



STATEMENT
MEDICAID HEALTH PLANS OF AMERICA
JULY 7, 2016
ENERGY AND COMMERCE COMMITTEE HEALTH SUBCOMMITTEE HEARING
“EXAMINING THE ADVANCING CARE FOR EXCEPTIONAL (ACE) KIDS ACT”

Medicaid Health Plans of America (MHPA) submits the following comments for the record for the Energy and Commerce Health Subcommittee hearing on "Examining the Advancing Care for Exceptional (ACE) Kids Act" scheduled for July 7, 2016. These comments are specific to HR 546 and the substitute “discussion amendment.”

MHPA is the national trade association representing 165 managed Medicaid plans covering over 30 million enrollees in 39 states. Medicaid managed care organizations (MMCOs) provide high quality, coordinated health care services across the continuum of care at a negotiated, predictable, and cost-effective rate. MHPA agrees with the sponsors of HR 546 that children with complex medical needs must be assured access to the highest quality coordinated health care. The original language of HR 546 would make reaching this goal for very sick children significantly less effective, more expensive, and would lead to less accountability. As MHPA has noted in prior communications, most recently in MHPA’s July 22, 2016 letter (attached), the current language in HR 546 would turn back the clock on 20 years of progress in achieving better outcomes for these children through fully integrated, at-risk plans.

In some respects, the substitute/discussion amendment is significantly different from the original bill and more clearly focuses on providing specialized coordinated care for children with complex medical needs. MHPA agrees eliminating several highly problematic provisions improves some aspects of the original language of HR 546. Specifically, the financial and structural incentives of the original that strongly favored carve-out specifically to free-standing children’s hospitals have been dropped. In addition, the creation of a national network that shifts financial control for these children from states to HHS has also been eliminated. These are important changes that improve the provisions.

But MHPA continues to believe the “health home” structure described in the amendment puts children at risk. The language shows clear bias toward providing the care for these medically complex children through a fee-for-service payment model that lacks the rigorous quality monitoring and oversight required of Medicaid managed care plans. Specifically, the amendment 1) implements significantly higher federal matching funds for providing care coordination services (something not necessary with a capitated model), 2) provides a supplemental payment for providing the coordinated service (again unnecessary under a capitated model), and 3) fails to mention options that focus on structured, built-in incentives to achieve both savings and coordinated care.

Additionally, the amendment specifically permits “hospital emergency departments to refer children with medically complex conditions to designated providers.” (p.4) This referral by a hospital emergency room rather than by a child’s care coordination team or primary care provider suggests these “designated providers” operate outside established care coordination programs and existing Medicaid managed care systems. It appears this provision may empower hospital emergency rooms to initiate, or at least contribute to, a carved-out structure resulting in a fragmented care system for these children.

By contrast, federal and state law requires Medicaid managed care plans to adhere to rigorous quality metrics and undergo stringent oversight and monitoring. These mandates, including mandatory external assessments, 1) measure whether Medicaid enrollees receive the care they should, 2) provide a mechanism for state agencies to track plan successes both in patient outcomes and proper processes, 3) identify weaknesses in care provision, and 4) track corrective action. The fee-for-service structure has neither the quality oversight required of managed care plans, nor processes to identify best practices or possible areas of weakness that need to be addressed. MHPA is concerned that the health home structure proposed in the amendment continues to leave children at risk of falling into care systems that lack adequate quality oversight.

Children with complex medical needs are currently enrolled in the Medicaid managed care programs in 34 states and territories and currently receive the benefit of quality care guaranteed by the rigorous quality oversight mentioned above. MHPA suggests that instead of endorsing “one-off” programs that further fragment the system and are not proven to provide optimal care, a better approach is to build on current successful models, such as the managed, capitated, at-risk model that already have a proven track record treating children with complex medical needs. These managed care models encourage the use of best practices in key program areas such as care coordination, data collection, and alternative payment options like value-based purchasing (VBP). Furthermore, many Medicaid managed care plans have implemented medical-social models of care that are holistic in scope and encourage Medicaid MCOs to collaborate with their provider networks to tailor key practices to the individual enrollee.

The language of the amendment allows for reimbursement to health homes using payment structures other than fee-for-service. The fact that the amendment specifically mentions alternative payment methods are permitted suggests in practicality that most, if not all, health homes will operate under a fee-for-service structure.

Regardless, the language is silent on how these structures, no matter which payment methodology is used, would interface with existing care coordination systems such as MMCOs. For example, if a provider directs a child toward one of these health homes (as is allowed and specifically provided for in the amendment), how does the care provided to the child continue to be integrated with the child's MMCO care coordinators? With the child's current health care provider? Again, the amendment appears to exacerbate, rather than mitigate, fragmentation.

MHPA is certainly not opposed to the health home concept, per se. In fact, every enrollee having a functional health home (such as a primary care physician, etc.) is precisely the reason many states have moved to managed care for Medicaid enrollees in the first place and remains a fundamental concept of managed care. But the value of a stand-alone health home structure separate from existing capitated managed care structures, particularly in situations where children with complex medical needs are already enrolled in MMCOs, is questionable. MHPA believes these children would be far better served by a system that integrates all services for the child across the continuum of care. MMCOs are experts at providing high quality coordinated care to numerous populations with special health care needs -- including children with complex medical needs.

Clearly, state Medicaid agencies also see the success of the capitated, risk-based model for nearly all enrollees under their care. In 2015, a PwC analysis showed 70% of all Medicaid enrollees received their care through capitated, risk-based models and that number continues to grow. CMS also recognizes the dominance of Medicaid managed care. In a statement before this Subcommittee a year ago, Vikki Wachino, Director, CMCS, CMS/HHS declared "Medicaid is no longer a fee for service delivery system. Managed care is the delivery system that provides care to the majority of our beneficiaries, and we want to maximize its potential to ensure coordination and quality of care."

Unlike any of the fee-for-service alternatives, Medicaid managed care plans provide an essential quality guarantee and a proven track record for continuing success over time. Children with complex medical needs deserve no less.

Attachment

MHPA's Concerns HR 546 and S298 Advancing Care for Exceptional (ACE) Kids Act

MHPA member plans are full-risk capitated health plans that contract with states to operate a patient-centered, comprehensive and integrated payment and delivery system. Both federal and state regulation require Medicaid managed care plans adhere to stringent quality, program integrity and network adequacy standards, a practice not followed by Medicaid fee-for-service (FFS). In addition, the managed care structure incentivizes at-risk health plans to go above and beyond their contract requirements in order to better serve members, provide more coordinated/integrated care and ensure good stewardship of tax dollars for the states they serve.

MHPA's key concerns with the provisions of HR546 "Advancing Care for Exceptional Kids Act" (ACE) that establishes "Medicaid Children's Care Coordination Programs" (MCCC) are as follows:

Quality of Care and Data

HR 546 creates a new, federally controlled structure that incentivizes states to move an undefined population of children with complex medical needs into a fragmented, uncontrolled FFS structure that lacks quality oversight. While it is true that HR 546 suggests MCCC's should be able to eventually provide coordination, utilization and quality monitoring, HR 546 allows the MCCC's to move forward with only the promise that these functions will be accounted for at some point in the future. We believe it is duplicative at best, and at worst detrimental to high quality care to allow entities like MCCC's to be responsible for providing care to medically complex children while being free of the quality and program integrity oversight currently required of fully functional managed care organizations.

State Medicaid managed care programs (as mandated by law) have always required MCOs adhere to quality monitoring, improvement and data collection (42 CFR Part438 copied below). The excerpted language below illustrates the regulatory emphasis on quality assessment and performance improvement generally, but also focuses on services to special populations (see #4 below). No comparable federal requirements for quality monitoring or improvement exist for services delivered through Medicaid fee-for-service or in the proposed ACE language.

Further, although HR 546, in Section (e) "Quality Assurance" requires the Secretary of HHS to establish QA protocols, develop pediatric quality measures and network

adequacy standards, and “take into account HEDIS measures,” implementation of the MCCC’s is not contingent on these quality processes being completed, nor is there any recognition or accommodation for the fact that fully validated quality measures take years to complete. The proposed language in HR 546 is silent on how those standards, protocols, etc. will be used in monitoring quality or measuring outcomes and/or applied to value-based payment concepts, etc.

42 CFR 438.240 Quality assessment and performance improvement program.

(a) *General rules.*

(1) *The State must require, through its contracts, that each MCO and PIHP have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees.*

(2) *CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by States in their contracts with MCOs and PIHPs.*

(b) *Basic elements of MCO and PIHP quality assessment and performance improvement programs. At a minimum, the State must require that each MCO and PIHP comply with the following requirements:*

(1) *Conduct performance improvement projects as described in paragraph (d) of this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.*

(2) *Submit performance measurement data as described in paragraph (c) of this section.*

(3) *Have in effect mechanisms to detect both underutilization and overutilization of services.*

(4) *Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.*

External Review

One notable, long-standing requirement of a quality assessment and performance improvement program is the mandatory External Review.

Federal regulations (see 42 CFR Part 438, subpart E) require Medicaid MCOs to undergo an external quality review (EQR) by an External Quality Review Organization (EQRO) (as defined by 42 CFR 438.354). The process includes a number of mandatory and optional protocols. The mandatory category include:

- Review, within the previous three-year period, to determine Medicaid MCO compliance with state standards for access to care, structure and operations, and quality measurement and improvement;
- Validation of performance measures; and,

- Validation of performance improvement projects (PIPs)

The EQRO (private accreditation organization review) culminates in several reports and assessments provided to the state that cover

- an assessment of each Medicaid MCO's strengths and weaknesses with respect to quality, timeliness, and access to care;
- recommendations for improving the quality of care provided by the Medicaid MCOs; and,
- an assessment of each Medicaid MCO's response to the quality improvement recommendations made in the previous year's review.

These external reviews provide an independent assessment of the state's Medicaid managed care program, indicate whether any program areas need additional monitoring, and include an assessment of the MCO's response to recommendations. Again, no comparable requirements exist for services provided under the current Medicaid fee-for-service program, nor do they appear to apply to the MCCCs established by the ACE language.

Updated and Significantly Strengthened Regulations

On May 6, 2016, CMS finalized a comprehensive update of Medicaid managed care rules and regulations (doubled in volume) that significantly clarified, updated and strengthened already stringent requirements in a number of key areas (Fed. Reg. Vol. 81, No. 88, May 6th, 2016). In the category of quality reporting and monitoring specific to children's services noteworthy additions included the following (Fed Reg. Vol. 81, No. 88, May 6th, 2016, p. 27658):

- states must ensure children's health care be accounted for under provider and network adequacy, specifically requiring –
 - time and distance standards for pediatric primary care providers and specialists
 - pediatric providers of behavioral health care
 - pediatric providers of dental services

HR 546 by contrast seems to limit networks for MCCCs to only stand-alone children's hospitals and the providers associated with those networks, leaving out a number of children's service providers and other excellent hospitals that have a proven track record and provide additional options that may in many cases be closer to a child's home.

Beneficiary Choice and Protections

As with the Quality Assurance provisions noted above, creating a new pathway for states to force children with complex medical needs be cared for through a fee-for-service model denies these children a number of access and appeals protections required for enrollees

in Medicaid managed care. Again, the ACE language does not replace them with comparable protections.

Patient Protections in Medicaid managed care programs:

Sections 4701, 4704 of the Balanced Budget Act of 1997 (Subtitle H – Medicaid, Chapter 1 – Managed Care) require states ensure that Medicaid managed care plan enrollees have a number of protections including but not limited to: (1) freedom to choose between at least two managed care plans, (2) access to grievance procedures, (3) guaranteed access to emergency services, (4) access standards including capacity and service adequacy, waiting times, travel times, access to specialty providers, etc. (5) compliance with maternity and mental health services requirements, (6) protection against balance billing, etc.

Disruption of Treatment and Lack of Coordination

HR 546 allows the state to prospectively enroll children in an MCCC program by assigning eligible children to a nationally designated children’s hospital network for an initial period of up to 90 days. The bill does include an “opt out” provision, but it is weak at best. Although the child can be proactively enrolled in the network by the state (often after being identified by the children’s hospital as needing care), opting out requires the child’s caregivers to initiate a separate action using a yet to be defined state process. In short, while the assignment of the child to an MCCC is virtually automatic and requires no action on the part of the caregiver, opting out appears undefined and bureaucratic, potentially disrupting treatment and care coordination, and costing the state Medicaid program more money in the process (additional discussion on “cost” included in Financing and Payments below).

Coordination with Mental Health Parity Act of 2008

Since the MCCC program is exempt from Medicaid managed care regulatory requirements, it would also fall outside the requirements of the parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA), again leaving children with complex medical needs outside the current protections required of Medicaid managed care plans.

Lack of Program Integrity

Medicaid health plans have a financial incentive to find and prevent improper payments. CMS reported FY 2015 payment error rates for Medicaid fee-for-service were 10.59% and for Medicaid managed care were 0.12% (HHS Financial Report, 2016, p. 193).

<http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf>

Creating a new pathway for states to carve-out populations of enrollees whose care is complex and costly eliminates the inherent incentive present in capitated at-risk models to ensure accountability and appropriate payment for service at all levels.

Financing and Payments

Funding for the MCCC initiative is open-ended, uncontrolled and unpredictable. While the proposal allows for a transition to an “equitable, risk-based payment model” over five years, initial payments must be FFS, even in the 34 states where risk-based payments are already being made to address the needs of children with medically complex conditions.

This type of provider-based model will surely require the infusion of up-front capital to cover, at a minimum, the costs of coordination and care supports, not to mention what it may cost in terms of data collection and quality monitoring/reporting. In fact, the ACE language appears to recognize the need for additional funding making it clear that the hospitals in the MCCC networks will be eligible for additional payments above their fee-for-service payment rates for “per capita care coordination payments” for items and services provided through medical home programs and other care coordination activities.

One additional note -- The Secretary of HHS rather than the individual state makes final determinations concerning the payment methodology. This requirement effectively removes a state’s control over managing services for this population and would appear to directly impact the state’s traditional control over amount, scope and duration of benefits provided under Title XIX.

Transparency

HR 546 waives numerous Medicaid statutory requirements related to statewide availability and comparability of services, freedom of choice of providers, and the application of managed care regulatory requirements to entities receiving capitation payments. Although many states in the course of implementing new programs apply for and are granted a variety of waivers by CMS, most are required to obtain public comment and other input from interested parties as part of the waiver process. By waiving these requirements statutorily, the ACE language nullifies important transparency processes.

State Preemption

Any state law or regulation that impedes the ability of an MCCC program to fulfill requirements established for its operation is preempted, giving the Secretary of HHS rather than state regulators supremacy over the regulation of MCCC in states.

June 22, 2016

The Honorable Joe Pitts
Chairman
Energy and Commerce Health Sub-Committee
U.S. House of Representatives
Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pitts:

On behalf of Medicaid Health Plans of America (MHPA), thank you for your commitment to ensuring the Medicaid program remains viable for future generations of those who have no other way to obtain health care for themselves and their families except through safety net programs like Medicaid. In particular, MHPA is grateful for your leadership and support of the Medicaid Task Force. As you know, MHPA has been working closely with Medicaid Task Force members to catalogue critical issues that must be addressed.

In the context of reforming Medicaid to ensure its viability, guarantee quality patient care, and curtail escalating costs, I want to underscore MHPA's serious concerns with the model proposed in HR 546, the "Advancing Care for Exceptional (ACE) Kids Act of 2015." Everyone agrees that poor children with complex medical needs must have access to appropriate medical interventions, and that care coordination is the key to making this work for the patient and their parents. Unfortunately, HR 546 as currently written would make reaching the goal of integrated, coordinated care for very sick children and their families significantly more expensive, less effective, and would ultimately lead to far greater spending in Medicaid with far less accountability. The legislation would "turn back the clock" on the sickest children by placing them in a separate fee-for-service (FFS) system, carved out of Medicaid managed care, reversing 20 years of progress in achieving better outcomes through fully integrated, at-risk plans.

Specifically, HR 546 creates Medicaid Children's Care Coordination (MCCC) entities, a new, federally designed structure that incentivizes states to move an undefined population of children with complex medical needs from coordinated, quality-monitored care provided by Medicaid managed care plans back into the fragmented, FFS payment structure. While it is true that HR 546 states that MCCC's must be able to coordinate, integrate and provide for the "full range of MCCC program services," none of these terms is defined nor are there specified timeframes for compliance. HR 546 allows the MCCC's to move forward with only the promise that these functions will be accounted for at some point in the future. We believe it is detrimental to high quality comprehensive care to allow entities like MCCC's to be responsible for providing care to medically complex

children while remaining free of the quality and program integrity oversight currently required of fully functional managed care organizations.

Medicaid managed care plans are highly regulated, particularly in the area of care management, quality monitoring, data collection, and program improvement. On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) released the final rule for Medicaid managed care regulation. The rule significantly strengthens many aspects of an already rigorous quality monitoring program. Moving these children back to fee-for-service, with only a vague promise that MCCC's will develop needed safeguards, denies medically complex children the guarantee that the quality of their care will be closely monitored.

Furthermore, using children's hospitals as both anchor and portal to the MCCC makes little sense if the true goal of the legislation is to ensure children with complex health care needs receive the highest quality, coordinated care across the full continuum of health care providers.

These premier specialty hospitals provide wonderful, compassionate, and near miraculous care. But neither their mission nor their expertise is in providing care coordination, or the kinds of administrative, "back-room" support and payment analysis called for in HR 546. This expertise will take years to develop and require significant financial investment. The period of time permitted for having fully developed MCCC's in place and the delay permitted for many features described in HR 546 appears to recognize this shortcoming. What is concerning is there is no guarantee that these systems will ever be developed, or consequences if they are not, leaving children with complex medical needs at risk of not receiving the full range of services they should.

Lastly, the national structure described in HR 546 overly federalizes Medicaid, diminishing the role of governors at a time when states are asking for more autonomy and control over their own programs, not less. HR 546 shifts authority to CMS to determine how care to children with complex medical needs will be provided, but does not diminish any of the state's responsibility to pay for the program. Our analysis shows HR 546 as currently written will significantly increase costs to Medicaid and we urge the Committee to take a close look at this aspect of HR 546 as well. With the cost in mind, I point out that states currently have the authority to create the type of MCCC structure described in HR 546. According to the National Association of Medicaid Directors (NAMD), a few Medicaid agencies have created an MCCC-type structure to focus on individuals with behavioral and other serious health care needs. But it appears states have not chosen to set up an MCCC structure with a children's hospital in the position of control as provided for in HR 546.

We at MHPA and our 165 member plans in 39 states are very proud of our commitment and proven track record providing the best quality care to the 28 million Medicaid enrollees we serve, including children with complex medical needs. We are also fully committed to ensuring verified gaps in care are resolved. But we are resolute in our conviction that the new structure created by HR 546 denies vulnerable children access to

the higher standards of quality, transparency, and accountability required of all Medicaid managed care plans.

Attached for your consideration is a more detailed discussion of MHPA's position.

Again, thank you for your commitment to ensuring the Medicaid program is available for future generations of those who need assistance receiving health care and for your undaunted stewardship of taxpayer resources.

As always, I am available for questions or further discussion. Please feel free to contact me directly at 202-857-5720 or Jeannine M. Bender at jbender@mhpa.org.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jeff M. Myers', with a large, stylized flourish at the end.

Jeff M. Myers
President and CEO
Medicaid Health Plans of America

June 22, 2016