

NHeLP's Capital Communique

August 2011

This issue is part of a series of periodic reports from the National Health Law Program's Washington office, reporting briefly on recent and forthcoming developments in federal policy of interest to NHeLP advocates and friends.

We always appreciate your feedback and comments. Please send them to Deborah Reid at reid@healthlaw.org

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Debt Ceiling

On August 2, President Obama signed the Budget Control Act into law to raise the debt ceiling and address the federal deficit. The House passed the Act on August 1 by a vote of 269-161. The Senate passed the Act on August 2 by a vote of 74-26. The Act includes significant spending cuts but no certain revenue increases, despite widespread public support for a balanced approach to addressing the federal deficit. It also guarantees debt ceiling increases past the 2012 elections.

The Act includes two stages - immediate cuts to discretionary spending and then a longer-term plan to identify additional deficit reductions. In the first stage, Medicaid and other entitlement programs would not be impacted by cuts. However, other health and social services programs assisting low-income and underserved populations - which are funded through the yearly appropriations process - will see drastic cuts. The first stage does not include any tax revenues but does include defense spending cuts.

The second stage of the Act creates a 12-person bipartisan Joint Select Committee on Deficit Reduction (with an equal number of Democrats and Republicans from the House and Senate) that is charged with identifying \$1.5 trillion in future deficit reduction. In this stage, Medicaid and other entitlement programs could be cut, and tax revenues could also be included. In addition to the possibility of Medicaid cuts, the Committee could also recommend restriction or repeal of Medicaid-related provisions in the ACA. If the Committee does not come up with at least \$1.2 trillion in deficit reductions or Congress fails to act on the Committee's recommendations, it would trigger \$1.2 trillion in automatic cuts to defense and non-defense discretionary spending, but Medicaid and other entitlements are exempt from these automatic cuts.

IOM Recommends Additional Preventive Services for Women's Health

On July 20th, the Institute of Medicine (IOM) released their report, Clinical Services for Women: Closing the Gaps, that details recommendations for eight additional preventive services to improve women's health and well-being. IOM recommends adding these preventive services to the services that health plans must cover at no cost under the Patient Protection and Affordable Care Act (ACA).

The IOM reviewed existing guidelines and used evidence-based approaches to determine the effectiveness of various preventive approaches. The suggested additional services are:

- screening for gestational diabetes;
- human papillomavirus (HPV) testing as part of cervical cancer screening for women over 30;
- counseling on sexually transmitted infections;
- counseling and screening for HIV;
- contraceptive methods and counseling to prevent unintended pregnancies;
- lactation counseling and equipment to promote breast-feeding;
- screening and counseling to detect and prevent interpersonal and domestic violence; and
- yearly well-woman preventive care visits to obtain recommended preventive services.

For the complete IOM report, [click here](#) .

HHS Updates

Proposed Rule: ACA Establishment of Exchanges and Qualified Health Plans - Comments Due by September 28th

On July 15th, HHS published a proposed rule to implement the ACA's Health Insurance Exchanges. Beginning in January 2014, individuals and small businesses will be able to choose and purchase health insurance through a competitive Exchange marketplace. The proposed rule explains the federal requirements that states must satisfy if they plan to establish and operate an Exchange; describes the minimum requirements that health insurers must meet to participate in an Exchange and offer qualified health plans (QHPs); and recommends general standards that employers must satisfy to participate in the Small Business Health Options Program (SHOP).

Some of the features of the proposed rule include requiring that Exchanges:

- be either a governmental agency or a state established non-profit entity;
- be capable of beginning operation by October 1, 2013 for the first open enrollment period;
- conduct outreach activities to educate consumers about the Exchange to encourage participation and implement a Navigator Program (that also offers consumers information on eligibility and enrollment);
- have a process for establishing and evaluating the service areas for QHPs;
- establish an appeals process for eligibility determinations; and
- do not discriminate based on race, color, national origin, disability, age, sex, gender identity and sexual orientation.

HHS must receive comments on the proposed rule by September 28. For the Federal Register notice, [click here](#).

HRSA Investment in School Based Health Centers

On July 14th, HHS Secretary Kathleen Sebelius announced the award of \$95 million to 278 school-based health center programs that serve an estimated 790,000 students. The ACA provided funding for this program, administered through the Health Resources and Services Administration (HRSA). School-based health centers improve the health of children through health promotion, disease prevention activities, health screenings, and assist children with chronic health issues to attend school. The additional funding will help school-based health centers provide care to an additional 440,000 students.

For more details on HRSA's school-based health center capital program, [click here](#).

Initiatives to Improve Care for Dual-Eligibles

On July 8th, HHS Secretary Sebelius announced three new initiatives to assist states in improving care to individuals who are eligible for both Medicare and Medicaid (dual eligibles). The CMS Center for Medicare and Medicaid Innovation (Innovation Center) will test these models to determine their effectiveness in improving quality and saving costs.

The first initiative, "Testing Financial Models to Better Coordinate Care" is a model that allows states, CMS, and health care plans to enter into an agreement to allow a managed care plan to receive a prospective blended payment rate to provide coordinated and comprehensive care. States and CMS can also enter agreements so that the states would be eligible for benefits from savings coming from managed fee-for-service initiatives created to improve quality and reduce costs for Medicaid and Medicare. In a managed fee-for-service model, states that invest in care coordination between Medicaid and Medicare could be eligible to receive a retrospective performance payment if they achieve a specified level of savings. The CMS Office of the Actuary would evaluate each state's savings determinations from Medicare and Medicare spending.

The second initiative, "Improving Care Quality for Nursing Facility Residents," is designed to reduce preventable inpatient hospitalizations among residents of nursing facilities. Almost two-thirds of nursing facility residents are Medicaid enrollees, and most are also enrolled in Medicare. The initiative allows CMS to competitively select and partner with independent organizations to implement evidence-based interventions at nursing facilities, including implementing best practices to prevent falls, pressure ulcers, and other events that lead to poor health outcomes.

Lastly, under the "Technical Assistance Resource Center Available to States" initiative, HHS plans to create a resource center to assist states in providing coordinated health care to high-need, and high-cost enrollees, such as individuals with chronic health conditions and/or dual-eligibles. The resource center will provide technical assistance to states to improve quality and reduce costs.

For fact-sheets on each of the three initiatives, [click here](#) . Other information relating to these initiatives can be found in the July 8th CMS Dear State Medicaid Director (DSMD) letter, "Financial Models to Support Efforts to Integrate Care for Medicare-Medicaid Enrollees." For the DMD letter, [click here](#) .

Resources

NHeLP, Issue Brief: "Non Profit Hospitals and Community Benefit."The Issue Brief includes a brief overview of nonprofit hospitals and a description of the requirements hospitals must meet to obtain the benefits that flow from nonprofit status. It also discusses problems that have been identified with the current regime and recent legislative and regulatory changes that have been

introduced to address them. Lastly, the Issue Brief suggests opportunities for advocates to use these new tools to advance the health rights of low-income uninsured and under-insured patients. For the Issue Brief, [click here](#).

NHeLP, Short Paper: "The ACA and Health Disparities." This Short Paper examines provisions of the ACA that address health disparities for particular communities (such as data collection, prevention of chronic illnesses, workforce development and quality improvements). The short paper also identifies those areas where further development is needed to address disparities. For the Short Paper, [click here](#).

NHeLP's updated Advocates Guide to the Medicaid Program is available in hard copy and online subscription. The Guide incorporates provisions from the ACA, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and the Deficit Reduction Act of 2005 (DRA). Other new features include live updates, and user forums. [Click here](#) to order the Guide.