



March 28, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: NAMD Response to CMS Pediatric Request for Information

Dear Ms. Verma:

On behalf of the nation's Medicaid Directors, thank you for the opportunity to comment on the request for information on pediatric alternative payment model (APM) concepts. Our comments focus on areas where CMS could partner with states to most effectively support Medicaid innovations for children.

The National Association of Medicaid Directors is a bi-partisan, non-profit association representing the administrators of the Medicaid program in all 50 states, the District of Columbia and the territories. Medicaid is the largest health care safety net program and is responsible for the health care of 73 million Americans, including nearly half of all births and 2 in 5 children nationally who are served by Medicaid and CHIP. Medicaid has led the way in implementing care delivery innovations and value-based payment reforms across our health care system, including for the next generation of Americans.

Medicaid Directors recognize that delivery system and payment reform for the pediatric population must reflect the unique health care needs of kids. In particular, social determinants of health and adverse childhood events are a key cost driver for children and impact their long-term health as adults. The earlier these factors can be addressed, the better the results for the immediate health of the child, as well as the long-term health of the child and his/her family. Similarly, evidence shows that children can be best served by concurrently addressing the needs of these kids and their families. Advancing family-centered models of care is a key goal for states.

Medicaid Directors appreciate CMS's desire to partner with states to advance innovations that address these unique health care needs of children. The following comments identify six ways CMS

can support state Medicaid initiatives that improve health outcomes for children and deliver value for the taxpayer dollar.

- 1. We ask CMS to partner with states to design pediatric innovations tailored to each unique Medicaid program and that align with existing transformation efforts in the state.** To improve health outcomes and contain costs, pediatric Medicaid reforms must reflect each state's unique delivery construct, provider landscape, budget parameters, geographic features, and population health needs. CMS leadership have acknowledged the importance of state variation, and in fact, this variation must be reflected in the quality strategy states submit to CMS. Likewise, CMS should work with states to design pediatric innovations that are tailored to each state's Medicaid program and the children it serves.

Similarly, CMS should work with states to deploy pediatric innovations that build on the state's overarching transformation approach. The key to the long-term success of Medicaid's comprehensive delivery system and payment reforms is to ensure broad alignment of purpose, organization and implementation. States are seeking to align delivery system and payment reform strategies across populations, providers, and payers, while reflecting the unique needs of beneficiaries, including children. In some cases, this may be achieved by creating new child-focused episodes of care in an episode-based payment strategy. In others, it may be building on the foundation of a medical home or total cost of care model, or exploring innovations that strengthen the role of MCOs in integrating care for kids. We encourage CMS to work with states on strategies to achieve this broad alignment while reflecting children's differences in health care utilization, rapid developmental changes, and the need for family-centered care.

- 2. We encourage CMS to work with its federal partners to break down federal silos between medical and social support programs.** As noted above, health outcomes and costs for kids are largely driven by adverse childhood events and social determinants of health, such as housing, food insecurity, education, etc. Integration between health and social supports is needed to address these issues. However, current federal statutory and regulatory frameworks often prevent state and community partners from pursuing such innovations. Each program is subject to a distinct and complex set of federal rules and oversight. This generally limits how funding streams can be leveraged in a holistic and value-based way. For example:

- The Health Resources and Services Administration's (HRSA) maternal and child health programs target low-income mothers, many of whom are covered by Medicaid. But the distinct federal structures and rules prevent Medicaid and state maternal and child health programs from creating the most value across funding streams for infants and their mothers.
- Budget neutrality calculations in Medicaid 1115 waivers cannot consider the cost savings these innovations generate for other federal programs. This prevents states from testing integrated service delivery initiatives that are cost-effective across federal programs.

In addition, the lack of coordination across programs at the federal level prevents data from flowing between health and health-related programs. The exchange of this information is essential to integrated care models. For example, the education system and Medicaid operate under distinct information privacy requirements. This prevents data from flowing between schools and pediatricians who are seeking to deliver integrated care.

Therefore, we call on CMS to work with its federal partners to address the siloed program structures that prevent integrated care at the state and community level. In particular, there need to be clear regulatory pathways for states to holistically leverage Medicaid and other Health and Human Services programs for children, such as:

- HRSA's maternal and child health programs (i.e., Healthy Start and Healthy Babies);
- Programs in the Centers for Disease Control (i.e., Vaccines for Children);
- Substance Abuse and Mental Health Services Administration block grant funding for children; and
- Programs in the Administration for Children and Families (i.e., child care assistance).

Similarly, this coordination should extend to other federal agencies and programs that have a direct impact on the health of children in Medicaid, such as the Department of Education, Department of Justice, Department of Housing and Urban Development and others.

- 3. We urge CMS to align pediatric quality measures across Medicaid and other health care programs.** Purchasers of health care regularly identify the lack of alignment across quality measure sets as a major barrier to health system transformation. This holds true to Medicaid as well. For example, there are substantial differences between the Medicaid meaningful use incentive program measures and the Medicaid child core set. This type of misalignment across federal measure sets prevents states, providers, and managed care organizations from working towards common quality goals for children. It also creates a significant administrative burden on the pediatric providers that serve them.
- 4. We recommend CMS partner with states and stakeholders to strengthen quality measurement for children.** In addition to the need for quality alignment, there are also gaps in existing quality measures that address disparities among racial and ethnic minorities, children with complex physical and behavioral health conditions, and children in urban versus rural areas. CMS can play a role in directing states and stakeholders to address these gaps in a strategic and aligned manner. This effort could also build on the work beginning in some states to measure the social determinants of health, such as school readiness, food insecurity and stable housing. Finally, CMS could provide support related to data and analytic capacity to strengthen quality measurement for children, as well as assist states in developing regional benchmarks for pediatric quality improvement.
- 5. We encourage CMS to continue investing in the state infrastructure to drive health transformation for children.** Transformation activities are resource-intensive. Capital and technical assistance resources are required not only by state and local entities, but by the health

systems and affiliated pediatric providers who are working to analyze impacts and modify systems. It is especially resource-intensive to create new linkages between the health care and social support system for children and their families, which have traditionally been separate. States must develop IT systems and data analytic tools that support providers in delivering coordinated care across sectors. In addition, it also requires significant staff time and resources to bring new stakeholders and community partners to the table.

An ongoing federal investment in state infrastructure for payment and delivery system reform, such as through the State Innovation Model Program, is needed to advance our shared objectives of integrated care for children. We also urge CMS to continue allowing states to use federal advanced planning funding for IT infrastructure development, which provides critical support for this work.

6. We request CMCS and CMMI decision-makers closely coordinate with one another as they work with states on pediatric innovations. As we have noted in previous comments, there is often a lack of coordination between CMMI and CMCS on new delivery and payment models with states. This creates process challenges that impede state innovation. After CMMI approves a model, states often face significant delays as they work with separate decision-makers on the approval of Medicaid waivers, SPAs and managed care contracts. CMS can address this challenge by:

- Providing an expedited pathway for state approval of any necessary SPAs and waivers once a model is approved by CMMI;
- Engaging both CMMI and CMCS decision-makers throughout state design and implementation of a model; and
- Coordinating across CMS and the Office of Management and Budget (OMB) throughout the design of models that will require an 1115 waiver. This will ensure budget neutrality considerations in these waivers do not delay the implementation of models that states develop in partnership with CMS.

We applaud CMS's interest in supporting state Medicaid innovations that improve care and contain costs for children in the program, and we welcome ongoing engagement with CMS on this work. If you have additional questions, please contact Lindsey Browning at 202-403-8626 or lindsey.browning@medicaiddirectors.org.

Sincerely,



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