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National Indian Health Board

ISSUE 11 -27

OCTOBER 21, 2011

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NIHB UPDATES

NIHB to Continue to Lead Amicus Brief on ACA

The National Indian Health Board will continue to be the lead among hundreds of Tribes and Tribal organizations in an Amicus Brief in a prominent case pertaining to the Patient Protection and Affordable Care Act (ACA)- *State of Florida et al. vs. U.S. Department of Health and Human Services et al.* Immediately filed after the enactment of the ACA, 26 state government plaintiffs challenged the constitutionality of the individual mandate – the ACA requirement for all individuals who can afford health care insurance to purchase a minimally comprehensive insurance policy.

In his opinion, Judge Roger Vinson, a federal District Court judge in the Northern District of Florida, concluded that Congress overstepped its bounds with this requirement and because this provision is unseverable from the ACA, i.e., not able to be separated from rest of the law, the entire ACA must be struck down along with the individual mandate provision

The case then went to the 11th Circuit of Appeals. It was at this time that the National Indian Health Board, Tribes and Tribal organizations added their voice in the case as amicus curiae – meaning "friend of the court." (Individuals or entities that are not parties in the case but have an interest or perspective on issues of a case may seek to file an amicus brief to provide input on the issues being argued.) The amicus brief effort was initiated by the Seminole Tribe of Florida, and with their backing, the National Indian Health Board is serving as the lead on the Tribal amicus brief.

In this brief, the Tribes expressed that the lower court's ruling on this issue was overbroad and that the IHCIA and the Indian specific provisions of the ACA are independent from ACA's individual mandate provision and these provisions should not be struck down.

The 11th Circuit of Appeals found the individual mandate unconstitutional by a 2-1 vote on Aug. 12. The court, however, found the individual mandate to be severable from the rest of the law, and found the remaining provisions "legally operative." Judge Marcus dissented. The federal government on Sept. 28 appealed the case to the Supreme Court. The subsequent Tribal amicus brief will continue the arguments above.

HILL UPDATES

Senate Interior Appropriations Subcommittee Releases Draft of FY 2012 Interior Appropriations Bill

The Bipartisan Leadership of the Senate Appropriations Subcommittee on Interior, Environment, and Related Agencies, Senators Jack Reed (D-RI) and Lisa Murkowski (R-AK), has released draft legislation for their Fiscal Year (FY) 2012 Appropriations bill, calling it a "starting point" for discussion with House and Senate colleagues. Using the spending limits imposed by the debt ceiling deal, the draft legislation funds the Indian Health Service at a level of $4.282 billion. This figure includes $829,927,000 for Contract Health Services, $442,693,000 for Contract Support Costs, and $446,342,000 for the Facilities line item.

Although this marks a $213,230,000 increase from FY 2011 levels, it remains $341,358,000 less than the President's request. It is also less than what was approved by the House Committee on Appropriations: $4.462 billion.

With the current Continuing Resolution expiring on November 18th, both Chambers of Congress are facing some pressure to either finish passing individual appropriations bills and then reconcile them, or they must pass a large package containing appropriations for all Federal agencies. However, it seems as though they may be awaiting the Joint Select Committee on Deficit Reduction's recommendations. NIHB is monitoring this situation carefully and will report on new information as it arises.

SAMHSA Suicide Prevention Block Grant Not in Senate Labor HHS Appropriations Bill

A proposed new grant program, the Behavioral Health-Tribal Prevention Grant, requested by the Obama Administration was not funded in the Senate full Committee-approved Fiscal Year (FY) 2012 Labor, HHS, Education, and Related Agencies Appropriations bill. This program would have provided $50,000 to each Federally-Recognized Tribe in a non-competitive grant to address the prevention of suicide and substance abuse in their communities.

NIHB continues to fight for this grant and will provide updates as they occur.

Ways and Means Committee Approves Bill with Changes to Medicaid Eligibility

On October 13th, House Ways and Means Committee approved a bill that would affect eligibility for Medicaid and new health insurance subsidies. The committee approved HR 2576, a bill that would change a provision in the Affordable Care Act that would allow people to exclude Social Security benefits from their income when applying for health benefits, including Medicaid and subsidies to purchase private insurance on new state-run exchanges.

Ways and Means Chairman, Dave Camp, said the measure would bring the definition of income in the health care law in line with the standards used by other federal programs for low-income people.

The nonpartisan Congressional Budget Office and the Joint Committee on Taxation estimated that the bill would raise $13 billion over 10 years. The Super Committee has explored the option of using this bill as a potential offset in the upcoming budget negotiations.

HEALTH REFORM UPDATES

CMS Releases Final ACO Rules

A final regulation was issued on October 20th by the Department of Health and Human Services (HHS) regarding Accountable Care Organizations (ACOs). Created by the Affordable Care Act, ACOs are sets of providers that have the ability to manage the

full continuum of care for patients and receive financial incentives to improve the quality and efficiency of care.

The two initiatives launched today – the Medicare Shared Savings Program and the Advance Payment model – will help providers form Accountable Care Organizations and reflect the significant input provided by stakeholders as well as lessons learned by innovators in care coordination in the private sector.

- The Medicare Shared Savings Program will provide incentives for participating health care providers who agree to work together and become accountable for coordinating care for patients. Providers who band together through this model and who meet certain quality standards based upon, among other measures, patient outcomes and care coordination among the provider team, may share in savings they achieve for the Medicare program. The higher the quality of care providers deliver, the more shared savings the providers may keep.

- The Advance Payment model will provide additional support to physician-owned and rural providers participating in the Medicare Shared Savings Program who also would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems. The advanced payments would be recovered from any future shared savings achieved by the Accountable Care Organization.

Both the Medicare Shared Savings Program and Advance Payment model create incentives for health care providers to work together to treat an individual patient across care settings – including doctors' offices, hospitals, and long-term care facilities.

Unlike a managed care plan, Medicare beneficiaries will not be locked into a restricted panel of providers. Rather, a determination of whether an Accountable Care Organization was responsible for coordinating care for a beneficiary will be based on whether that person received most of their primary care services from the organization.

Other changes from the proposed rule include expanding participation to Rural Health Clinics and Federally Qualified Health Centers and organizations where specialists provide primary care, and providing a flexible starting date in 2012. Federal savings from this initiative could be up to $940 million over four years.

The Shared Savings Program final rule is posted at: www.ofr.gov/inspection.aspx.

The Advanced Payment solicitation is posted at: http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/

For more information, fact sheets are posted at: http://www.HealthCare.gov/news/factsheets/2011/10/accountable-care10202011a.html and http://www.cms.gov/ACO/.

Medicare Now Covers Screening for Alcohol Misuse, Depression

The Centers for Medicare & Medicaid Services (CMS) recently announced two new national coverage determinations that cover alcohol misuse screening and behavioral counseling for Medicare beneficiaries as well as screening for depression. These new coverage policies add to the existing portfolio of covered preventive services, most of which are now available to people with Medicare at no additional cost.

Annual alcohol misuse screening by primary care providers, such as a beneficiary's family practice physician, internal medicine physician, or nurse practitioner, in settings such as physicians' offices are covered under CMS' new policies. The benefit also includes four behavioral counseling sessions per year furnished by the primary care provider, if beneficiaries screen positive for alcohol misuse.

Among people 65 years and older, one in six suffers from depression. Annual screening for depression for Medicare beneficiaries is now covered in primary care settings that have staff resources to follow up with appropriate treatment and referrals. The purpose of this screening is to assure accurate diagnosis, effective treatment and follow-up.

The coverage decision on alcohol misuse screening is online at http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=249 and the decision on depression screening is online at http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=251.

CMS Announces Innovation Advisors Program

On October 17th, the Centers for Medicare & Medicaid Services announced that it was accepting applications for a new Innovation Advisors program to help health professionals deepen skills that will drive improvements to patient care and reduce costs. These health care improvements will benefit people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Made possible by the Affordable Care Act, this initiative will be managed by the Center for Medicare and Medicaid Innovation (Innovation Center).

Under the new program, there will be up to 200 Innovation Advisors, including clinicians, allied health professionals, health administrators and others. They will attend in-person meetings as well as remote sessions to expand their skills and knowledge, and apply what they learn in their organizations and areas.

After an initial, intensive orientation phase, Innovation Advisors will work with the Innovation Center to test new models of care delivery in their own organizations and communities. They will also create partnerships to find new ideas that work and share them regionally and across the United States.

Applications for the Innovation Advisors program are due on November 15, 2011. Applications will be reviewed and Innovation Advisors will be notified of their selection by mid-December 2011.

More information, including a fact sheet, frequently asked questions, application and terms and conditions can be found at: http://innovations.cms.gov/innovation-advisors-program

CLASS Act Implementation Terminated

The Obama administration announced recently that it will stop implementation of the Community Living Assistance Service and Supports (CLASS) Act – a the long-term care program included in last year's health care overhaul – after determining they cannot find a way to make it fiscally sound and still meet the law's requirements.

The late Senator Edward M. Kennedy (D-MA) pushed for the program to help bridge the coverage gap for long-term care between Medicaid and more expensive private plans. And the program came with a benefit: The Congressional Budget Office scored it as saving $70.2 billion over 10 years because the program would collect premiums for five years before paying for the long-term care.

However, implementation of the Act has been difficult. The Department of Health and Human Services (HHS) Secretary Kathleen Sebelius said after 19 months of work, her

department was unable to find a way to structure a voluntary, self-financing, long-term care program that would be sustainable over 75 years, as the law requires.

HHS Assistant Secretary for Aging Kathy Greenlee reported the health care law will still reduce the deficit by $127 billion between 2012 and 2021, even if, as expected, President Obama strikes the CLASS Act from his 2013 budget proposal, thus losing the program's scored savings.

Administration officials emphasized that some kind of long-term care solution still needs to be created.

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NEXT WEEK IN WASHINGTON

SENATE COMMITTEE ON INDIAN AFFAIRS OVERSIGHT FIELD HEARING ON, "H.O.P.E. FOR THE FUTURE: HELPING OUR PEOPLE ENGAGE TO PROTECT OUR YOUTH"
DATE: OCTOBER 22ND
TIME: 1:00 PM
LOCATION: DENA'INA CIVIC & CONVENTION CENTER
600 W. SEVENTH AVENUE
ANCHORAGE, AK 99501

HOUSE COMMITTEE ON ENERGY AND COMMERCE HEARING ON, "CLASS CANCELLED: AN UNSUSTAINABLE PROGRAM AND ITS CONSEQUENCES FOR THE NATION'S DEFICIT"
DATE: OCTOBER 26TH
TIME: 9:00 AM
LOCATION: 2123 RAYBURN HOUSE OFFICE BUILDING

JOINT SELECT COMMITTEE ON DEFICIT REDUCTION (SUPER COMMITTEE) HEARING ON "OVERVIEW: DISCRETIONARY OUTLAYS, SECURITY AND NON-SECURITY"
DATE: OCTOBER 26TH
TIME: 10:00 A.M.
LOCATION: 216 HART SENATE OFFICE BUILDING.
WITNESS: DR. DOUG ELMENDORF, DIRECTOR, CONGRESSIONAL BUDGET OFFICE.