CMS Medicaid Regulations Thwarted in the House of Representatives

Medicaid and the State Children’s Health Insurance Program (SCHIP) form a critical health care safety net for approximately 67 million beneficiaries in the United States. These programs, along with Medicare, are administered by the Centers for Medicare and Medicaid Services (CMS). Together, these public health insurance programs comprise the financial foundation of the U.S. health care infrastructure through their support of hospitals, dentists and physicians, community health centers, and nursing homes.

Over the past year CMS has issued seven regulations and a guidance that would eliminate or significantly reduce Medicaid spending and would change longstanding Medicaid policy through regulation without the direction or authorization of the U.S. Congress. Governors overwhelmingly oppose the regulations, which they claim would cost states $50 billion over five years.

Dental educators and researchers participating in AADR/ADEA Advocacy Day took a message to Capitol Hill on April 23 urging their delegations to pass legislation (H.R. 5613 and S. 2819) that would impose a one-year moratorium on the regulations.

- The Protecting the Medicaid Safety Net Act (H.R. 5613) was introduced on March 13, 2008, by Energy and Commerce Committee Chairman John Dingell (D-MI) and Representative Tim Murphy (R-PA). The legislation would suspend the new CMS proposed regulations until April 1, 2009.

- The Economic Recovery in Health Care Act (S. 2819) was introduced on April 3, 2008, by Senators John Rockefeller (D-WV), Olympia Snowe (R-ME), and Edward Kennedy (D-MA). The legislation includes a similar one-year moratorium as well as a moratorium on a CMS SCHIP directive issued in August 2007 that limits the ability of states to expand coverage to children in families above 250 percent of the federal poverty level (FPL). The bill also includes $12 billion in targeted Medicaid fiscal relief to states.

On April 23, the House passed H.R. 5613 by an overwhelming bipartisan margin, 349-62, to delay implementation of the regulations. The margin was well over the two thirds majority needed to pass the bill and sufficient to overturn the President’s threatened veto.

The issue now moves to the Senate, where Senate Minority Leader Mitch McConnell (R-KY), Minority Whip Jon Kyl (R-AZ), and Senate Finance Committee ranking member Charles Grassley (R-IA) oppose the legislation. Conservative Republicans are circulating a letter to their colleagues asking them to reject the moratorium on the regulations and to instead focus on making changes to improve the legislation. They hope to gain enough support to sustain a Presidential veto.

But Now Comes a Proposed Compromise

In the face of a Congressional veto-proof rebuttal of the CMS regulations, the Bush Administration is floating a compromise in which there would be a short-term moratorium on two rules of the seven while the remaining five would go into effect on May 25. The offer from HHS Secretary Michael Leavitt would stay rules on intergovernmental transfers to public hospitals and Medicaid graduate medical education (GME) funding for a few months while negotiating a long-term solution with Members of Congress. “We would defer the implementation until August, and if we’re not able to do that, it would be deferred until March,” Secretary Leavitt said publicly. Leavitt reiterated the Administration’s intention to veto the bill absent a deal.
Of the two regulations that the White House is willing to negotiate, the rule limiting intergovernmental transfers to public hospitals (that is, states transferring money to public hospitals in order to draw more matching federal funds) has generated more controversy because, according to states, it would threaten public hospitals’ federal payments for treating low-income patients. The Medicaid GME rule would disallow states from using Medicaid funds to pay for the costs of medical interns and residents, which would threaten teaching hospitals.

Deborah Darcy Joins ADEA Advocacy Team

This week Deborah Darcy, M.A., joined the ADEA Center for Public Policy and Advocacy as Director of Congressional Affairs. Ms. Darcy has extensive experience on Capitol Hill, having worked for several members of the House of Representatives. As his legislative assistant, Ms. Darcy advised Representative Steve Israel (D-NY), a member of the powerful House Appropriations Committee and Co-Chair of the House Cancer Caucus, on all issues related to health care. She also served as legislative assistant to Congressmen Mike Doyle (D-PA) and Steve Rothman (D-NJ), who were members of the House Energy and Commerce Committee and the House Appropriations Committee respectively. Prior to joining the ADEA CPPA staff, Ms. Darcy was Director of Grassroots Advocacy for the 130,000 member American Speech-Language-Hearing Association, where she advocated on health care and education issues and managed the association’s grassroots program.

Deborah earned a master’s degree in public policy from the George Washington University, Washington, DC, in 1999. She will join Ms. Myla Moss in ADEA's continuing efforts to educate Members of Congress and Congressional staff about the legislative priorities of academic dental institutions and advanced and allied dental education programs and to raise awareness on Capitol Hill that oral health is essential to general health and well being.

ADEA Endorses Veterans’ Access to Oral Health Care Proposal

On April 17, 2008, ADEA President Charles N. Bertolami, D.D.S., D.Med.Sc., and ADEA Executive Director Richard W. Valachovic, D.M.D., M.P.H., wrote to Representative Christopher Carney (D-PA) endorsing his bill “Make Our Veterans Smile Act” (H.R. 5595) that would increase America’s veterans’ access to much needed dental care through the Department of Veterans Affairs (VA).

“Dental care should be part of the uniform benefits package that should available for all of America’s veterans,” Drs. Bertolami and Valachovic wrote. “Service men and women who have served our country are entitled to a full continuum of health care. ADEA believes that the VA should be the dental home for all of America’s veterans.”

Poor oral health and the need for dental care is a leading cause of preventing service men and women from being ready for deployment. The VA currently covers dental care for approximately 360,000 veterans; however, an additional 1,075,000 veterans would be eligible if Congress passes H.R. 5595.

AADR/ADEA Advocacy Day on Capitol Hill

As mentioned above, dental educators and researchers were in Washington participating in AADR/ADEA Advocacy Day two weeks ago, attending a Legislative Workshop and delivering three important advocacy messages to their elected officials:

1. Extend the moratorium on the CMS Medicaid regulations by passing H.R. 5613/S. 2819
2. Reverse the erosion of dental and biomedical research by increasing funding for the National Institute of Dental and Craniofacial Research to $438 million for fiscal year 2009
3. Co-sponsor and pass the Deamonte Driver Dental Care Access Improvement Act of 2008 (H.R. 5549/S. 2723)
Over 60 AADR and ADEA members, in addition to several advocates from the Friends of the National Institute of Dental and Craniofacial Research (FNIDCR), participated in the two-day event.

**Military Dentistry Profiled on Hill**
The House Armed Services Oversight and Investigations Subcommittee recently held a hearing about the challenges associated with achieving full dental readiness in the National Guard and Reserve.

Subcommittee Chairman **Vic Snyder** (D-AR) stated that oral health is an often overlooked but extremely important aspect of overall pre-deployment readiness. He further stated that increasing emphasis on oral health will reduce pressure on units in the months before deployment.

According to the U.S. Department of Defense, 95 percent of military personnel, active and reserve, should fall into the Class 1 or 2 dental fitness categories, meaning that they are healthy enough to deploy. Right now, none of the Uniformed Services meet this goal for the reserve component; however, the Army and Marine Corps struggle the most. Only 43.2 percent of the Army National Guard, 50.6 percent of the Army Reserve, and 77.7 percent of the Marine Corps Reserve are currently ready to deploy.

To watch the video webcast and to read the witness testimony, visit the House Armed Services website at: [http://armedservices.house.gov/hearing_information.shtml](http://armedservices.house.gov/hearing_information.shtml).

**Former Senate Majority Leaders Tackling Healthcare Reform**
Four former Senate majority leaders are teaming up to develop recommendations for Congress on reforming the nation's health care system: Senators **Howard Baker** (R-TN), **Tom Daschle** (D-SD), **Robert Dole** (R-KS), and **George Mitchell** (D-ME). The Senators will each oversee forums on four pillars for reform: 1) improving quality and value, 2) improving access, 3) ensuring a strong role for consumers, and 4) finding a way to finance. The group will wait until after the presidential election to make its recommendations.

**Health Care Reform Veterans Recount Lessons Learned**
*Lessons Learned: The Health Reform Debate of 1993–1994*, an issue brief written by Bob Rosenblatt for the Alliance for Health Reform, provides a glimpse of the behind-the-scenes meetings of 1993 and 1994 that produced a wealth of knowledge on what should be done differently the next time Congress and the White House take up this issue. The issue brief recounts nine lessons learned as recalled by veterans from both sides of the aisle and from the administration.

The lessons:
- **Strike while the iron is hot**—in the first year after an election. That's when attention is focused on the message voters sent, and before lawmakers have to worry about the next election.
- **Go for the easiest procedural path.** Putting your ideas into a budget reconciliation bill means avoiding the chance of a Senate filibuster.
- **Involve Congress from the very beginning.** If you expect legislators to vote for your bill, they need to be involved in shaping it.
- **Raising taxes is tough, but NOT raising taxes can also carry a price.** In an attempt to redirect existing dollars rather than raise taxes, the administration's health plan of 1993-94 was more than a thousand pages long.
• **Don’t try to put everything into one bill.** The Massachusetts health reform experience proves that you can leave some details for later.

• **Be willing to deal.** Health reform could possibly have passed in 1994 if proponents had been more willing to compromise.

• **Expect pushback.** Major health reform means change, and many people resist change, especially if their own income stream is threatened.

• **If you’re from Venus, listen to the people from Mars.** Meaningful health reform is not just about covering the uninsured, nor is it just about reining in costs. It’s about both.

• **It won’t happen if it's not a priority.** For major reform to have a chance, many leaders must put it near the top—or at the top—of their priority lists.


**ADEA Annual Session Address on Health Care Reform**

**Henry E. Simmons, M.D., M.P.H., F.A.C.P., President of the National Coalition on Health Care,** defined the daunting challenges facing U.S. policymakers in his presentation at the 2008 ADEA Annual Session in Dallas in March in the following manner:

“There are three massive problems in American health care: 1) rapidly escalating costs; 2) a huge and growing number of American without any health coverage; and 3) an epidemic of substandard and dangerous care.”

To review Dr. Simmons’ address in the context of what solutions are being offered by the three Presidential candidates, go to [www.adea.org/CPPA_Materials/Presentation/SimmonsSpeech.pdf](www.adea.org/CPPA_Materials/Presentation/SimmonsSpeech.pdf).

**Crisis in the U. S. Health Care System: Presidential Candidates Respond**

All three Presidential candidates have now fleshed out their solutions to the crisis in the U.S. health care system. Last week, Senator **John McCain** (R-AZ) announced a market-based solution that bears a striking resemblance to a proposal put forth by President Bush last year.

The presumptive GOP nominee’s reliance on the power of the economic marketplace starkly contrasts with proposals offered by Senators **Hillary Clinton** and **Barack Obama,** who rely more on government involvement than the free market to address the challenge confronting the American health care system: expanding access, controlling costs, and improving quality.

Democrats Clinton and Obama favor mandates for coverage and new regulations on insurers, whereas Candidate McCain proposes tax incentives and less direct regulation. As reported in the April 30, 2008, edition of the *Washington Post,* the Arizona Senator dismissed his rivals’ proposals for universal health care as riddled with “inefficiency, irrationality and uncontrolled costs.” He said that the 47 million uninsured Americans would get coverage only when they are freed from the shackles of the current employer-dominated system.

McCain’s plan is similar to one that President Bush offered that would have replaced employer tax breaks for health insurance with a $15,000 tax deduction for married couples. “Clinton and Obama would put the government in charge of the choices you have to make,” a McCain spokeswoman said. “John McCain’s plan,” she asserted, “puts the choice, the power, the decision in the hands of the individual and family.”
The following chart compares key provisions of the candidates' health care proposals:

<table>
<thead>
<tr>
<th>Plan to expand coverage</th>
<th>Senator John McCain</th>
<th>Senator Hillary Clinton</th>
<th>Senator Barack Obama</th>
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<tbody>
<tr>
<td><strong>Requirement to have coverage</strong></td>
<td>No provision. Opposes mandates for coverage.</td>
<td>Individuals must have health insurance coverage. Large employers must provide an employee plan or contribute to the cost. Most small employers are not required but are provided incentives to do so.</td>
<td>Requires all children to have health insurance. Requires employers to offer &quot;meaningful&quot; coverage or contribute a percentage of payroll toward the costs of a public plan.</td>
</tr>
<tr>
<td><strong>Premium subsidies to individuals</strong></td>
<td>Removes the favorable tax treatment of employer-sponsored insurance and provides a tax credit to all individuals and families to increase incentives for coverage; promotes competition; and contains costs through payment changes to providers and changes in laws.</td>
<td>Income-related tax subsidies will be made available. Private and public plan options available to individuals through a new federal Health Choices Menu. Coverage through employers and programs such as Medicare continues.</td>
<td>Creates a new public plan and expands Medicaid and SCHIP. Creates the National Health Insurance Exchange, through which small businesses and individuals without access to other public programs or employer coverage could enroll in new plans.</td>
</tr>
</tbody>
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**Student Loans and the Higher Education Act Reauthorization**

It is anticipated that Congress will not complete its work on the reauthorization of the Higher Education Act (HEA) and will therefore need to give itself another extension. Members have been informally negotiating the House and Senate higher education bills (H.R. 4137 and S. 1642) since the House passed its measure on February 7 by 354-58. The Senate passed its version on July 24, 2007, by 95-0. There are hundreds of differences between the two bills that are presently being worked out by negotiators from each chamber. The current short-term extension expires at the end of this month. The HEA law sets policy and authorizes funding for colleges, universities, and federal student aid. The underlying law (P.L. 105-244) has not been fully rewritten in 10 years, although pieces of it have been revised.
ADEA has closely followed the developments in the $85 billion student loan market. There has been growing concern about loan availability this summer, when students apply for student aid before the fall term.

House Education Committee Chairman George Miller (D-CA) sponsored the Ensuring Continued Access to Student Loans Act of 2008 (H.R. 5715) while Senator Edward Kennedy (D-MA), chairman of the Health Education Labor Pensions Committee, introduced similar legislation, the Strengthening Student Aid for All Act (S. 2815). The bills would help eliminate the possibility of disruptions in federal student loans this coming academic year. While H.R. 5715 has passed in the House, the Senate has not yet voted on S. 2815.

H.R. 5715 increases the following loan amounts effective July 1, 2008:

- Adjusts the maximum aggregate loan limits for graduate students to reflect the increased annual loan limits
- Increases the annual unsubsidized Stafford base amounts by $2,000 for graduate, independent, and dependent students
- Increases aggregate loan amounts for undergraduate dependent students from $23,000 to $31,000
- Increases aggregate loan amounts for undergraduate independent students from $46,000 to $57,500

ADEA will keep its members posted on further developments in the ADEA Washington Update.

Comment Period on Proposed MUP/HPSA Rule Extended Until May 29
The Health Resources and Services Administration (HRSA) extended to May 29, 2008, the deadline for comment on the proposed rule “Designation of Medically Underserved Populations and Health Professional Shortage Areas,” which was published in the Federal Register on February 29, 2008.

Although no changes to the criteria for designating dental and mental health Health Professions Shortage Areas (HPSAs) are proposed at this time, it should be noted that a draft report on a proposed approach or methodology for the designation of Dental HPSAs has been held for clearance at the U.S. Department of Health and Human Services since 2006. On page 11251 of the proposed rules, it states that “the proposed procedures in Subpart A would apply to the designation of dental and mental health HPSAs as well. The criteria currently in use for these types of HPSA designations are contained in Appendices B and C of the current part 5. No changes to these appendices are proposed at this time, but efforts are under way to revise the criteria for dental shortage areas (pursuant to Section 302(d)(1) of the Health Care Safety Net Amendments of 2002) and those for mental health professional shortage areas. When these efforts are complete, Appendices B and C will be revised.”

The proposed rule includes three methods for making funding eligibility designations: Tier 1, Tier 2, and Safety Net Facility. The proposed rule is intended to improve the way underserved areas are designated by:

- Simplifying and consolidating two processes of determining underserved areas into one
- Improving the identification of areas of need
- Reducing the data reporting burden for obtaining designations

You may submit comments by U.S. Postal Service; send one original and two copies to Ms. Andy Jordan, HHS-HRSA, 8C-26 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Please allow sufficient time for mailed comments to be received before the close of the comment period. For additional information, visit http://bhpr.hrsa.gov/shortage.
Funding Opportunities Update

**www.GRANTS.gov**

You must use **www.GRANTS.gov** to apply for a federal grant. The registration process can take up to one month. Assistance is available from **www.Grants.gov** help desk at support@grants.gov or 800-518-4726. To successfully register, it is necessary to do all of the following:

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with Central Contractor Registry (CCR)
- Identify the organization's E-Business Point of Contact (POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

**Health Resources and Services Administration**

- **Grants to States to Support Oral Health Workforce Activities Program** HRSA-08-134 (CDFA 93.236). The application deadline for the fiscal year 2008 grant is May 1, 2008. The application is now available online at **www.GRANTS.gov**. While the average award is expected to be approximately $200,000, a total of $2.7 million is available for the one-year grant cycle. It is anticipated that grants will be awarded by September 1, 2008. States must use the grant to improve the accessibility of the oral health workforce for underserved geographic areas and populations. Grantees must contribute non-Federal funds to activities carried out under this grant to an amount equal to at least 40 percent of the federal funding support of the project. Matching funds may be a combination of in-kind contributions, fairly valued, and any other funding from State, local, community, or other organization sources. As a condition of the award, grantees must include in the narrative the amount and type of matching funds proposed for their project. Failure to do so will be considered nonresponsive to this grant announcement. HRSA contacts: General information: Jamie King, Division of Grants Management Operations, 301-443-1123, jamie.king@hrsa.hhs.gov. Technical assistance: Jerald Katzoff, Operations Research Analyst, Division of Medicine and Dentistry, BHPr-HRSA, 301-443-4443, jkatzoff@hrsa.gov.

**HIV/AIDS Bureau**

- **2007 HIV/AIDS Program Dental Reimbursement Program** (DRP) recipients were mailed the 2008 Dental Services Report (DSR) annual mailing on April 17, 2008. It was addressed to the Program Contact reported in item #4 of the 2007 DSR. The mailing includes the DSR form and instructions, the Database Utility, and supporting materials. Additional copies of the application and materials are available at [http://hab.hrsa.gov/tools.htm](http://hab.hrsa.gov/tools.htm). To download these materials, see **2008 Dental Services Report** in the ‘Grantee Reports’ section. The DSR submission must be received by **Monday, June 23, 2008**. If you do not receive the mailing by the end of April or if you have DSR-related questions, contact the Ryan White HIV/AIDS Program Data Support at RWdatasupport.wrma@csrinincorporated.com or 1-888-640-9356 from 9:00 a.m. to 5:30 p.m. Monday through Friday.

**National Institutes of Health**

- Midcareer Investigator Award in Patient-Oriented Research (K24) (PA-08-151), [http://grants.nih.gov/grants/guide/pa-files/PA-08-151.html](http://grants.nih.gov/grants/guide/pa-files/PA-08-151.html)
Upcoming Meetings and Conferences

- **June 23, 2008**, National Advisory Dental and Craniofacial Research Council, NIH Campus, Building 31, 6C10, Bethesda, MD. For the agenda, members, and other information, visit [www.nidcr.nih.gov/AboutNIDCR/CouncilAndCommittees/NADCRC/default.htm](http://www.nidcr.nih.gov/AboutNIDCR/CouncilAndCommittees/NADCRC/default.htm).


Resources, Recent Reports, and Items of Note

- **Examining a Major Policy Shift: New Federal Limits on Medicaid Coverage for Children** by the National Association of State Health Policy is available at [www.nashp.org/Files/shpbriefing_limitsoncoverage.pdf](http://www.nashp.org/Files/shpbriefing_limitsoncoverage.pdf). The paper provides an overview of the Center for Medicare and Medicaid Services’ (CMS) recent decisions that contradict long-standing Medicaid policy providing state flexibility to expand Medicaid for children; the policy consequences of CMS's decision in limiting a state's ability to expand coverage; and a review of language in the twice-vetoed Children's Health Insurance Program Reauthorization Act, which would grant states authority denied to them by the new CMS policies.

- **Dental therapists: a global perspective**, by David A. Nash, Jay W. Friedman, Thomas B. Kardos, Rosemary L. Kardos, Eli Schwarz, Julie Satur, Darren G. Berg, Jaafar Nasruddin, Elifuraha G. Mumghamba, Elizabeth S. Davenport, and Ron Nagel, *International Dental Journal* (2008) 58, 61-70. The paper profiles six countries that utilize dental therapists, with a description of the training they receive and the context in which they practice. It also updates the number of dental therapists practicing globally and the countries in which they practice. In several countries, dental therapy is being integrated with dental hygiene to create a new type of professional complementary to a dentist. The paper describes the status of a current initiative to introduce dental therapy to the United States. It concludes that dental therapists can become valued members of the dental team. Access the *International Dental Journal* at [www.fdiworldental.org](http://www.fdiworldental.org).

Quotable

“One must watch his allies, as well as his enemies.”

Prince Metternich (1773-1859)
Austrian Statesman