The American Recovery and Reinvestment Act

Provisions of interest to AAHSA members

HOUSING

Energy Retrofit Program: $2.25 billion

- $2 billion for 12 month funding of project based section 8 contracts

- $250 million for just energy retrofit funds
  - To be administered by the Office of Affordable Housing Preservation of HUD (OAHP)
  - As a condition of getting the funds, owner must maintain and preserve the property
  - Owners must have at least a "satisfactory management review rating" to receive an energy retrofit loan or grant
  - Owners must agree to continue to operate as affordable housing for another 15 years
  - Funding must be spent within 2 years
  - Secretary has waiver authority to expedite use of the funds.

CDBG: $1 billion

- Priority given to projects that can award contracts based on bids within 120 days from the date money becomes available to recipients
- Secretary may waive any statute or regulation to expedite use of funds where necessary (except for fair housing, non discrimination, labor standards and environmental)

Tax credit gap financing funds (via the HOME) program: $2.25 billion

- To be distributed competitively according to the program formula
- Projects with 2007, 2008, 2009 LIHTC awards are eligible
- Priority for projects that are expected to be completed within 3 years of the stimulus bill's passage (2/17/12)
- States must allocate 75% of funds within 1 year
- Recipients must spend 75% of the funds within 2 years and 100% within 3 years
- HOME program restrictions do not apply, but state LIHTC requirements do
- These grants will not reduce the eligible basis for the project

Low Income Housing Tax Credits (LIHTC) exchange provision allowing states to exchange credits for grant funds

- States may exchange 40% of 2009 tax credits and 100% of prior year tax credits
- Exchange rate is 85 cents per dollar
- Recipients must demonstrate good faith efforts to obtain investment commitments
- State LIHTC program requirements apply to awardees
- These grants will not reduce the eligible basis of a project
- Grants will not be counted as taxable income to recipients
- Funding for any awards not made by January 1, 2011 will be returned to the Treasury

American Association of Homes and Services for the Aging
2519 Connecticut Avenue, NW Washington, DC 20008-1520 | aahsa.org | 202.783.2242

HOME AND COMMUNITY BASED SERVICES

- Blocks the scheduled FY09 Medicare payment cut to hospice providers. [The Budget Neutrality Adjustment Factor for Hospice reimbursement will not be phased out until October 1, 2009. This gives CMS and hospice providers time to work on a permanent fix to this reimbursement problem. Prevents a 4% cut in payments.]

- Extends the moratoria on the Medicaid regulations (would have shifted about $100,000,000 of Medicaid costs to the states), that would have gone into effect on April 1, 2009. The Medicaid regulations include targeted case management, provider taxes, school–based services, inter-governmental transfers, graduate medical education and rehabilitation services. The moratoria are extended to 6/30/09.

- Senior Nutrition program: $100,000,000.

- Community Service Employment Program for Older Adults: $120,000,000.

- $650,000,000 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, that deliver specific, measurable health outcomes that address chronic disease rates. Some of the AoA programs would be included in this section. $1,000,000,000 for the Prevention and Wellness Fund (includes CDC immunization program and the healthcare associated infection program)

FMAP/MAINTENANCE OF EFFORT (Section 5001):

Current law: FMAP ranges from 50% to 83%. Higher FMAPs go to states with lower per capita incomes relative to the national average.

ARRA provisions:

- Every state gets at least a 6.2% increase in its FMAP from 10/1/08 through 12/31/10
- All states held harmless from any scheduled reduction in their regular FMAPs
- States with high unemployment rates would receive reductions in the share of total Medicaid expenditures the state must bear.
- The bill requires states to maintain their Medicaid eligibility standards, methodologies and procedures as in effect 7/1/08.
- States are prohibited from depositing the additional federal FMAP monies into reserve or rainy day funds.
- States may not require local governments to pay a larger share of the state's Medicaid expenditures than required as of 9/30/08.
- No requirement that states spend the additional federal FMAP money on their Medicaid programs.
- No requirement that they maintain provider payments at 2008 levels.

FMAP – FAQs

My State says it is going to spend the increased FMAP on school books and roads; is this legal?

- It is legal for a state to use the increased FMAP to reduce what the state would otherwise be paying for its state share of Medicaid and then to use state funds for anything it chooses.
- The increased FMAP does not come to the State in a "grant," the state only gets federal FMAP payments when it incurs a Medicaid expenditure.
- If the state itself, out of state funds, is paying less in 2009 for its share of Medicaid, then the state might have "extra" money to spend on other things, for example –
    - The 2008 Medicaid NF rate in State X is $150/day. In 2008, State X had a 50% FMAP; so the state and the federal government each paid $75/day to the NF.
    - In 2009, due to the Stimulus, State X now has a 60% (federal share) FMAP. The state chooses to keep 2009 NF rates at $150/day; in 2009 the state would pay $60 to the NF and the federal government would pay $90/day

My State says it plans to use the increased FMAP for roads by billing tractors for road-building to Medicaid; is this legal? NO

My State says it is going to use the increased FMAP to increase hospital rates but not NF rates; is this legal?

- Yes. The new law does not require a state to maintain the same rates for providers as before; nor does the federal law require states to apportion the increased FMAP in any particular way.
- States will get the new FMAP percentage when the federal government is asked to cover its portion of state Medicaid spending; the federal government does not prescribe which rates go up or down or stay the same.

OTHER MEDICAID

Prompt payment by state Medicaid programs of nursing facility and hospital claims

- The stimulus bill extends federal "prompt payment" requirement to nursing facility and hospital claims
- 99 percent of "clean claims" must be paid within 90 days

Note: Previous law [Section 1902(a)(37)(A) of the Social Security Act] requires state Medicaid programs to have claims payment procedures which "ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims….."

<u>Moratorium prohibiting implementation of certain CMS-issued regulations</u> before July 1, 2009

- In 2007 and 2008, CMS issued seven Medicaid regulations that states and others opposed because of potential harmful effects on Medicaid services; Congress was moved to prohibit implementation until April 1, 2009.
- The stimulus bill extends that moratorium through June 2009 for the 4 regulations that had already been issued in Final form, and advises CMS of the sense of the Congress that it should not issue final regulations for 3 others pertaining to Graduate Medical Education payments to hospitals, school-based services, and cost limits for public providers.
- AAHSA members may be especially interested in these 4:
    - **Targeted Case Management-**implementation delayed
      If implemented, would restrict states from receiving Medicaid reimbursement for case management services. This regulation would have a negative impact on transportation services, and information and referral services.
    - **Rehabilitation Services-**CMS directed to not issue final
      The Rehabilitation Services option impacts some of the states that cover adult day health under their state Medicaid plan, as well as some other services that provide rehabilitation.
    - **Provider Taxes—**implementation delayed
        - But it implements a law that Congress previously passed that eliminated CMS' ability to reduce maximum provider taxes by Administrative fiat. *AAHSA believes that Congress likely did not mean for the Stimulus bill to cancel these provisions.*
        - Second, it clarifies certain "no hold harmless" provisions—specifically those prohibiting states from paying providers back for their provider taxes through special "Granny Grants" and the like.
    - **Cost limits for Public Providers**—CMS directed to not issue final
        - The rule would have affected IGTs, requiring that certain public providers retain all of their Medicaid reimbursements.
        - In addition, the rule would establish documentation requirements to substantiate that a governmental entity is making a certified public expenditure (CPE) when contributing to the state share of Medicaid.

LONG-TERM CARE HOSPITAL TECHNICAL CORRECTIONS

Long Term Care Hospitals (LTCH)[1]

- **The Stimulus** bill makes "technical corrections" to earlier legislation and regulations regarding Medicare payments to LTCHs; these changes are generally viewed favorably by LTCHs, but may be less so by SNFs that compete with them.
- **Modifies moratorium on new construction and expansion**
  - The stimulus bill provides an exception from the LTCH moratorium for bed expansion CONs that were issued on or after April 1, 2005, moving back the effective date of exceptions and thus extending number of LTCHs that are eligible for exceptions[2]
  - It also expands the exceptions to include an increase in beds in an existing long-term care hospital or satellite pursuant to a CON issued on or after April 1, 2005 and before December 29, 2007.
- **Modifies start date of relief from the 25% rule applicable to co-located hospitals and satellites in existence as of October 1, 2004**
  - The effective date of the 3-year relief is changed to the hospital's cost reporting period beginning on or after October 1, 2007, so that there are no gaps in relief.
- **Modifies start date of relief from the 25% rule applicable to freestanding hospitals and grandfathered hospitals**
  - The effective date of the 3-year relief is changed to the hospital's cost reporting period beginning on or after July 1, 2007 (changed from cost reporting periods beginning on or after December 29, 2007)[3]
- **Extends relief from the so-called "Freestanding" 25% rule to long-term care hospitals and satellites co-located on campuses of acute care hospitals where no acute care inpatient hospital services are provided**
  - A long-term care hospital or satellite which is co-located on the campus of an acute care hospital where no short-term acute care inpatient hospital services paid under the IPPS are provided is afforded the same relief from the so-called "freestanding" 25% rule as freestanding hospitals and grandfathered hospitals since, effectively, they function as freestanding hospitals. Accordingly, they are not subject to the 25% rule for the three year period.

---

[1] This analysis relies in part on documents shared with AAHSA by Ed Kahlman, Executive Director of NALTH, the association of LTCHs which principally represents the not for profit sector.

[2] Effective with the December 29, 2007 signing of the Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA"), Congress placed a three year moratorium on construction and establishing of new LTCHs and LTCH Satellite Facilities unless one of the following exceptions is met: (1)as of December 29, 2007, the LTCH has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a LTCH, and has expended, before December 29, 2007, the lesser of 10 percent of the estimated cost of the project or $2.5 million; or (2) the hospital began its qualification period for payment as a LTCH on or before December 29, 2007; or (3) the LTCH has obtained an approved certificate of need (CON) from the State if one is required on or before December 29, 2007. MMSEA also established a 3-year moratorium on the increase of LTCH beds in existing LTCHs or satellites, unless both of the following conditions are met: (1) the LTCH or LTCH satellite facility is located in a state where there is only one other LTCH; and (2) it requests an increase in bed size following the closure or decrease in beds of another LTCH in the state.

[3] Prior to rate year 2008, in general, CMS applied a payment adjustment for discharges in excess of a 25 percent threshold that an LTCH "hospital-within-a-hospital" (HwH) admitted from its co-located host hospital. The adjustment was not applied, however, to "grandfathered" HwHs or "grandfathered" LTCH satellites. In its May 1, 2007, LTCH PPS rate year 2008 final rule, CMS extended the 25 percent threshold payment adjustment to grandfathered HwHs and LTCH satellite facilities. This final rule also extended the "25 percent threshold" payment adjustment to LTCH discharges admitted from hospitals with which the LTCH or satellite facility was not co-located. The Medicare, Medicaid, and SCHIP Extension Act of 2007 ("MMSEA") provided for: a three year delay in implementation of the "25 percent rule;" the extension of the 25 percent threshold payment adjustment to "grandfathered" LTCH HwHs and also to freestanding LTCHs; and increasing the patient percentage thresholds from 25 percent to 50 percent for certain LTCH HwH and satellite discharges admitted from a co-located hospital, and from 50 percent to 75 percent for certain LTCH HwH and satellite discharges admitted from a co-located rural, MSA-dominant, or urban single hospital.

TECHNOLOGY

- Goals:
  Ultimately the goal is for each individual to have an electronic health record by 2014. The purpose of the health technology provisions (known as the HITECH Act) in H.R. 1 is to put in place the governmental and private structure needed to achieve that goal. This is important for our members because long-term care providers and our residents/clients are included in this goal.

- "Health care provider" definition
  The definition of "health care provider" is broad enough to include most AAHSA members who provide some form of health care, and "includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, …a pharmacist, a pharmacy … and any other category of health care facility, entity, practitioner or clinician determined appropriate by the Secretary [of HHS]".

- Study on Aging Services Technology
  The final bill contains the study on aging services technology proposed by CAST and included in one of the two House IT bills introduced last Congress. This study by HHS will examine "matters relating to the potential use of new aging services technology to assist seniors, individuals with disabilities, and their caregivers throughout the aging process".

- Study on need by health care providers for incentive payments
  Acute care hospitals and physicians receive incentive payments to invest in electronic health record technology (hard and software). The final bill includes a study to determine if other providers -- including LTC providers, long-term care hospitals, and rehabilitation hospitals -- also need incentives to encourage them to implement EHR technology prior to 2014.

- State grants to promote HIT
  Money will be available for states in the form of matching grants to encourage development and use of HIT. These grants are directed at health care providers that are not covered by the incentive payments, so LTC providers would be eligible for grants. Specific grants and requirements are to be developed by states. There are extensive requirements to involve providers as state plans are developed and implemented.

- Health Information Technology Regional Extension Centers
  The bill creates regional centers to facilitate HIT in rural and other underserved areas, and to address needs of providers in those areas. Allows any US-based NFP or consortium to apply to be a regional center.

TAX EXEMPT BOND CHANGES (Sec. 1502):

The rules for "bank qualified bonds", bonds issued by banks to 501c3 organizations at lower interest rates and instead of a public offering, have been changed. Under current rules, a "qualified small issuer" eligible for favorable interest rates has to be a governmental entity, and it can only issue a total of $10M in tax-exempt bonds for itself and 501(c)(3) organizations.

The bill now provides that for 2009 and 2010, the amount available for each 501(c)(3) entity is $30M (the governmental entity still issues and distributes the bond, but the requirement to aggregate all bonds has been eliminated). This change should dramatically increase the availability of bank qualified bond financing to more bond issuers and 501(c)(3) borrowers

PRIVACY--HIPAA

- Fundraising remains in the definition of "health care operation."

  In the original versions in both House and Senate, fundraising was removed as a protected operation and would have been subject to all the provisions in HIPAA. The final bill did not include this provision.

  However, the bill as enacted contains a provision that any written fundraising communication contain a clear and conspicuous statement that the recipient can elect not to receive further fundraising requests. The request to be removed from fundraising is considered a revocation of consent. The Secretary is directed to issue regulations implementing this section within 12 months from date of enactment.

- There are other privacy issues related to using EHR that we will evaluate separately.

OTHER PROVISIONS IN ARRA

COBRA coverage

- Eligible individuals receive a 65% subsidy of the COBRA premiums they otherwise would be required to may for any group health plan in which they participated at the time of their termination. (Income limits apply)
- Subsidy effective only as of February 17, 2009.
- Covers employees involuntarily terminated between September 1, 2008 and December 31, 2009, and who prior to February 17, 2009 did not elect COBRA coverage and can now make a re-election, or can re-elect coverage in an alternate eligible plan.

Employers are responsible for the 65% share of the payment; however, it is reimbursed by Department of the Treasury. Employer will claim any payments made as a tax credit when filing Form 941 for the applicable period -- payments are treated as a deposit of payroll taxes. Departments of the Treasury and Labor will be issuing further clarifying instructions.

One time $250 payment to nearly every Social Security recipient:

- Who gets the $250 check?
  - Adults who were eligible for Social Security benefits, Railroad Retirement benefits, or veteran's compensation or pension benefits; or individuals who were eligible for Supplemental Security Income (SSI) benefits (excluding individuals who receive SSI while in a Medicaid institution). [The Social Security Administration defines a "Medicaid institution" as the "Living arrangement for persons in public or private institutions when more than 50 percent of the cost of care is met by the Medicaid program. In these situations, the monthly federal SSI payment is limited to no more than $30."]
  - Only individuals who were eligible for one of the four programs for any of the three months prior to the month of enactment will receive the $250.
  - Individuals who are otherwise eligible will not receive a payment if their federal program benefits have been suspended because they are in prison, a fugitive, a probation or parole violator, have committed fraud, or are no longer lawfully present in the United States.

- **What special rules apply to a Social Security recipient's "representative payee"?**
  - If an individual who is eligible for the $250 has a representative payee, the payment shall be made to the representative payee and the entire payment shall only be used for the benefit of the individual who is entitled to the $250.

- **How is the $250 treated for computation of eligibility for other benefits; how is it treated for income tax purposes?**
  - The $250 will not be taken into account as income, or taken into account as resources for the month of receipt and the following 9 months, for purposes of determining the eligibility of such individual or any other individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds.
  - The $250 will not be considered gross income for income tax purposes and that the payments are protected by the assignment and garnishment provisions of the four federal benefit programs.

- **When will people get their checks?**
  - The Law requires the Secretary of the Treasury to start making payments "as soon as possible, but no later than 120 days after the date of enactment."

Extension of Emergency Unemployment Compensation
Employers not liable; payments made from general funds of the Treasury.

Digital television coupons

$650 million in additional funding for coupons to purchase digital television converter boxes. Approximately 6 million Americans will lose television reception when digital broadcasting becomes mandatory in June unless they purchase converter boxes for their analog televisions or sign up for cable or satellite service.

Some things thought to be in the Stimulus which are NOT

No "hidden provisions" that spell Big Brother government control of medicine to the special detriment of Seniors

- Erroneous statements in an "opinion" piece published on-line and picked up by Rush Limbaugh, led to widespread concerns that health information technology (HIT) and comparative effectiveness studies specified in the Stimulus would mean government control of medical practice and particularly bad outcomes for seniors. Congress' phones and faxes were inundated and AAHSA members called with their concerns.

- Larry did a newsletter piece about this last week.

- One of his further explanations to a concerned member included this statement: "We badly need a common HIT platform and interoperability standards through out the health system. There are enormous numbers of deaths and mal-treatment as well as financial waste associated with the lack of a system—especially in the care of the elderly. I personally lost a close relative and had another sent to the wrong hospital just prior to death in part because of this issue. Having a common platform and standards does not mean rationing or socialized medicine any more than world-wide ATM cards means socialized banking. This article and the rhetoric surrounding it are just that: partisan, ideological rhetoric. The provisions in the stimulus surrounding HIT are carried forward from the Bush Administration based on work done over several years which included us through CAST and corporate giants like Intel. Craig Barrett, Intel's Chairman, spoke about this at our Philadelphia meeting….. Hope this puts your concerns into perspective… Larry"

For more information on this issue, go to these sites:

- The original opinion piece which started it all: http://www.bloomberg.com/apps/news?pid=20601039&refer=columnist_mccaughey&sid=aLzfDxfbwhzs
- How the erroneous statements spread: http://mediamatters.org/items/200902100001
- A rejoinder on the HIT issues: http://wonkroom.thinkprogress.org/2009/02/12/big-pharma-myth/
- A balanced view of issues related to "comparative effectiveness studies" http://healthcare.nationaljournal.com/2008/11/would-a-federal-health-board-help.php