NAMD
National Association of Medicaid Directors

August 12, 2016

Senator Charles Grassley
135 Hart Senate Office Building
Washington, D.C. 20510

Senator Michael Bennet
261 Russell Senate Office Building
Washington, D.C. 20510

Dear Senators Grassley and Bennet:

On behalf of the nation's Medicaid Directors, thank you for the opportunity to comment on the Advancing Care for Exceptional Kids Act (ACE Kids) discussion draft. The National Association of Medicaid Directors (NAMD) is a bi-partisan, non-profit professional organization representing leaders of state Medicaid agencies in all 50 states, the District of Columbia, and the territories. Our members are working aggressively to redesign the fragmented delivery system and reorient misplaced financial incentives that have challenged the U.S. health care system for many years, including for the 1 in 3 children served by state Medicaid and the Children's Health Insurance Programs (CHIP). Key to the success of this work, including for children, is to avoid creating payment and delivery system reforms that are overlapping, duplicative or misaligned.

Medicaid Directors appreciate the work of you and your colleagues to consider feedback on the initial and revised language for ACE Kids, including the shared concerns of states and many other stakeholders. We especially appreciate that the Senate's latest draft calls for enhanced funding to support investment in infrastructure and the underlying services tailored to children with complex medical conditions as well as the identification and dissemination of best practices for providing payment for services delivered across state lines.

However, the enhanced pediatric health home option created in the revised Senate bill retains the fundamental components of the original ACE Kids Act which are most concerning to NAMD's members. Preserving these policies would be counterproductive to state Medicaid delivery system and payment reforms underway, including for children with complex conditions. The remainder of our letter underscores why the proposed provisions are misaligned with current Medicaid delivery system and payment innovation; consequently we believe state Medicaid agencies would be unlikely to pursue this option.

The Senate's ACE Kids discussion draft calls for the creation of an entirely new delivery system for children with complex medical conditions supported by an unspecified payment structure. This proposal actually risks reverting to a fragmented system and silos that inhibit integrated

care in states that have already stood up programs tailored for this population. In other situations, the option as currently envisioned could conflict with the health care delivery system and marketplace landscape on-the-ground, thereby rendering the option impractical.

The Senate's ACE Kids discussion draft is a significant departure from the existing Section 1943 health home program which allows states the flexibility, within nationally specified standards, to design programs that address the delivery system, payment systems, and provider characteristics in their markets. For instance, the enhanced pediatric health home criteria in the Senate legislation appear to allow only large children's hospitals to serve as the care coordination entities. This inappropriately limits state flexibility to work directly with other highly-qualified providers and entities operating in the state's delivery system, including in remote areas. This could discourage effective integration of care for the state's population of children with complex medical conditions, and counteracts state efforts to deliver services in community-based systems of care and through telemedicine. In contrast, guided by the federal parameters in the existing health home authority, states can tailor their programs to allow providers with specialized training or experience or teams of providers or professionals to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

In addition, the draft Senate legislation would create new silos in the Medicaid delivery system by being overly prescriptive around the payment structure for the health home and giving the provider an unprecedented role in establishing the payment methodology. The prescriptive payment requirements, and federal agency and provider roles in this proposal would make it difficult—and in some instances impossible—for states to align this model with the payment transformation that is underway in Medicaid, as well as with risk-based managed care delivery systems. For example, the payment methodology would have to incorporate a risk-adjustment method, re-insurance system, or risk-corridor method, as well as shared savings into the payment model. This usurps the state's responsibility in designing and implementing Alternative Payment Models (APMs), and also presumes the use of ACO-like or sub-capitated payment structures, which may not be appropriate in many states. The existing health home framework, on the other hand, provides flexibility for states to set the payment within broad criteria and to identify APMs, with CMS approval, for use in the program.

Finally, the legislation also would insert CMS into new and unprecedented ways into state operation of the Medicaid program. It directs CMS to establish the menu of APMs for the enhanced pediatric health home model. This is unlike other Medicaid innovations where states have the flexibility to design an APM that is most appropriate for that state and its local market, such as episodic payments, shared savings, population-based payment or per member per month arrangements. Similarly, it inserts CMS into the work of establishing data sharing agreements between providers. Given the operational realities of this work, CMS involvement would neither be feasible nor appropriate. Likewise, claims data would directly be reported to

the public—and presumably CMS—under this program. In all other aspects of the Medicaid program, data is first reported to the managed care entities and states to ensure states' ability to oversee and operate their programs.

As lawmakers continue to consider federal legislation in this area, we wish to make you aware of NAMD's comments on the House Energy and Commerce Committee's ACE Kids discussion draft. **We advised the House Committee leaders that—should Congress advance legislation in this area—their revised framework appropriately builds on the existing health home construct, is closer to comporting with comprehensive state reform, and holds greater promise to improve timely and well-coordinated access to medically necessary services as compared to the initial ACE language**. In particular, while not perfectly aligned, the original health home option is relatively more consistent with the work of a number of states that are designing and implementing new models of care for children with special health care needs. These include Colorado's Accountable Care Collaborative and California's "Whole Child Model." Therefore, the framework and level of specificity established under the Energy and Commerce Committee draft is preferable for potentially facilitating state adoption and success of this option.

Thank you for the opportunity to comment on the ACE Kids discussion draft and your commitment to consider stakeholder input. We look forward to continued engagement with you to identify ways that states and federal policymakers can break down the silos in our health care delivery system and improve care for all Medicaid beneficiaries, including children with complex needs.

Sincerely,

Thomas J. Betlach
Arizona Health Care Cost
Containment System Director
President, NAMD

Matthew Salo
Executive Director, NAMD

Cc:
Senator Orrin Hatch, Chairman, Committee on Finance
Senator Ron Wyden, Ranking Member, Committee on Finance
Senator Rob Portman
Senator Roy Blunt
Senator Lindsey Graham

Enclosure:
NAMD Letter to House Energy and Commerce Committee

NAMD
National Association of Medicaid Directors

August 1, 2016

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone, Jr.
Ranking Member
Committee on Energy and Commerce
United States House of Representatives
2322a Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton and Ranking Member Pallone:

On behalf of the nation's Medicaid Directors, thank you for the opportunity to comment on the Advancing Care for Exceptional (ACE) Kids Act discussion draft. Medicaid Directors believe that goals to reduce fragmentation and eliminate silos in our health care delivery system should ground federal and state-driven initiatives to improve care coordination and outcomes for all Medicaid enrollees, including children with complex medical conditions. Our comments address the importance of these objectives. Additionally, we identify how the pediatric health home approach proposed in the House Energy and Commerce Committee's discussion draft has greater potential for aligning with these goals and state Medicaid delivery system and payment reforms that are underway as compared to the previous version and related proposals under consideration.

The National Association of Medicaid Directors (NAMD) is a bi-partisan, non-profit association representing Medicaid Directors in all 50 states, the District of Columbia, and the territories. Our members are aggressively working to redesign the fragmented delivery silos and reorient misplaced financial incentives that have challenged the U.S. health care system for many years. In advancing these comprehensive payment and delivery system reforms, Medicaid Directors are designing innovations that improve outcomes for the 1 in 3 children served by state Medicaid and the Children's Health Insurance Programs (CHIP), including children with complex medical conditions.

The key to the long term success of Medicaid's comprehensive delivery system and payment reforms, including innovations for children, is to ensure broad alignment of purpose, organization and implementation. The core components of the failed system we are moving away from include fragmentation, delivery silos, and financial incentives that do not reward optimal outcomes. While the member populations Medicaid programs serve look very different from one another, it is critical to the long-term viability of our broad reform efforts that we avoid defaulting back into fragmentation or

setting up new silos that inhibit integrated care and do not reflect the health care delivery system and marketplace landscape on-the-ground.

As such, in drafting and advancing any payment and delivery system legislation, the foremost objective of Congress should be to support state efforts to break down the silos in our health care system, which will benefit all Medicaid members, including children with complex needs. States are aligning care delivery structures, payment models and performance objectives to move the system in a common direction that results in value. Driving coherence, rather than perpetuating or creating new silos, will ensure that children with complex needs receive timely, appropriate, and coordinated care. We urge the Committee to refrain from reverting to the previous iteration of the ACE Kids Act and otherwise avoid building such silos in Medicaid through distinct and separate delivery constructs.

We appreciate the work of Committee leaders and sponsors to respond to stakeholder concerns and to develop this discussion draft. Should Congress find it appropriate to proceed with federal legislation, we believe the framework and level of specificity established under the Energy and Commerce Committee draft is preferable for potentially facilitating state adoption and success of this option. This language offers a more workable approach that may better integrate with existing programs, such as the dominant risk-based managed care model and the growing number of patient-centered medical home programs.

In the sections that follow, we offer comment on the three primary components of the ACE Kids discussion draft – health homes, best practices for care delivered across state lines, and additional research – and how we can achieve our common goals through this effort.

Health Homes for Children with Medical Complexity

An option for states to develop health homes for children with complex health care needs is a reasonable and practical step in state Medicaid efforts to improve care coordination and service integration for this population. The health home model is known to states, with the first health home program approved by the federal Centers for Medicaid and Medicaid Services (CMS) in 2011. This model is outlined by CMS criteria, and aims to deliver integrated care for individuals with chronic conditions, at risk for chronic conditions, or with a serious mental illness by having an assigned provider communicate with the patient's care team to ensure timely delivery of all appropriate services. To implement a health home model, states submit a State Plan Amendment to CMS for review and approval.

States are using the health home model to deliver integrated care for some of Medicaid's most complex populations and some early results are promising. While children have been included in health home programs to date, few states have designed a model specific to them as existing health homes cannot be targeted based on age. Further, the quality measures and data reporting requirements in the existing program are not child-focused. Therefore, while there are opportunities

for learning around the broader health home program, the Energy and Commerce Committee's proposed pediatric health home option may streamline states' ability to design a model exclusively for children with the most significant health care needs.

Further, the proposed option is also consistent with the work of a number of states that are designing and implementing similar delivery constructs for these children. For example, Colorado established criteria for medical homes in 2007 for children enrolled in Medicaid and used these criteria as the foundation to develop the state's Accountable Care Collaborative in 2011, which ensures beneficiaries receive coordinated, comprehensive, and person-centered care. Similarly, California is working to transform its delivery system for children, with a particular focus on children with medical complexity under the "Whole Child Model." One objective of the Whole Child Model is to ensure that eligible children have access to a patient-centered medical home; this is done by increasing coordination among managed care plans, children's hospitals, specialty care providers, and counties while maintaining critical consumer protections.

The child and family-centered health home option in the Energy and Commerce Committee's ACE Kids discussion draft could complement the broader delivery system transformation that is underway in state Medicaid programs, including the growing use of capitated managed care arrangements for individuals with significant health care needs. States have structured health home programs in a managed care delivery system in a variety of ways. For example, some states contractually obligate their MCOs to contract with health homes for certain populations, such as in New Mexico. Alternatively, states can structure the health home services so that they are provided outside of the managed care delivery structure but are complementary to MCO functions.

The flexibility in the Energy and Commerce Committee's health home construct is vital to the ability of states to design the model in a way that complements the functions and design of the managed care delivery system. Further, as proposed in this Committee's discussion draft, the health home option preserves the fundamental role of states to oversee their program and design value-based innovations in the context of their delivery system, provider landscape and marketplace. As a specific example, the Committee's proposed criteria around what entities may serve as a pediatric health home will allow states to design a health home program in partnership with providers and consumers. We especially support the flexibility for states to identify the providers that would serve as the coordinating entity and the providers that must or can be part of the health home and to set the payment approach that would accompany the model. We encourage the Committee to clarify that states could designate as a pediatric health home a Medicaid health plan contracting with a provider or provider entity. As a March 2016 NAMD report on value-based purchasing revealed, tailoring state models and payment mechanisms is essential to their success.

We also want to underscore the importance of an enhanced federal medical percentage (FMAP) for this new health home option. Assigning a higher FMAP rate for the development of health homes is an important incentive for states looking to embrace the option and is a key tool for state planning.

The additional federal support helps states build the infrastructure for health homes, including enhancing staff capacity necessary to sustain this innovation, creating data analytic supports for providers, and providing practice transformation assistance. Such investment has been critical to the success of other value-based purchasing models in Medicaid, including other health home programs created to date. In addition, the enhanced match would help states develop the infrastructure to collect and report on data to HHS that is required by the legislation.

Finally, in the implementation of this health home option, careful consideration should be given to the data reporting requirements, as well as the number and type of quality measures on which providers and states would be required to report. Quality and performance assessment should include a limited number of high value metrics that build off of existing measure sets to the extent possible and are child-focused (i.e., the Medicaid child core set). Measures should not only recognize medically-centric objectives, but also reflect the goals of linking children and their families to needed social services and supports. Further, the data reporting requirements should be implemented in a manner that is not operationally burdensome and appropriate for this population of children. NAMD and our members strongly encourage CMS to engage with states in the identification of the most appropriate measures and reporting requirements for such a program.

Best Practices for Care Delivered Out-of-State

Medicaid Directors agree that there is an opportunity to identify and share best practices for streamlining access to appropriate out-of-state care while safeguarding program integrity. In particular, while bordering states often have agreements in place to facilitate access to commonly used providers, there may be opportunities to address the administrative complexities for multi-state specialty providers and minimize the burden on families to navigate the care delivery system.

In undertaking this work, federal and state policymakers would benefit from better understanding the ways states may *currently* be supporting coordination of care and access to specialty services outside of a local geographic area, including across state lines. For example, service coordinators for children with disabilities in the Texas STAR Kids program must make connections to care for children with special healthcare needs who often travel long distances to access needed specialty providers. Similarly, MCOs in California's newly-designed Whole Child Model are expected to monitor the coordination of care provided both within and outside the MCO's provider network. These types of approaches, and others like them that specifically target out-of-state care, could inform best practices for children with medical complexity.

NAMD stands ready to work with our federal partners at CMCS to help identify and share best practices in this area. We also stand ready to assist states in facilitating coordination and out-of-state care delivery for children with medically complex conditions.

Additional Research on Children with Medical Complexities

While states have significant initiatives underway to improve care delivery for children with complex medical conditions, states and providers continue to face a number of hurdles in this work. The draft legislation directs the Medicaid and CHIP Payment and Access Commission (MACPAC) to conduct research which may help states overcome some of these hurdles and direct their efforts to design effective care delivery and payment models by better understanding this population of children, their unique health care needs, and the gaps in care that persist. We agree that MACPAC is well positioned to delve into these complex issues, and could inform future federal policymaking in this area as well as next iteration of innovations for this population of children.

However, we noted that the MACPAC report is due 18 months from the date of enactment, while the option itself is established as of January 1, 2018 and CMS best practices guidance to states is expected within one year of enactment. As the MACPAC report may identify information critical to the design and scope of the health home option and best practices, the Committee may wish to reconsider the sequencing of the MACPAC report, the establishment of the pediatric health home option and the best practices guidance.

Additional areas where MACPAC research could benefit state innovations for children with medically complex conditions include research on health outcomes, access to care (particularly in out-of-state hospitals), quality of care and quality measurement, and patient/family satisfaction. There also may be value in MACPAC exploring whether a "Center of Excellence" designation could be a potential pathway to support out-of-state contracting for particular pediatric subspecialty services, and whether that designation could encourage price competition between hospitals for Medicaid services.

In conclusion, NAMD appreciates the opportunity to comment on the ACE Kids Act discussion draft. We look forward to continued engagement with you and the broader Medicaid stakeholder community on this legislation and other efforts to improve the experience and optimize outcomes for children served by state Medicaid programs.

Sincerely,

Thomas J. Betlach
Arizona Health Care Cost
Containment System Director
President, NAMD

Matthew Salo
Executive Director, NAMD

Cc:
The Honorable Joe Barton
The Honorable Kathy Castor