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.