 11.5 percent for states with significant increases in their unemployment rates.

The House bill provided an across-the-board increase of 4.9 percent, which would have distributed about half of the increased FMAP funding across all of the states and half via the unemployment-related increase. The Senate bill included a provision which favored rural states, which would have provided 80 percent of its spending on an across-the-board increase and 20 percent based on unemployment-related increases. The conference agreement split the difference and provides about 65% of its spending via the hold harmless and across-the-board increases, and about 35% via the unemployment-related increase.

The bill also prohibits States that accept the funding from restricting Medicaid eligibility beyond the Medicaid beneficiaries they covered as of July 1, 2008. As a result, some states will re-enroll beneficiaries that had been removed from the Medicaid program since July 1. However, states are allowed to restrict Medicaid services and cut Medicaid provider payments if necessary. Despite the increased FMAP funding, some states will likely choose to divert some of these new funds to their overall state budgets and continue to implement cuts in services and payments.

The conference agreement also included a Senate provision prohibiting states from receiving the FMAP increase if they are out of compliance with requirements for prompt payment of Medicaid providers, nursing facilities and hospitals. This is a major victory for providers serving Medicaid beneficiaries, whose payments are often delayed by many months.

FMAP increases will not apply to other parts of state Medicaid programs such as calculations for payments for DSH, TANF, SCHIP, child/family services, etc. In addition, States cannot use FMAP/high unemployment increases for rainy day/reserve funds.

Extension of Moratoria on Medicaid Regulations

In the 2008 Medicare bill, Congress included moratoria until April 1, 2009 on six controversial Medicaid regulations covering graduate medical education, cost limits for public providers, rehabilitation services, targeted case management, school-based services and provider taxes. A seventh regulation on outpatient services was excluded from the moratoria and CMS finalized the rule last fall.

The House version of the stimulus bill would have extended the moratoria on all seven regulations. The Senate bill lacked a provision to extend any of the moratoria. The conference agreement extends the moratoria until June 30 for the rules that have been finalized: the targeted case management, school-based services, provider taxes and outpatient hospital services rules. The conference agreement also states that HHS should not finalize the graduate medical education, cost limits for public providers and rehabilitative services rules. The extension of the moratoria provides more time for the new administration to work through the time consuming process of analyzing the rules and figuring out how to rescind or modify them.

Disproportionate Share Hospital (DSH) Payments

The bill increases states' FY 2009 annual DSH allotments by 2.5 percent, and increases states' FY 2010 allotments by another 2.5 percent. After FY 2010, states' annual DSH allotments would return to 100% of the annual DSH allotments as determined under current law.

COBRA

The final bill extends COBRA coverage to employees who lose their jobs and create premium subsidies for COBRA coverage. The legislation provides a 65% subsidy for COBRA continuation premiums for up to 9 months for workers that lose their job between September 1, 2008 and January 1, 2010. The conference agreement added an income threshold as an additional condition on an individual's entitlement to the premium subsidy. If an individual making $145,000 or more receives the premium subsidy, that individual must repay the amount of the subsidy. The subsidy would terminate upon offer of any new employer-sponsored health care coverage or Medicare eligibility.

However, provisions of the House bill that were not adopted in the final bill would have made a number of very important changes to COBRA coverage. The House bill proposed for the first time that an individual who loses their job between ages 55 and 65 may keep their COBRA coverage until they qualify for Medicare or get another job that offers coverage. In addition, the bill allowed individuals who are employed by the same employer for more than 10 years and lose their job to maintain their COBRA coverage until they qualify for Medicare or until they find another job with health insurance.

Disability advocates argued that these provisions were important improvements to COBRA but that they required amendments in order to make them equitable for people with disabilities. Because one loses COBRA coverage when becoming enrolled in Medicare (due to disability status or age) the House provision would have eliminated the right of a person with a disability

to keep COBRA coverage as a wrap-around insurance benefit. The fact that there is no guaranteed issue for Medigap policies for people below age 65 made this all the more inequitable for people with disabilities. The solution would have been to terminate COBRA coverage only when a person qualified for Medicare based on age, not based on disability status.

HEALTH INFORMATION TECHNOLOGY (HIT)

ARRA provides approximately $19 billion over five years for HIT through Medicare and Medicaid and requires HHS to develop an initial set of HIT standards by 2010. The Congressional Budget Office estimates that the bill will assist about 90% of doctors and 70% of hospitals in adopting certified electronic health records (EHR) within the next decade. In addition, federal privacy and security laws were expanded to protect patient health information.

The bill establishes HIT Policy and Standards Committees comprised of public and private stakeholders (e.g., physicians, hospitals and other providers) to provide recommendations on the HIT policy framework, standards, implementation specifications, and certification criteria for electronic exchange and use of health information.

Physicians

The conference agreement provides $18,000 of incentive payments in the first year for physicians that show "meaningful use" of EHR in 2011 or 2012. For physicians that begin using EHR in 2013 or 2014, the bill provides an incentive payment of $15,000 for the first year. The payments decrease over time, except that incentive payments would be increased by 10% if the provider predominately serves beneficiaries in any area designated as a health professional shortage area. The bill provides no payment incentives after 2016 and does not provide incentive payments for physicians adopting EHR in 2015 or later. HHS will be authorized to make available an HIT system to providers for a nominal fee. The maximum amount a physician can collect through HIT bonuses is $44,000 over a five-year period.

There are limited out-year penalties (with a sun-set maximum of 6%) for physicians who do not adopt or use a certified HIT system. Due to concerns with double-dipping, physicians who also report electronic health records using "e-prescribing" will no longer be able to collect bonuses for this activity established under existing law. Because the bill also provides hospitals with incentive payments, the conference agreement prohibits incentive payments for hospital-based professionals.

Hospitals

The bill provides incentive payments for qualified hospitals over a four year period. The incentive payments include a base amount ($2 million) and a discharge payment, which would then be multiplied by its Medicare's share. A qualified hospital would receive $200 for each discharge paid under the inpatient prospective payment system (IPPS) starting with its 1,150th discharge through its 23,000th discharge.

The incentive payment would decrease after the first year to: 75 percent of the amount in the second year; 50% for the third year; and 25 percent in the last year. Hospitals that start using EHR in or after FY2015 would not receive incentive payments.

EHR measures would include clinical quality measures and other measures selected by the Secretary. Prior to implementation, the measures would be subject to public comment. The electronic reporting of the clinical quality measures would not be required unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

Starting in FY2015, the bill provides for steep penalties, implemented over a three year period, for IPPS hospitals that do not submit required quality data and for those that do not adopt EHR. Those that fail to submit the data will face a 25 percent decrease in their annual update. Hospitals that are not meaningful users of EHR will be at risk of losing the other 75 percent.

Aging Services Technology Study

The bill also requires HHS to conduct a study, not later than 24 months after enactment, of matters relating to the potential use of new aging services technology to assist seniors, individuals with disabilities and their caregivers throughout the aging process.

COMPARATIVE EFFECTIVENESS

The conference agreement provides $1.1 billion for comparative effectiveness research (CER), of which $300 million will be administered by the Agency for Healthcare Research and Quality, $400 million by the National Institutes of Health and $400 million by the Secretary of Health and Human Services.

The bill establishes the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER) to be comprised of up to 15 representatives of federal agencies of which at least half must be physicians or other experts with clinical expertise. HHS is required to contract with the Institute of Medicine to submit a report to Congress and HHS by June 30, 2009 with recommendations on national CER priorities.

The comparative effectiveness House report language caused some concern amongst stakeholders, as the language implied that CER could include cost comparisons and ultimately result in Medicare rejecting more expensive but necessary treatments. The conferees rejected a Senate limitation to "clinical" research but included the following explanation in the agreement: "The conferees do not intend for the comparative effectiveness research funding included in the conference agreement to be used to mandate coverage, reimbursement, or other policies for any public or private payer. The funding in the conference agreement shall be used to conduct or support research to evaluate and compare the clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition. Further, the conferees recognize that a 'one-size-fits-all' approach to patient treatment is not the most medically appropriate solution to treating various conditions and include language to ensure that subpopulations are considered when research is conducted or supported with the funds provided in the conference agreement." The provisions will not include national clinical guidelines or coverage determinations.

REPEAL OF THE 3 PERCENT WITHHOLDING TAX

The conference report delays by one year implementation of a controversial provision in a 2005 tax law that would withhold 3 percent of Medicare payments to doctors and hospitals. The Tax Increase Prevention and Reconciliation Act (TIPRA) of 2005 provision was scheduled to take effect at the end of 2010, but ARRA pushes implementation to the end of 2011. The House version of the bill repealed the tax, but the Senate version included only a delay.

The new tax would withhold 3 percent for government payments to contractors in any industry, including health care providers who accept Medicare payment. The rule is intended to collect underreported tax revenues and was inspired by a 2005 Government Accountability Office report that found 33,000 government contractors could owe as much as $3 billion in unpaid federal taxes. However, it would be tremendously burdensome on physician practices, as they have relatively small operating margins.

NATIONAL INSTITUTES OF HEALTH

The conference agreement provides $10 billion for the National Institutes of Health, including $1.3 billion for the National Center for Research Resources and $8.2 billion for the Office of the Director to distribute at his discretion and according to the grant scores achieved through the peer review process. The conference agreement states that $800 million should be retained in the Office of the Director for purposes that can be completed within two years. This is a huge influx of funds for NIH at a time when the percentage of grant applications to funded grants is historically low. The entire FY 2008 budget for NIH was approximately $29.5 billion.

MEDICARE

Teaching Hospitals

Medicare sets separate per-discharge payment rates to cover a variety of expenses in acute care hospitals. Under the 2008 Inpatient Prospective Payment System ("IPPS") rule, one of those payments—Medicare's capital IPPS indirect medical education (IME) adjustment—was scheduled to be phased out over a 2-year period. In FY2009, teaching hospitals would have received half of the IME adjustment in Medicare's capital IPPS; in FY2010 and in subsequent years, the capital IME adjustment would be eliminated.

The conference agreement eliminates the FY 2009 cut and requires that Medicare payments be recomputed for discharges after October 1, 2008. The elimination of capital IME in FY2010 will not be affected. The House and Senate versions of the bill both had the provision. The Conferees expect the hospital community to seek a permanent fix in the annual IPPS rulemaking cycle.

Hospice

When Congress changed the wage data source used to adjust hospice payments in 1997, a budget neutrality adjustment factor ("BNAF") was instituted as part of the new payment system. The

BNAF prevents participating hospices from experiencing reductions in total payments as a result of the wage data change. Last summer, HHS issued a final rule that would phase-out the BNAF over three years, resulting in cuts to hospice payments.

The House bill would require that the Secretary not phase-out or eliminate the budget BNAF before October 1, 2009. The hospice wage index used for FY2009 would be recomputed with the BNAF. The Senate bill lacked a provision on the BNAF. The Conference Agreement adopts the House provision temporarily eliminating the threat to hospice provider payments. The Conferees expect a permanent fix in the annual rulemaking cycle for Medicare hospice payments.

WORKFORCE TRAINING

The conference agreement provides $500 million towards training of health professionals. $300 million is allocated for the National Health Service. $200 million is allocated for a number of disciplines, including disciplines trained through the scholarship and loan repayment programs authorized in Title VII (Health Professions) and Title VIII (Nurse Training) of the PHS Act. These funds are designed to assist in addressing shortages in the numbers of physicians, nurses and other providers.

CHRONIC DISEASE PREVENTION

The conference agreement provides $1 billion for a Prevention and Wellness Fund, which includes $650 million to carry out evidence-based clinical and community-based prevention and wellness strategies authorized by the Public Health Service Act, as determined by the Secretary. These strategies are to deliver specific, measurable health outcomes that address chronic disease rates. The amount also includes $50 million towards States activities to implement healthcare-associated infections (HAI) reduction strategies. The total amount was less than the House requested for the Fund. The Senate bill did not include a provision for the Fund.

WORKFORCE INVESTEMENT ACT

The conference agreement includes $3.9 billion for Workforce Investment Act programs that provide training and employment services. This stimulus is a significant increase and will help ensure the funding of one-stop career centers. The conference agreement also provides the authority for local workforce investment boards to contract with institutions of higher education and other eligible training providers.

IDEA: SPECIAL EDUCATION FUNDING

The conference agreement provides $13 billion for the Individuals with Disabilities Act (“IDEA”) state grant program and $500 million for IDEA Part C early intervention. The funds are to be used during the 2009-2011 school years. ARRA also provides that school districts receiving stabilization funds may only use the funds for activities authorized under IDEA, the Elementary and Secondary Education Act (ESEA), the Carl D. Perkins Career and Technical Education Act of 2006 (Perkins), and for education infrastructure. This is a huge injection of

funds for special education that will place the federal share of special education funding at its highest level since the inception of the IDEA law.

VOCATIONAL REHABILITATION AND INDEPENDENT LIVING

In a significant victory for disability advocates, the conference agreement provides $540,000,000 for Vocational Rehabilitation State Grants, which is an increase from the 500,000,000 proposed by both the House and the Senate. The bill also provides $140,000,000 for the Independent Living Centers program: $18,200,000 for State Grants; $87,500,000 for Independent Living Centers; and $34,300,000 for Services for Older Blind Individuals. In this manner, the billions of dollars being spent by this bill on employment and training services for the general population will be equitable with the amount spent on employment and training assistance for people with disabilities.

SSA DISABILITY CLAIMS BACKLOG

The conference agreement includes $1 billion to assist the Social Security Administration (SSA) in the processing of a growing backlog of Social Security Disability Insurance ("SSDI") claims. Of the funding, $500 million is designated for a replacement of the SSA National Computer Center (NCC). Another $500 million is provided for processing disability and retirement workloads. The conference agreement also includes $2 million for the SSA Inspector General to provide oversight and audit of the implementation of these funds.

PAYMENT TO SOCIAL SECURITY BENEFICIARIES

Finally, the conference agreement directs the Secretary of the Treasury to disburse a one-time payment of $250 to adults who are eligible for Social Security benefits, veteran's compensation or pension benefits; or individuals on Supplemental Security Income (SSI) benefits.