

NHeLP's Capital Communique MAY 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. For updates and information on NHeLP publications, go to <http://www.healthlaw.org>.

SUBJECTS COVERED

New Law

- Full-Year Continuing Appropriations Act, 2011

Bills of Interest

- FY 2012 Budget Resolution
- Debt Ceiling and Federal Caps

HHS Updates

- Action Plan to Reduce Health Disparities and OMH National Strategy Stakeholder Strategy for Achieving Health Equity
- Proposed Rule: Waivers for State Innovation – Comments Due by May 13

- Proposed Rule: Medicare Shared Savings Program – Accountable Care Organizations – Comments Due by June 6

- Final Rule: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities

New Resources

New Law:

Full-Year Continuing Appropriations Act, 2011

On April 14, the House passed a FY 2011 appropriations bill, (H.R. 1473), by a vote of 260-167. The legislation funds the operation of the federal government through September 30, 2011.

H. R. 1473 is a compromise between President Obama and Congressional Democratic and Republican leaders to avoid shutting down operation of the federal government when the previous continuing resolution expired, while cutting an estimated \$39.9 billion in current federal spending. Eighty-one Democrats voted in favor of the legislation, and 59 Republicans voted against it.

Among other provisions, the legislation:

- avoids legislative riders that were included in H.R. 1 (the FY 2011 appropriations act that passed the House in February 2011, but failed in the Senate) to defund the Patient Protection and Affordable Care Act (ACA);
- rejects the elimination of the \$750 million Prevention and Public Health Fund that was proposed in H.R. 1 (the fund was mandatory funding appropriated in the ACA);

- includes \$885 million for the AIDS Drug Assistance Program (ADAP), which was \$8 million more than what was included in H.R. 1;
- prevents the District of Columbia from using local funds to provide abortion services;
- provides \$300 million for Title X Family Planning funding, which was originally defunded in H.R. 1; and
- includes \$662 million for the Maternal Child Health block grant, which was cut by \$50 million in H.R. 1.

The Senate also approved H.R. 1473 on April 14, by a vote of 81-19. President Obama signed the bill into law on April 15.

Bills of Interest:

FY 2012 Budget Resolution

On April 15, the House voted to approve the FY 2012 budget plan (H. Con. Res. 34) by a vote of 235-193. No Democrats supported the legislation, and four Republicans voted against it. House Budget Committee Chairman Paul Ryan (R-WI) proposed the budget plan. Over the next ten years, the resolution cuts federal program funding by at least \$5.8 trillion. Among other provisions, the bill:

- converts Medicaid into a block-grant program that cuts federal funding to the states by \$700 billion over the next ten years, causing states to eventually be faced with restricting coverage and services;
- changes Medicare by requiring seniors who become 65 years old after 2023 to use vouchers to obtain coverage through private health plans (that have been estimated to cover only part of private premiums); and
- provides further cuts to non-health related federal programs impacting housing, education, and the environment over the next ten years.

The Senate Budget Committee must submit its budget resolution to the Senate for a vote. If a Senate resolution is approved, the House and Senate Budget Committees will attempt to reconcile the differences between their two resolutions for a final vote on a FY 2012 budget resolution which would be used to guide the annual appropriations bills.

Possible Action:

Those wishing to do so could contact their elected officials in the Senate to support the current structures of Medicaid and Medicare and oppose cuts that would affect the scope of services for low-income communities and the elderly.

Debt Ceiling and Federal Caps

As the U.S. nears its \$14.3 trillion debt limit by the mid-May, Congress will introduce legislation to raise the limit of the nation's debt (debt ceiling) so that the country can maintain its ability to borrow money. Although President Obama has indicated his preference for considering a "clean" debt ceiling bill without any amendments, it is also expected that House Republicans may attach a provision for federal spending cuts with this legislation.

Similarly, Senator Bob Corker (R-TN) sponsored the "Commitment to American Prosperity (CAP) Act of 2011" (S. 245) that would establish a limit on federal spending to no more than 20.6 percent of the Gross Domestic Product (GDP) for FYs 2013 – 2022. The CAP Act has bipartisan support of some Senate Democrats. In the event that federal spending limits were reached, the bill would trigger significant cuts to certain programs. The Congressional Budget Office estimates that these cuts could total \$1.3 trillion from Social Security, \$856 billion from Medicare, and \$547 billion from Medicaid from 2013 – 2021.

In addition, primarily due to the aging of the population and increased costs in the U.S. health system, the Center on Budget and Policy Priorities (CBPP) noted that more substantial cuts would be necessary to stay below federal spending limits after 2035 because Medicare, Medicaid, and other federal health programs will continue rising as a percentage of the GDP. This would require:

- eliminating Medicare's current structure;
- block-granting Medicaid;
- repealing major coverage provisions of the ACA that reduce the number of uninsured individuals (e.g., premium and cost-sharing subsidies to purchase coverage in the health exchanges); and

- cutting Social Security benefits immediately and in the future.

The Senate Budget Committee is currently considering S. 245.

Possible Action:

Those wishing to do so could contact their elected officials in the Senate to express opposition to S. 245 which would cause states to implement harmful cuts to Medicaid and other programs, and to avoid the repeal of coverage protections in the ACA.

HHS Updates:

Action Plan to Reduce Racial and Ethnic Health Disparities and OMH National Stakeholder Strategy for Achieving Health Equity

On April 8, HHS announced two new approaches to address health disparities. The first is the *HHS*

Action Plan to Reduce Racial and Ethnic Health Disparities

. The

Action Plan

includes goals and corresponding strategies that focus on disparities, including:

- using data collection and data to improve the health of communities of color;
- increasing the proportion of people with health insurance;
- providing patient protections for individuals enrolled in CHIP, Medicaid, and plans in the health exchanges; and
- increasing the proportion of individuals who have a primary care provider and a patient-centered medical home.

The second strategy is the Office of Minority Health's *National Stakeholder Strategy for Achieving Health Equity*. The *Stakeholder Strategy*

promotes goals and strategies such as, supporting cultural and linguistic competency in providing health care, improving access to quality health services, and addressing community factors that impact health.

For the *Action Plan* and the *Stakeholder Strategy*, click [here](#) and [here](#). □

Proposed Rule: Waivers for State Innovation – Comments Due by May 13

On March 14, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule in the *Federal Register*, “Application, Review, and Reporting Process for Waivers for State Innovation” that permits the Secretaries of HHS and the Treasury to waive certain features of the ACA. The ACA requires the establishing of this waiver process.

The proposed rule applies to health insurance coverage within a state for plan years that begin on or after January 1, 2017. To develop innovative strategies to ensure access to high quality care, the Secretary may grant waivers from certain ACA provisions such as maintaining consumer choices and insurance competition requirements in health exchanges, establishing qualified health plans, and reducing cost-sharing for individuals in qualified health plans. Among other requirements, states can only obtain waivers if they can provide coverage that is “at least as comprehensive” as coverage provided in the health plans that will be offered in the health exchanges, and “at least as affordable” as the provisions in the ACA. It is unclear how these requirements would be interpreted and applied.

The proposed rule includes procedures for submitting state waivers; providing public notice and opportunity for commenting on waivers on the state and federal levels; reviewing waiver applications by the Secretaries of HHS and the Treasury; and monitoring and evaluating approved waivers.

For the complete *Federal Register* notice **click [here](#)** . The proposed rule seeks comments on issues such as, the impact of the waiver on stability of coverage for individuals and employers, and the choice of health plans for individuals and employers. Comments on the proposed rule must be received by May 13.

Possible Action:

Those wishing to do so could submit comments supporting the need for public notice and comment requirements before states submit waiver requests and ensuring that there are stringent requirements to evaluate waivers for comprehensive coverage and affordability.

Proposed Rule: Medicare Shared Savings Program: Accountable Care Organizations – Comments Due by June 6

On April 7, CMS issued a proposed rule in the *Federal Register*, “Medicare Shared Savings Program: Accountable Care Organizations.” The proposed rule implements the section of the ACA relating to Medicare payments to providers of service and suppliers in Accountable Care Organizations (ACOs) and improving the quality of Medicare services. ACOs are recognized legal entities under state laws that are eligible as groups to work together to manage and coordinate care for Medicare fee-for-service beneficiaries

The proposed rule explains that ACO providers of services and supplies can continue to receive traditional Medicare fee-for-service payments for inpatient and outpatient services, and be eligible for additional payments for meeting certain quality and saving requirements. Some other provisions included in the proposed rule include:

- a legal definition of ACOs and their governance requirements;
- eligibility requirements for ACO organizations to participate in the ACA’s “Shared Savings Program” that focuses on providing accountability for patient populations, coordinating inpatient and outpatient services under Medicare A and B, and encouraging the development of infrastructure changes and care processes for quality service delivery;
- accountability requirements for ACOs to Medicare fee-for-service beneficiaries relating to quality, cost, and overall care; and
- .processes to promote evidence based medicine and patient engagement.

Comments on the proposed rule must be received by June 6. Click [here](#) for the *Federal Register* notice.

Final Rule: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities

On April 19, CMS published a final rule in the *Federal Register* on “Federal Funding for Medicaid Eligibility Determination and Enrollment Activities.” The final rule acknowledges the impact of enrolling uninsured but eligible children in Medicaid and CHIP in an expedited fashion, due to the enactment of “Express Lane Eligibility” requirements in the Children’s Health Insurance Program Reauthorization Act (CHIPRA). In addition, because of the anticipated number of newly eligible Medicaid enrollees due to expanded eligibility provisions in the ACA, states will need to develop new processes to determine eligibility.

As a result, the final rule revises Medicaid regulations for claims processing and information retrieval systems, as well as modifies regulations to obtain enhanced federal funding (Federal financial participation or FFP) for designing and installing enhanced eligibility systems until December 31, 2015. Among other provisions, the final rule also:

- determines that the 90 percent FFP would be available for the design, development, installation, or enhancement of eligibility determination systems for state expenditures through calendar year 2015 (while the 75 percent FFP is available after 2015 to operate and maintain the previously 90 percent FFP-eligible systems); details standards and eligibility criteria to obtain the enhanced FFPs; and
- requires periodic performance reviews of Medicaid management information systems.

The effective date of the final rule was April 19. For the *Federal Register* notice, click [here](#).

New Resources:

NHeLP, Amicus Brief in *Florida v. HHS*. NHeLP filed an amicus brief in April on behalf of more than a dozen national and Florida health care organizations, including the American Academy of Pediatrics, Families USA, and the American Public Health Association. The brief was filed in federal appeals court in a case broadly challenging the constitutionality of the ACA. NHeLP attorneys argued that the Medicaid expansions contained in the Affordable Care Act were a permissible exercise of Congress's powers under the Spending Clause of the U.S. Constitution. **Click [here](#)** for further details and the amicus brief.

Institute of Medicine of the National Academies (IOM), *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building A Foundation for Better Understanding*. The IOM determined that in spite of some preliminary research documenting disparities impacting the LGBT community, there is a need for including sexual orientation and gender identity data in HHS federal health surveys to get additional information to provide better care to that community. The report also noted that providers may not be educated on understanding sexual orientation development, gender identity, and the impact of stigma and discrimination on health of the LGBT population. This impairs the ability of providers to ask the right questions about support at home, make referrals, and order appropriate tests for physical and mental health care. For more information on the IOM's analysis, **click [here](#)**.