



September 5, 2018

Hon. Michael Burgess
Chairman
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Hon. Gene Green
Ranking Member
Energy and Commerce Committee
Subcommittee on Health
U.S. House of Representatives
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Dear Mr. Chairman and Ranking Member,

Thank you for the opportunity to submit testimony for the record for the Health Subcommittee's September 5th hearing "Opportunities to Improve Health Care" regarding H.R. 3325, the ACE Kids Act.

Medicaid Health Plans of America (MHPA) member plans are committed partners with Congress, the Administration and the states in strengthening Medicaid and ensuring that the program improves the delivery of care for beneficiaries.

MHPA is the national trade association representing more than 90 managed care health plans that contract with state Medicaid agencies in 39 states plus DC to provide comprehensive, high-quality health care to nearly 25 million Medicaid enrollees in a coordinated and cost-effective way. The number of Medicaid beneficiaries who receive their care through managed care plans continues to rise annually, in part, as more states turn to the expertise of managed care plans to help coordinate, manage and integrate health care for growing numbers of populations of Medicaid enrollees, including Children with Special Health Care Needs (CSHCNs).

We appreciate that the legislation has been significantly improved since the 114th Congress to address some of the concerns expressed by MHPA and other stakeholders. However, it continues to rely on a model that would create silos that fragment the medical care and support services that are essential for these children.

Under current law States already have the ability to deploy various medical home and care-coordination models¹ to meet the needs of CSHCNs and most

¹ Several pathways already exist for states to create provider led medical homes and health plan led care coordination programs for CSHCN's, including, for example, ACA Sec.

of them have chosen not to deploy provider-led models for sound policy reasons. This calls into question the appropriateness of creating a substantial financial inducement to the states² for programs and mechanisms states already have the ability to implement.

Impact on beneficiaries: MHPA is concerned that in states with managed care systems for Medicaid that adoption of a provider-led model outside of managed care networks would negatively impact the health and wellbeing of children and their families while simultaneously increasing the cost of care.

As you know, three states³ have implemented MMCO operated specialized plans for CSHCNs. In about half of the other 36 states that utilize managed care plans for Medicaid, state contracts with MMCOs contain a variety of provisions requiring MCOs to maintain specific specialized capabilities, networks, procedures and protocols to meet the needs of CSHCN's. These special plans cover the comprehensive range of services these children need, and the MMCO networks include the best pediatric hospitals in the state and offer access to national "super-specialists" as needed.

These managed care contracts also create important operational safeguards to ensure the solvency and sustainability of MMCOs and the care they manage. While the proposal strives to allow states to give provider-led health homes much of the responsibilities of an MMCO, we should be careful that it also assures a commensurate level of oversight and minimal operational standards to protect states and beneficiaries.

States already have the ability, to create a variety of care coordination mechanisms, including pediatric health homes:

Additional federal legislation is not required for states to create either provider-led or managed care based enhanced pediatric health homes. Through specialized managed care contracts or under pilots and waivers, states are increasingly adding CSHCNs into managed care plans, opting for the comprehensive and effective model that MMCOs provide. MMCOs already routinely meet and far exceed the capabilities mandated under the proposal's "Health Home Qualification Requirements". States already have the ability to create health homes serving children under current law⁴.

²703health homes, waivers, specialized managed care plans and special provisions in managed care contracts.

² The Enhanced FMAP proposed in the legislation

³ CA, FL and DC

⁴ For example, through ACA Sec. 2703, state waivers, or alternative payment arrangements.

Out-of-state care: In rare instances where the necessary specialist care is not available in-state, MMCO's send the child and family to "super-specialists" in various locations across the country, negotiating one-off contracts and relying on pre-established reimbursement rates⁵.

Identifying and utilizing these "super-specialists" does not create an operational challenge for MMCOs, however we understand that CMS-State provider enrollment procedures may represent a challenge for fee-for-service programs. MHPA strongly supports efforts to streamline the process for CMS-State enrollment of providers.

Medicaid is not just medical care: MMCO's operating either special plans for CSHCNs or plans with special provisions have developed networks and capabilities to efficiently and effectively provide, integrate and manage a wide and comprehensive range of both medical and non-medical support services for children and their families. This is not a core capability of a hospital-based medical home.

Often times the most challenging part of managing care for CSHCNs is managing homecare, transportation, prescription drugs, nutrition assistance, and a wide variety of other medical and non-medical services. The variety of services MMCOs offer for CSHCNs can be far broader than what a hospital system provides.⁶

Ability to take and manage cost risk: CMS experience with ACOs in recent years has demonstrated the inability or unwillingness of provider led entities to take and manage full-risk. The proposal removes this important incentive to keep patients healthy and out of the most expensive care setting – the hospital.

While the legislation does encourage exploration of various alternative payment models, it does not require EPHH's to operate under a full-risk capitation model. Given the reluctance of provider-led models to take the kind of risk that MMCO's routinely take, the proposal removes incentives for effective cost containment and creates incentives for fee for volume.

Conflict of interest: The proposal gives the provider control over where a patient will receive their care. When a provider-led entity routinely determines where a child will receive care, it creates an inherent conflict of interest that may result in suboptimal care decisions as EPHH hospitals seek

⁵ Either the state established fee for service rate, or the rates negotiated by the MMCO if it operates in the destination state.

⁶ SEE Appendix 1 "Examples of Services Provided by Managed Care to CSHCN's"

to retain revenue by keeping children “in house” rather than sending them to the most appropriate pediatric specialist, or to a less cost-intensive service provider.

Efficiency: Many routine, non-critical services that don’t require treatment by high cost specialists or in high cost institutional settings would often cost many times more through a provider-led EPHH than they cost through an MMCO network⁷, which utilizes a comprehensive network of providers to deliver care most efficiently and effectively. These lower intensity cost providers are often also more convenient and accessible for families than a hospital-based health home.

We share concerns that by increasing federal matching funds offered to states implementing EPHH’s the proposal will create perverse incentives to states to abandon innovative and effective managed care-based approaches to caring for these children. While intending to advance care for CSHCN’s, the proposal, for the reasons we mention, is likely to reverse recent progress in several states.

Access to Care: It is reasonable to assume that provider-led EPHH’s will routinely steer CSHCNs into their EPHH even if the engagement with the provider entity is minimal or occasional, even if adequate care is available closer to home. This steering could have negative consequences for local health care providers, FQHCs, rural hospitals, and other community-based providers, driving them out of business and leaving those communities without access to services. The resulting hospital consolidation would not only limit access to care but would also have the unintended consequence of reducing the ability of individual states to manage costs effectively, unnecessarily driving up program costs.

Separate coverage for family members: From experience, we know that keeping families together under the same insurance plan and provider network improves access to care and results. The proposal would have the effect of moving children out of their family or caregiver’s Medicaid plan and into an EPHH, greatly complicating compliance with treatment and care regimens for both CSHCN’s and family members. As such, the model proposed would fragment the care provided to the child in need of extraordinary services from their family and/or other caregivers. Creating a dynamic that separates the child from their parents via different service

⁷ Some states, such as Florida, limit reimbursement to providers for services to a percentage of Medicaid fee for service rates, but in most states is it common for routine visits, vaccines and other services to cost several times more than they would at a lower cost-intensive provider such as a CHC/FQHC.



providers is likely to add to, rather than reduce, the scheduling and other service difficulties the families already face. Because many of these children's parents are low-income or otherwise disadvantaged, this increased complexity is likely to create additional barriers that would be even harder to overcome.

Legislation creates a federal definition of CSHCN: This is an important definition that has additional implications for states and should be given thorough consideration.

Thank you again for the opportunity to comment on the legislation and suggest improvements. The most important change we can recommend to the legislation to ensure that the full capabilities of both provider-led entities and managed care are brought to bear to meet the needs of CSHCNs is to modify the legislation to require that, if implemented in a state with Medicaid managed care, that an Enhanced Pediatric Health Home must operate as a network element in the MMCO's network and that payments to the EPHH be included in the MMCO's capitated full risk payment rates established by the state.

All the best,

Francis J. Rienzo

A handwritten signature in black ink, appearing to read "FJR", with a long horizontal line extending to the right.

Vice President for Government Relations and Advocacy

Appendix 1

“Examples of Services Provided by Managed Care to CSHCNs”

Behavioral health services

In home care

Prescription drugs and medication management

Lab testing

Vaccines

Equipment and supplies

Family transportation and lodging for out of town/state specialist visits

Care coordination for low-income or geriatric patients/members

Nutrition education

Transportation to and from medical appointments

Parent education

School-based healthcare services