National Indian Health Board

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HILL UPDATES

Congress Passes FY 2012 Appropriations with Increase to IHS

Over the weekend, Congress passed the remaining nine appropriations bills for Fiscal Year (FY) 2012 in a $1 trillion omnibus package. By a vote of 296-121, the House passed H.R. 2055 on December 16th. On December 17th, the Senate cleared the measure 67-32 while also approving H. J. Res. 95, a short-term continuing resolution (CR) that will allow the federal government to remain open during the time it takes for the bill to reach the President's desk for signature (until December 23rd). The President is expected to sign H.R. 2055 into law later this week.

The legislation is the result of weeks of negotiation between the House and Senate. Among funding for other agencies, it contains FY 2012 funding for the Indian Health Service at a total of $4.31 billion. This represents a 6% increase from FY 2011 enacted levels (click here for a chart comparing FY 2011 and FY 2012 funding levels).

The bill contains $3.08 billion for total Clinical Services which includes $845 million for Contract Health Services. Contract Support Costs are funded at $472 million and Preventive Health is funded at $147 million. Indian Health Facilities will receive a total of $441 million in funding.

In a joint statement, those who managed the process of reconciling the House and Senate proposed levels of funding also noted that the bill assumes a reduction of $7 million in small grants programs from IHS' budget. These small grants identified in the President's budget request include programs that serve elders, women, and children, as well as the National Indian Health Board's cooperative agreement with IHS.

The managers' statement also contained a directive with regard to Contract Support Costs. The Congressional managers wrote, "The conferees direct the Service to meet its annual Contract Support Costs reporting requirement due date, and to provide the Committees with current Contract Support Costs estimates in conjunction with its annual budget submission."

House Still In-Session Due to Differences over Payroll Tax, SGR

Immediately following the passage of FY 2012 appropriations on December 17th, the Senate also passed a bill providing for a temporary, two-month extension of a payroll tax holiday, unemployment benefits, and a patch to the Sustainable Growth Rate (SGR), the formula that ties physician reimbursement under Medicare to economic growth. If the patch is not enacted

before the first of the year, Medicare providers could face a 27% cut to reimbursements. Typically, a patch is enacted annually prior to Congress recessing for the year.

The Senate's temporary extension is an amendment to a House-passed bill that had previously been under veto threat from President Obama. The House bill would have extended the payroll tax holiday and unemployment insurance for one year and offered a SGR patch for two years. The House version had contained changes to requirements for unemployment insurance, changes to benefits in Medicare, and $30 billion in cuts to discretionary spending over the next decade as a method of paying for the bill.

The Senate removed all of this, but did keep one provision favored by the House majority: a requirement that the President expedite a decision on whether to approve an oil pipeline running from Canada through the United States. When the Senate passed the amended, temporary legislation, it was under the impression that a deal had been negotiated with the House to pass this compromise while the two bodies resolved differences on payment for the extensions. The Senate has been in recess since December 17th.

Since then, negotiations on the issue have broken down. The House voted against consideration of the Senate version of the bill and then to reject the Senate amendments on Tuesday. The House is calling for the Senate to return to session for a conference on the different versions of the bill, but thus far, the Senate remains in recess.

If a resolution is not reached before January 1st, Americans will see an increase in taxes, unemployment insurance will lapse, and 500,000 Medicare providers will see a 27% drop in reimbursement payments.

NIHB is closely monitoring this situation and will provide new information as it develops.

HEALTH REFORM UPDATES

Supreme Court Schedules Oral Arguments on Healthcare Law

The Supreme Court has officially scheduled oral arguments on the Patient Protection and Affordable Care Act (ACA) over three days in late March 2012.

On March 26th, the Court will hear 1 hour of oral arguments on whether the Anti-Injunction Act prevents them from ruling on the constitutionality of the individual mandate before 2014. The individual mandate requires that nearly every American purchase health insurance or face a financial penalty levied by the Internal Revenue Service (IRS). Some are calling this financial penalty a tax. If that is the case, then current federal law (the Anti-Injunction Act) prevents the Supreme Court from ruling on the constitutionality of a tax until it is actually levied.

On March 27th, two hours of oral arguments are scheduled on whether the individual mandate is constitutional. On March 28th, the justices will hear arguments on what portions of the law can be upheld if the individual mandate is struck down and on the constitutionality of the expansion of Medicaid under the law.

NIHB (along with hundreds of Tribes and Tribal organizations) is serving as the lead on a Tribal amicus (or "friend of the court") brief arguing that the Indian Health Care Improvement Act (IHCIA) and Indian-specific provisions within the ACA are separate from other provisions in the Act and should stand on their own even if the controversial individual mandate provision is held to be unconstitutional.

The Court is expected to issue a ruling on these issues in June 2012.

32 Healthcare Organizations Receive Funds to become Pioneer ACOs

Thirty-two leading health care organizations from across the country will participate in a new Pioneer Accountable Care Organizations (ACOs)

initiative made possible by the Affordable Care Act, HHS Secretary Kathleen Sebelius announced on December 19th. The Pioneer ACO initiative will encourage primary care doctors, specialists, hospitals and other caregivers to provide better, more coordinated care for people with Medicare and could save up to $1.1 billion over five years.

Under this initiative, operated by the Centers for Medicare & Medicaid Services (CMS) Innovation Center (Innovation Center), Medicare will reward groups of health care providers that have formed ACOs based on how well they are able to both improve the health of their Medicare patients and lower their health care costs.

The Pioneer ACO initiative is just one of a menu of options for providers looking to better coordinate care for patients and use health care dollars more wisely. The Pioneer ACO model is designed specifically for groups of providers with experience working together to coordinate care for patients. The Medicare Shared Savings Program and the Advance Payment ACO Model, both announced in October 2011, are also ACO options for providers. More information about the full menu of options for providers and how to apply to participate is available here.

The 32 Pioneer ACOs underwent a rigorous competitive selection process by the Innovation Center, including extensive review of applications and in-person interviews.
The initiative will test the effectiveness of several innovative payment models and how they can help experienced organizations to provide better care for beneficiaries, work in coordination with private payers, and reduce Medicare cost growth. These payment models will allow organizations that are successful in achieving better care and lower cost growth to move away from a payment system based on volume under the fee-for-service model, towards a model where the ACO is paid based on the value of care it provides.
The Pioneer ACO model requires ACOs to engage other payers in similar efforts to reward health care providers that deliver high-quality care. The Pioneer ACO model also includes strict beneficiary protections, including the ability for patients to seek care from any Medicare provider they wish. Selected Pioneer ACOs include physician-led organizations and health systems, urban and rural organizations, and organizations in various geographic regions of the country, representing 18 States and the opportunity to improve care for about 860,000 Medicare beneficiaries. The first performance period of the Pioneer ACO Model will begin January, 1st.

For the final list of participating Pioneer ACOs and more information about the Pioneer ACO Model, a fact sheet is posted at
http://www.cms.gov/apps/media/fact_sheets.asp
or you can visit:
http://innovations.cms.gov/initiatives/aco/pioneer

The Pioneer ACO Model is one of several initiatives underway at CMS designed to support the formation of ACOs. For more information, visit www.cms.gov/aco.
For more information about the CMS Innovation Center, visit innovations.cms.gov.

HHS Allows States to Define Essential Health Benefits

The Department of Health and Human Services recently released a bulletin outlining proposed policies that will give states more flexibility and freedom to implement the Affordable Care Act.

The Affordable Care Act ensures all Americans have access to quality, affordable health insurance. To achieve this goal, the law ensures that health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges), offer a comprehensive package of items and services, known as "essential health benefits."

The bulletin describes an inclusive, affordable and flexible proposal and informs stakeholders about the approach that HHS intends to pursue in rulemaking to define essential health benefits. HHS is releasing this intended approach to give consumers, states, employers and insurers timely information as they work toward

establishing Exchanges and making decisions for 2014. This approach was developed with significant input from the public, as well as reports from the Department of Labor, the Institute of Medicine, and research conducted by HHS

Under the Department's intended approach, states would have the flexibility to select an existing health plan to set the "benchmark" for the items and services included in the essential health benefits package. States would choose one of the following health insurance plans as a benchmark:

- One of the three largest small group plans in the state;
- One of the three largest state employee health plans;
- One of the three largest federal employee health plan options;
- The largest HMO plan offered in the state's commercial market.

The benefits and services included in the health insurance plan selected by the state would be the essential health benefits package. Plans could modify coverage within a benefit category so long as they do not reduce the value of coverage. Consistent with the law, states must ensure the essential health benefits package covers items and services in at least ten categories of care, including preventive care, emergency services, maternity care, hospital and physician services, and prescription drugs. If a state selects a plan that does not cover all ten categories of care, the state will have the option to examine other benchmark insurance plans, including the Federal Employee Health Benefits Plan, to determine the type of benefits that will be included in the essential health benefits package.

The policy proposed by HHS would give states the flexibility to select a plan that would be equal in scope to the services covered by a typical employer plan in their state. States and insurers would retain the flexibility to evolve the benefits package with the market as innovative plan designs are developed and advancements in care become available, and meet the needs of their citizens.

The bulletin addresses only the services and items covered by a health plan, not the cost sharing, such as deductibles, copayments, and coinsurance. The cost-sharing features will be addressed in future bulletins and cost-sharing rules will determine the actuarial value of the plan.

Public input on this proposal is encouraged. Comments are due by Jan 31st and can be sent to: EssentialHealthBenefits@cms.hhs.gov.

For the essential health benefits bulletin, visit: http://cciio.cms.gov/resources/regulations/index.html#hie

For a fact sheet on the essential health benefits bulletin, visit: http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

UPCOMING EVENTS

DECEMBER 26TH—JANUARY 2ND
NIHB OFFICES ARE CLOSED

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