

NHeLP's Capital Communique

MARCH 2011

This issue is part of a series of periodic reports from the National Health Law Program's Washington office, reporting briefly on recent and forthcoming developments in federal policy of interest to NHeLP advocates and friends. We always appreciate your feedback and comments. Please send them to Deborah Reid at reid@healthlaw.org.

SUBJECTS COVERED

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New Resources

BILL OF INTEREST

2011 Spending Bill -- Full Year Continuing Appropriations Act, 2011

On February 18, the House voted to approve the 2011 Spending Bill/Continuing Resolution (C.R.), "Full Year Continuing Appropriations Act" (H.R. 1), by a vote of 235-189. The legislation approves an estimated \$65 billion in federal program cuts. No Democrats voted in favor of H.R. 1, while three Republican congressmen voted against the legislation -- Representatives Jeff Flake (R-Ariz.), John Campbell (R-Calif.), and Walter Jones (R-N.C.). H.R. 1 supports funding federal government agencies through September 2011. The federal government is currently operating under a C.R. that expires March 4.

Among various provisions, H.R. 1 included:

- prohibitions of funds from being used to pay any federal agency, grantee, employee, or contractor from implementing or enforcing the Affordable Care Act (ACA);

- a prohibition of funds from being used to implement the medical-loss ratio requirements in the ACA;
- additional cuts to various HHS programs and program areas, such as the Maternal Child Health Block Grant, community health centers, family planning, and Teen Pregnancy Prevention Community Grants; and
- elimination of federal funding for Planned Parenthood.

Assessments of the impact of the H.R. 1 concluded that low-income communities, communities of color, children, rural residents, and the nation's economic growth would be harmed by the proposed budget cuts in federal programs. According to Goldman Sachs, the proposed cuts would reduce the nation's projected economic growth by 50 percent. Specifically, the Center for American Progress determined that:

- the budget for Maternal and Child Health Services Block Grant Program would be cut by \$210 million, which would reduce the program's ability to provide services such as primary care and immunizations;
- the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) would be cut by \$758 million, even though the program serves 45 percent of all infants born in the U.S.; and
- the C.R. prevents funding for the regulation of greenhouse gases and limits the Environmental Protection Agency from enforcing the Clean Water Act (negatively impacting communities of color that are often located near environmentally hazardous areas).

On March 1, the House approved a short-term C.R. that would provide funding at the current level of spending to keep the federal government operating until March 18, except for the termination or reduction of several non-health-related programs. The Senate is expected to pass it as well, giving Congress an additional two weeks to work out details for funding the government through the end of FY 2011. For further details on the short-term C.R., [click here](#) .

Possible Action: Those wishing to do so could contact their respective elected officials to encourage them to fund the government through the rest of the fiscal year without harmful impacts to HHS and other federal programs; with the necessary funding to implement and enforce the ACA; and to allow funding to continue for Planned Parenthood, which provides critical reproductive health services to women and men.

CONGRESSIONAL HEARINGS

On March 1, the House Committee on Energy and Commerce held a hearing on the impact of the ACA on Medicaid and state health care reform activities. While state budget shortfalls are leading many Governors to consider cuts to Medicaid, states have significant flexibility to sustain Medicaid while addressing budget shortfalls.

NHeLP and over 125 organizations submitted statements to the Committee expressing their continued support for Medicaid, the Children's Health Insurance Program (CHIP) and the implementation of health care reform. Cutting Medicaid to address budget cutbacks

significantly affects access to care for low-income and vulnerable communities, such as the elderly, people with disabilities, and children. [Click here](#) for details in a NHeLP press release.

For further details on Medicaid eligibility and enrollment requirements, see the New Resources section below.

HHS UPDATES

Proposed Rule -- Medicaid Payment Adjustment for Provider-Preventable Conditions.
Comments Due by March 18

On February 17, as required by the ACA, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule prohibiting payment of federal Medicaid funds to states related to health care-acquired conditions.

Under the proposed rule, states would also have to identify provider-preventable conditions (PPCs) that would similarly be ineligible for Medicaid payment. The proposed rule explains that PPCs are an overall term for hospital and non-hospital conditions that states identify for non-payment to ensure high-quality Medicaid services. PPCs are then broken into two categories -- Hospital Care Acquired Conditions (HCACs) and Other Provider-Preventable Conditions (OPPCs). The ACA defines a HCAC as, "a medical condition for which an individual was diagnosed that could be identified as acquired in the hospital" (e.g. foreign object remaining after surgery, pressure sores, and some surgical site infections). The ACA and now this rule apply Medicare-defined HCACs to Medicaid for non-payment, as long as the prohibition on payment does not result in a loss of access to care or services for Medicaid enrollees.

Among other provisions, the proposed rule:

- directs the Secretary to determine current state practices that prohibit Medicare payment for HCACs and hospital-acquired conditions (HACs) and apply these practices (or elements of them) to Medicaid;
- defines OPPCs to include, at a minimum, wrong surgical or other invasive procedures performed on a patient, or surgical procedures performed on the wrong body part or the wrong patient;
- allows states to identify OPPCs related to health services provided in settings other than hospitals, such as nursing facilities, ambulatory care settings, and other health care settings; and
- restricts any payment reductions to the amounts directly identifiable as related to the PPC and the resulting treatment so that states cannot unduly reduce provider rates and limit access to care of enrollees.

Comments on the proposed rule should be received by March 18. For the complete *Federal Register* notice, [click here](#)

Community Supports as Alternatives to Long-Term Care for Medicaid Enrollees

On February 22, HHS Secretary Sebelius announced the availability of \$4.3 billion in new funding through the ACA to move eligible Medicaid enrollees from long-term care institutions into their homes or to community-based settings. This funding is available through the Money Follows the Person (MFP) Demonstration Program and the Community First Choice (CFC) Option Program (see proposed rule below).

The MFP Program allows individuals with disabilities, those experiencing mental illnesses, the elderly, and individuals with several of these conditions who are living in nursing homes and other institutions with the opportunity to live in the community with appropriate support services. Thirteen additional states will receive a total of \$45 million to establish their MFP Programs, which will assist an estimated 13,000 individuals. Although the MFP Program was set to expire at the end of 2011, the ACA extends the program until 2016.

For the HHS news release about these new programs, [click here](#).

Proposed Rule -- Medicaid Community First Choice Option Program -- Comments Due by April 26

On February 25, CMS released a proposed rule on the Community First Choice (CFC) Option Program, which was created by the ACA. The CFC program gives states an option to provide home and community-based attendant services and supports under their Medicaid state plans. The option becomes available on October 1, 2011. States would be provided with additional resources to make community living a priority choice for Medicaid enrollees who are eligible for long-term care, and re-prioritizing institutional care as a secondary option.

Under the CFC Program, instead of states' usual federal Medicaid matching rates, they would receive an additional six percent increase to provide community-based attendant services (e.g., assistance and supports that help individuals with activities of daily living, such as bathing and eating and health-related tasks) and the costs related to moving individuals from institutions to community settings (including security and utility deposits and basic household supplies). Through 2014, states could receive \$3.7 billion in funding to provide these services.

Among various provisions, the proposed rule discusses the requirements for the state participation in the CFC Program, such as:

- conducting an assessment of individuals' functional needs, that will include a face-to-face meeting with that individual, to determine an appropriate person-centered service plan;
- incorporating the individual's strengths, capacities, preferences, needs, and desired outcomes, along with his/her health needs into a patient-centered service plan; and
- collecting data on the estimated number of individuals who receive CFC Program services

for each fiscal year, based on their type of disability, age, gender, education level, employment status, and whether they have received services under other home and community based service programs.

Comments on the proposed rule should be received by April 26. For the complete *Federal Register* notice, [click here](#) .

CHIPRA Anniversary and Guidance on Core Set of Child Health Quality Measures

On February 3, CMS' Center for Medicaid, CHIP and Survey & Certification observed the second anniversary of the Children's Health Insurance Program Reauthorization Act (CHIPRA). It released an Informational Bulletin that contained supplemental guidance for states that voluntarily report the initial core set of quality measures for children enrolled in Medicaid and CHIP. The supplemental guidance included links to a CHIPRA Anniversary Report, information on \$40 million in outreach and enrollment grant funds, FY 2010 Children's Enrollment Data, and the Child Health Quality Measures Manual.

For further details in the Informational Bulletin, [click here](#) .

Final Rule -- CHIP Allotments Methodology and States' FY 2009-2015 Allotments

On February 17, CMS published a final rule describing the implementation of funding provisions for CHIP, as well as methodologies and procedures for determining states' fiscal years 2009-2015 allotments and payments. The final rule includes state-by-state tables of CHIP allotment increase factors for 2010 and 2011, and FYs 2010 and 2011 allotments as authorized by CHIPRA. The effective date of this regulation is April 18, 2011. [Click here](#) for the *Federal Register* notice.

Final Rule -- Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws

On February 23, HHS released the final rule regarding federal statutory health care provider conscience protections. The Department's Office for Civil Rights will be responsible for enforcement in conjunction with other HHS departments. The final rule rescinds in part and revises a December 19, 2008, Final Rule on conscience protections. [Click here](#) for the December 19 Final Rule.

Among other provisions, the 2008 Final Rule contained certain terminology that expanded the conscience protection against providing abortions to providing contraception. This is a concept

that was not covered by the relevant statutory provisions. There was also a concern that the 2008 Final Rule extended "conscience rights" of providers and other health workers (based on their moral or religious beliefs) to be able to object to providing medical services, information, or referrals to patients requesting or needing them. Because of the conscience protections, providers, health workers, or institutions that receive federal funding could not be discriminated against for their objections to providing medical services because of moral or religious reasons. There was concern that the 2008 Final Rule was broader than the statutory provisions authorizing the protections, and that low-income communities would have limited options to receive needed health services, should the services not be provided because of the conscience protections of providers and others.

The revised conscience protection regulation (2011 Final Rule) clarifies the 2008 Final Rule. It reflects that provider conscience protections were not intended to shield providers from liability for failing to obtain complete informed consent, or disclosing treatment options that the provider or other health workers may object to providing to patients.

Prior to releasing the 2011 Final Rule, HHS Secretary Sebelius announced the creation of a new awareness initiative for HHS grantees that describes the statutory conscience protections, and the enforcement process for individuals who believe their rights have been violated.

The 2011 Final Rule is effective as of March 25. [Click here](#) for the *Federal Register* notice, and [click here](#) for details on the new HHS conscience awareness initiative.

NEW RESOURCES

[NHeLP Breaks Down the Florida Decision and What It Means.](#) NHeLP provides clarification on the status of the ACA case filed in Florida (*State of Florida ex rel. Bondi et al. v. U.S. Depart. Of Health & Human Services et al*).

[NHeLP Breaks Down the Arizona Maintenance of Effort Issue.](#) NHeLP offers information on the Governor of Arizona's request to HHS to use the Social Security Act's 1115 demonstration authority to waive the Maintenance of Effort (MOE) requirements of the ACA, the HHS response, and the outlook for MOE in Arizona and nationwide.

Georgetown University Health Policy Institute, Center for Children and Families. [Eliminating Medicaid and CHIP Stability Provisions \(MoE\): What's At Stake for Children and Families.](#) This issue brief explains how the stability of Medicaid and CHIP is due to the short-term fiscal relief and federal requirements that states maintain their eligibility rules and enrollment processes until the implementation of health reform. The issue brief describes the Medicaid and CHIP stability protections, those at most risk of losing their coverage if these protections are weakened or eliminated, and analyses the policy implications.