

PROPOSED REGULATION

HHS Rule Impacts Health Care

The Department of Health and Human Services (HHS) this month published (Federal Register, Vol. 73, Number 166, August 26) a proposed regulation to enforce so-called “conscience clause” provisions in the Weldon Amendment, the Public Health Service Act, and the Church Amendment (see the July 2008 issue of the *Capital Communique*). Among other provisions, the proposal requires that all recipients of federal health program aid certify that they will not refuse to hire health personnel who object to performing or assisting in the performance of medical services or research activity based on their “religious beliefs or moral convictions.”

The proposed regulation employs sweeping definitions of the terms it uses, so that, as written, providers could not be disciplined (or denied employment) for refusing to prescribe needed medications, refer patients to specialists, or train staff in performing certain medical procedures, if any of these activities conflicted with their religious or moral beliefs.

In the event of non-compliance with the proposed regulation, HHS will consider termination of federal funding, the return of federal assistance, as well as other legal action. The proposal does not address how health employers would be able to provide these services according to accepted standards of care to patients who request or need them, if health provider candidates or current staff refuse to perform those services.

So far, health providers, such as the American College of Obstetricians and Gynecologists and the American Medical Association; state legislators; state attorney generals; and numerous national and local advocates have expressed objections to the proposed regulation. In addition, the American Board of Obstetrics and Gynecology has requested that HHS schedule formal hearings to obtain public comment to determine the overall implications of the proposed regulation.

Potential providers that will be directly impacted by this proposed regulation include, but are not limited to, health settings that treat Medicaid beneficiaries, federally funded Title X clinics, and hospital emergency rooms seeing survivors of sexual assault.

Possible action: Those wishing to do so can file comments to this troubling proposed regulation with the Secretary of HHS before the end of the comment period on September 25, 2008, and/or request that the comment period be extended an additional 30 days for needed input from potentially impacted stakeholders and concerned members of the public.

CMS GUIDANCE ON TARGETED CASE MANAGEMENT

On July 30, the Centers for Medicare & Medicaid Services (CMS) issued guidance to the states concerning the moratorium on targeted case management services which was included in the war "Supplemental Appropriations Act of 2008," (H.R. 2642) signed into law on June 30. The new law delays the implementation of six CMS Medicaid regulations which would have resulted in reduced federal spending on case management, as well as on other Medicaid services.

Among other provisions, the guidance states that individuals will not be restricted to one case manager; CMS will not require case management services to be billed in 15 minute increments; will not limit individuals to 60 days of case management services to prepare for discharges from institutions to residential settings, or only pay for such discharge planning when it proves successful; and will permit employees in state programs such as juvenile justice and child welfare to provide covered case management services. The guidance, however, is silent on enforcement of the rule's prohibition of federal reimbursement for "activities integral to the administration of another non-medical program." In addition, it requires states to adopt State Plan Amendments (SPAs) that comply with the provisions of the interim final rule, regardless of the moratorium.

AUGUST 17 CMS SCHIP DIRECTIVE

Earlier this month, California informed CMS that it would not comply with the August 17, 2007 directive purportedly designed to reduce substitution of State Children's Health Insurance Program (SCHIP) coverage for private insurance ("crowd-out"). See the November 2007 and May 2008 issues of the *Capital Communique* for details. California officials stated that certain requirements in the directive were not consistent with current California law, and that they were determined both to follow California's legal requirements and continue to request federal financial participation. Shortly thereafter, CMS announced at least a temporary retreat from its previously announced intention to begin this month to pursue financial penalties against states who had not yet complied with the August 17 CMS directive.

BILLS OF INTEREST

Empowered at Home Act of 2008

On July 24, Senators John Kerry (D-MA) and Charles Grassley (R-IA) of the Senate Finance Committee introduced the "Empowered at Home Act of 2008" (S. 3327). Among other provisions, the bill would permit states to provide home and community based services under an approved waiver program or demonstration project to individuals with incomes up to 300 percent of the Supplemental Security Income (SSI) benefit rate; allow states with approved State Plan Amendments to continue to provide home and community based services to such individuals even if they would otherwise not be eligible for medical assistance under the state plan, as long as they meet the states' needs-based requirements for eligibility; and amend the tax code as of December 31, 2009 to provide deductions for long term care premiums.

The Act is currently pending before the Senate Committee on Finance.

HEALTH IS A HUMAN RIGHT

The National Economic & Social Rights Initiative (NESRI) and NHeLP have released a new human rights analysis of the 2008 presidential nominees' health plans in "The Human Right to Health Care: Nominees' Plans Lag Behind Public Demand." The critique can be found at: http://www.healthlaw.org/library/folder.128017-Health_Care_as_a_Human_Right

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RESOURCES

The Guttmacher Institute's report on "Equipping Title X for the Future," demonstrates the importance of supporting publicly funded health providers, and explores strategies to improve the quality of care for diverse patient populations in the future. The analysis is located at: <http://www.guttmacher.org/pubs/gpr/11/3/gpr110319.html> .

FEDERAL FACTOID

The CMS report on National Health Expenditures determined that on the average, between 2000 and 2004, total personal health care spending grew the fastest in Nevada (12.2 percent) and the slowest in Louisiana (6 percent). Meanwhile, the Centers for Disease Control indicated that in 2005, Nevada's infant mortality rate was 5.86 percent, compared to Louisiana's 2004 infant mortality rate of 9.95 percent. The U.S. infant mortality rates for the two years were 6.83 percent and 6.86 percent, respectively. For further details, go to: <http://www.cms.hhs.gov/NationalHealthExpendData/> ; http://www.cdc.gov/nchs/pressroom/data/state_profile_NV.htm ; http://www.cdc.gov/nchs/pressroom/data/state_profile_LA.htm

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