DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

March 8, 2011

The Honorable Max Baucus
Chairman
Senate Finance Committee
Washington, DC 20510

Dear Mr. Chairman:

In a recent letter, you asked specifically how Medicare and Medicaid would be affected if the House-passed version of H.R. 1 were enacted. Sections 4016 and 4018 of H.R. 1 would preclude use of Continuing Resolution (CR) funds for implementing or carrying out provisions of the Affordable Care Act.

The Affordable Care Act modifies and improves almost every Medicare payment system – including the inpatient hospital prospective payment system, the outpatient hospital prospective payment system, the physician fee schedule, Medicare Advantage plan payments, and prescription drug plan payments. If H.R.1 were enacted, the Centers for Medicare & Medicaid Services (CMS) would not be able to use CR funds to administer payments based on any rate calculated on the basis of the provisions of the Affordable Care Act – which is to say virtually all rates.

Where the Affordable Care Act effectively repealed prior payment methodologies and replaced them with new ones, H.R. 1 would seem to preclude any payments for the items or services at issue. For example, the Affordable Care Act replaced the old statutory provisions governing payments to Medicare Advantage (MA) organizations with new provisions, including a freeze in payment levels in 2011. Using CR funds to make payments to MA organizations under the new Affordable Care Act provisions would be prohibited by H.R. 1. Moreover, there would not appear to be legal authority to pay MA organizations under the prior payment methodology, given that this methodology was repealed in the Affordable Care Act. This would seem to mean that payments to MA organizations would have to be suspended, risking a significant disruption in services to beneficiaries enrolled in Medicare Advantage.

In the event that any prior payment methodologies that have not been fully repealed by the Affordable Care Act could be decoupled from all of the additions to the Medicare statute made by the Affordable Care Act, CMS would have to perform extensive analyses to determine whether it could permissibly make payments of some sort. But, even if CMS could do so, it would be required to undertake rulemaking to establish new rates under each payment system, as the existing rates are all in some way dependent on Affordable Care Act authorities. The

promulgation of each new rule could take several months to complete. While the new rates were implemented, CMS would be prohibited from paying providers and suppliers at the Affordable Care Act rates.

In a system where millions of claims are paid each week, millions of claims would accumulate, which CMS and its contractors would be prohibited from paying at the Affordable Care Act rates. At the point at which claims could begin to be paid at the new rates, it would take many months and significant resources to process the backlog – resources that H.R. 1 would not provide. As a result, providers and suppliers, many of which are small businesses – and, ultimately, beneficiaries – would experience significant disruption.

In addition to changes in Medicare payment methodologies, beginning this year, the Affordable Care Act authorizes Medicare to cover annual "wellness visits" for beneficiaries and waives coinsurance and deductibles for critical preventive services. Claims could no longer be paid for any of these benefits using CR funds, as payments for these benefits are authorized only by the Affordable Care Act.

Many of the provisions in the Affordable Care Act are aimed at slowing the growth rate of spending increases and improving health care for beneficiaries through innovative health service delivery reforms and value-based purchasing. None of these reforms – such as hospital value-based purchasing; payment incentives for reductions of hospital-acquired conditions; and the care transitions program for high-risk Medicare beneficiaries – could be implemented using CR funds.

H.R. 1 would adversely affect health care in rural areas as well. As an example, as a means to encourage physicians to provide services in rural areas, the Affordable Care Act established a new 10 percent bonus payment for primary care services furnished by primary care practitioners and for major surgical procedures furnished by general surgeons in shortage areas. Without available CR funding, CMS would no longer be able to provide the bonus to primary care and general surgery physicians for eligible services.

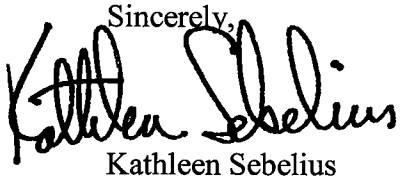
The Affordable Care Act also gives CMS new tools to fight fraud and helps us move from a pay-and-chase system to a comprehensive prevention-focused strategy. By precluding the use of CR funds for such efforts, H.R. 1 would substantially impede CMS's proven and successful efforts to reduce fraud and waste in the health care system, resulting in increased erroneous payments. H.R. 1 would effectively require CMS to cease enforcing new screening and enrollment standards, diminish CMS's ability to suspend payments when credible allegations of fraud are uncovered, and reduce resources that have been made available for investments in anti-fraud work.

The Affordable Care Act also provided States with a number of opportunities to compete for federal grants and expand eligibility and services for Medicaid beneficiaries at little or no cost to States. Among these are: funding for States to provide incentives to prevent chronic diseases in Medicaid beneficiaries, increased federal funding to provide preventive services for eligible adults in Medicaid, and enhanced funding to assist in providing health homes to Medicaid beneficiaries. Under H.R. 1, CR funds could not be used in furtherance of any of these provisions.

The Affordable Care Act also includes numerous other policies to make health care more affordable, accessible, and accountable for seniors, individuals with disabilities, children, and all other Americans, as well as businesses large and small. Its improvements are already woven into the fabric of our health care system. A broad prohibition on the use of CR funds would work to seriously impair or even halt the operation of the Early Retiree Reinsurance Program; the Pre-existing Condition Insurance Plan; and the health insurance rate review, consumer assistance, and Exchange grant programs.

I hope this information is helpful. We would be happy to answer any additional questions.

Sincerely,



Kathleen Sebelius