ADOLESCENT HEALTH NEWS

The National Alliance To Advance Adolescent Health

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HHS Set to Release Proposed Rule on State Benchmark Plans and Essential Health Benefits

CMS will soon be releasing a proposed rule for public comment on requirements pertaining to essential health benefits (EHB) and to state benchmarks that will serve as the standard for qualified health plans both in and outside of the state exchanges, as well as the plans offered as Medicaid benchmark coverage to older adolescents and young adults covered by Medicaid in families with incomes up to 138% of poverty. The proposed rule is currently under review by the Office of Management and Budget and will be released in the very near future, according to what Secretary Sebelius has told the governors.

Previously, CMS had provided guidance on EHBs to states in a 2011 EHB bulletin and in a subsequent document on frequently asked questions (FAQs). The agency had made clear that states could base their benchmarks one of the three largest small group insurance products, one of the three largest state health benefit plans, one of the three largest federal employee plans, or the largest commercial HMO plan. If coverage was not available in the chosen plan for each of the 10 mandatory benefit categories established under the ACA, states would need to supplement these packages by referencing another allowable benchmark plan. With respect to pediatric oral and vision care — which was interpreted to constitute the requirement for pediatric services — states were instructed to consider supplementing their benchmark product with the benefits provided in the federal employee dental and vision insurance program or in their separate CHIP programs. States were also directed to comply with mental health parity requirements. In addition, CMS clarified that states are required by the ACA to defray the costs of any state mandated benefits not part of the EHB, but that there would be a two-year transition period during which a state could adopt a benchmark plan subject to state mandates and have these benefits included. If, however, a state chose a benchmark not subject to these mandates, it would have to assume the cost of these covered services.

The proposed rule, which will likely include states' final benchmark plan sub-missions, will provide a period for comment. Although the submissions were due at the end of September, fewer than half of the states had submitted their bench-marks for approval at the end of October. These states have been in discussions with CMS in order to ensure that all 10 benefit categories are adequately covered and defined. To date, it appears, though, that most states are opting for small group products as their benchmark plans. In general, coverage in small group plans is less generous than in the other types of plans that states could have selected for their benchmarks.

In the same letter to the governors, it was noted that CMS will also be issuing a proposed rule for comment pertaining to the calculation of actuarial value and the provision of minimum value in employer-sponsored coverage. In addition, the communication stated that there will be an extension of the deadline for states to submit their exchange applications, leaving enough time for HHS to approve or conditionally approve state-based exchanges by the statutory deadline of January 1, 2013 for implementation the following year.

State Medicaid Expansions for Older Adolescents and Young Adults Could be Affected by Supreme Court Decision

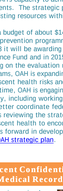
The Supreme Court, in its June 28, 2012 decision on the constitutionality of certain provisions of the Affordable Care Act (ACA), ruled that states cannot be required to expand Medicaid eligibility to uninsured adults ages 19 to 65 with incomes up to 138% of the federal poverty level or risk losing all federal matching funds for their Medicaid programs. As clarified in a July 10th letter from Secretary Sebelius to state governors, the Court's decision does not apply to the required Medicaid expansion for children ages 6 through 18. Beginning in 2014, all states must expand Medicaid eligibility to all children ages 6 through 18 with family incomes up to 138% of the federal poverty level, up from 100%. Secretary Sebelius' letter also clarified that the Court's decision does not affect the requirement that all children who were formerly in foster care can be covered by Medicaid up to age 26.

For all other older adolescents and young adults, Medicaid income eligibility, at least in some states, could remain at current levels, given that states are free to do so whether to cover uninsured adults. If all states do choose to adopt the coverage expansion, the Urban Institute has estimated that some 15.1 million uninsured adults would become eligible for Medicaid benchmark coverage, of which just over a quarter would be ages 19 through 24. Since the Supreme Court left the ACA language describing this group unchanged, it does not appear that states can cover some but not all of the uninsured adult population group. However, the Secretary has made clear that states are permitted to decide whether and when to cover this group and to decide to drop coverage after it is implemented. (The income eligibility level of 138% is equal to 133% of the federal poverty level plus a 5% income disregard, as provided in the ACA.)

Dissemination of Research Recommendations on Adolescent-Centered Primary Care

Following our successful research agenda conference on adolescent-centered primary care in April, The National Alliance has been actively promoting the conference recommendations among public and private funders. Throughout the summer and fall, we have met with agency and research directors from the National Institute for Child Health and Human Development, the Maternal and Child Health Bureau and the Bureau of Primary Health Care within the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Center for Medicare and Medicaid Services, and the Agency for Healthcare Research and Quality to discuss potential opportunities for incorporating these research recommendations into federal funding priorities. We also have met with senior staff at several private foundations that support medical home, integrated care, and health initiatives for children and adolescents. Meetings in collaboration with Grantmakers in Health and its behavioral health funders network and with the National Institute of Health Care Management and its affiliated Blue Cross Blue Shield foundations have been held as well in order to promote greater awareness of the conference objectives and encourage support for adolescent-centered primary care. These recommendations -- which address adolescent and parent engagement, clinical preventive services, and integrated physical, behavioral and sexual health care -- are expected to be published in the *Journal of Adolescent Health*.

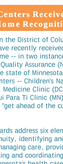
Office of Adolescent Health Releases New Strategic Plan



The HHS Office of Adolescent Health (OAH) recently released its first strategic plan to guide current and future federal directions in adolescent health and prepare for the development of a new national agenda for improving the health and well-being of adolescents. For fiscal years 2012-2015, OAH, under the leadership of its newly appointed director, Evelyn Kappeler, has identified five goals: 1) to lead national grant programs to prevent teen pregnancy and support pregnant and parenting teens and women; 2) to expand evidence of what works to reduce health risks among adolescents and to affect positive youth development; 3) to lead adolescent health policy, practice, and program development; 4) to promote, communicate, and disseminate accurate information on the full range of issues related to adolescent health; and 5) to increase OAH's capacity to achieve optimal performance and document accomplishments. The strategic plan emphasizes OAH's convener role leveraging existing resources within and outside of HHS.

In 2012, OAH administered a budget of about $140 million, the vast majority of which was for pregnancy prevention programming and evaluation. The OAH anticipates that in 2013 it will be awarding new competitive grants under the Pregnancy Assistance Fund and in 2015 under the Teen Pregnancy Prevention program. Drawing on the evaluation results from current teen pregnancy prevention programs, OAH is expanding the evidence base on what works to reduce adolescent health risks and promote positive youth development. At the same time, OAH is engaging other HHS agencies in making adolescents a priority, including working in HHS Region X on the Second Decade Project to coordinate federal services and funding for adolescents. Further, OAH is reviewing the strategic plans of other HHS agencies pertinent to adolescent health to encourage collaboration and avoid duplication as it moves forward in developing a national agenda for adolescents. Read the full OAH strategic plan.

Protecting Adolescent Confidentiality in Electronic Medical Records



Addressing adolescent privacy issues in electronic medical records (EMR) has become an increasing, but largely unaddressed, challenge for most health care systems. Confidentiality issues arise for this population when the adolescent makes an appointment and provides a reason for the visit and when the provider summarizes his or her health behaviors and problem lists, shares lab results, prescribes medicines, and sends home bills. In the November issue of the *Journal of Adolescent Health*, Stanford's Dr. Anashivaran and colleagues developed a set of suggestions for EMR vendors to protect adolescent confidentiality.

The recommendations include default privacy settings in order to designate adolescents' lab results, diagnoses, medications, and problem lists as "sensitive" or "confidential." These default settings should be customized to allow clinicians to designate certain health information as sensitive or not and also to provide adolescent patients with some control over what private health information they want to share and with whom. They also suggest clear on-screening labeling of confidential data elements and adolescent privacy decision support. In addition, they recommend upgrading capabilities for after-visit summaries, bills, and post-visit surveys along with the development of adolescent privacy standards for information exchanges, e-prescribing, and billing.

Adolescent Health Centers Receive NCQA State Medical Home Recognition

Adolescent health centers in the District of Columbia, New York, and Minnesota have recently received formal recognition as a medical home -- in two instances from the National Committee on Quality Assurance (NCQA) and in one instance from the state of Minnesota. According to the medical directors from the three centers -- Children's National Medical Center's Adolescent and Young Adult Medicine Clinic (DC), Mount Sinai's Adolescent Health Center (NY), and Aqui Para Ti Clinic (MN) -- the main reason for seeking certification was to "get ahead of the curve" with payers in order to ensure sustainability.

NCQA's medical home standards address six elements of primary care -- enhancing access and continuity, identifying and managing patient populations, planning and managing care, providing self-care and community resources, tracking and coordinating care, and measuring and improving performance. Minnesota's health care home standards focus on a similar set of elements.

Each adolescent health center decided which elements and specific health issues it would focus on. For example, to enhance access and continuity, Children's National Adolescent Health Center created a centralized call center staffed by two nurses to schedule appointments and refill prescriptions; Mount Sinai's Adolescent Health Center instituted a texting platform to increase teen show rates; and Aqui Para Ti expanded access to on-call adolescent-trained physicians starting at 9 pm. To plan and manage care for specific conditions, Children's elected to focus on preventive care visits for adolescents ages 15-17 and chronic care management of teens with obesity and asthma; Mount Sinai chose prevention of STIs, HIV, and pregnancy; and Aqui Para Ti selected healthy sexuality and mental health care for adolescents and their parents.

Despite the level of effort required, many benefits have come as a result of NCQA and state medical home certification. Adolescent health centers are devoting more attention to outreach, population management, and follow-up. Pediatric colleagues are gaining a greater understanding of adolescent confidentiality and privacy issues. Brand-name recognition is enhanced. Finally, in two of the three centers, new payment opportunities, including incentive payments for meaningful use of EMRs, are available. For more information about applying for NCQA medical home certification, please visit www.ncqa.org.

Adolescent Preventive Care Screening Tool Available with New Online Reporting Options

The Rapid Assessment for Adolescent Preventive Services (RAAPS), a 21-question health risk assessment tool for adolescents ages 11-20, is now available online with extensive web-based applications. Originally developed in 2006 at the University of Michigan, RAAPS has been enhanced so that it can be completed in clinical and other settings by adolescents in 5-7 minutes using any device with internet access, including mobile devices. To address low reading levels and English as second language, text and audio multilingual options are available to help teens answer the questions.

Survey results can be kept confidential and stored in a secure cloud-based server with no storage space required. Clinicians can electronically document the counseling they provide and receive individual and aggregated reports on their patient population by specific risk factors and demographic characteristics. They can also monitor changes over time and compare their patient results to a "benchmark" population of over 20,000 adolescents. It is also possible for clinicians to track and send referrals securely from RAAPS within their provider networks and to select and evaluate risk reduction strategies for adolescents more effectively. In addition, after completing the survey, teens can be sent specific online health messages and resources pertinent to their risk behaviors. These messages also can be used by clinicians when discussing survey responses with their adolescent patients. For more information about RAAPS, see www.raaps.org

Featured Model Teen Program: Walter Reed Medical Center's Adolescent Medicine Service

This month's featured model teen program is the Adolescent Medicine Service at Walter Reed National Military Medical Center in Washington, DC, the first military site in the country to establish an adolescent primary care program. This clinic focuses on comprehensive health maintenance by routinely emphasizing psychological issues -- such as risk-taking, substance use, and unhealthy eating -- and serves approximately 2,000 adolescent and young adults in military families and currently in the military. Opened in 2001, Walter Reed's clinic has an interdisciplinary staff of several adolescent medicine specialists, two part-time pediatricians, a nurse practitioner, and a social worker with an RN and two LPNs providing health education services to adolescents and their families. Two special features of the clinic are a confidential secure messaging system, called "Relay Health," which allows adolescents to communicate with their providers confidentially, and a one-way texting system for alerts and health education messages to adolescent patients. Learn more about the Featured Model Teen Program on our website.