



March 27, 2017

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Pediatric Alternative Payment Model Request for Information

Dear Administrator Verma:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. ASHA has carefully reviewed the Centers for Medicare & Medicaid Services' (CMS) Pediatric Alternative Payment Model (APM) request for information (RFI) and would like to offer comments on these topics:

- General principles for pediatric-focused APMs
- Challenges in existing pediatric-focused APMs

### **General Principles for Pediatric-Focused APMs**

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ASHA recognizes that there is an increased emphasis on moving from a fee-for-service volume based health care system to one that is aimed at improving health through value and patient outcomes. As CMS explores approaches to move children and youth who are enrolled in Medicaid and CHIP to APMs, we believe that the following concepts should be factored into any care redesign processes.

- **Pediatrics needs its own financial model that accounts for the long-term investment opportunity and the thin margins for short-term investments<sup>1</sup>**

The demographics of children and youth are highly diverse and have factors that influence their care that are different from any other age group. Children often have higher rates of poverty, which influences the prevalence and severity of disease as well as access and response to treatment. Children and youth also face highly prevalent chronic conditions and neurodevelopmental conditions. Finally, as compared to adults, the trajectories for improved outcomes and lower costs for children are often long-term, with short-term savings less achievable. In pediatrics, it is important to show progress over time; not a definitive short-term outcome.

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<sup>1</sup> Perrin, JM, Zimmerman E, Hertz A, et al. Pediatric Accountable Care Organizations: Insight from Early Adopters. *Pediatrics*. 2017; 139(2):e20161840

- **Evidence-informed vs. evidence-based quality measurement**

Pediatric interventions are often preventive in nature; therefore, evidence-based measures can be challenging because providers cannot ethically withhold medically necessary treatment. Supporting the development of pediatric-specific quality measures that assess overall long-term health and long-term savings, combined with shorter-term milestones, may be more appropriate for this population.

- **Care coordination and care transitions**

To support integrated service model concepts, it is important to adopt approaches that ensure proper referral patterns between the primary care physician and other treatment providers. While recent efforts on payment reform have intended to advance coordinated care models, much of health care delivery is still siloed. This is particularly true for complex, high-cost patients—those with fundamentally complex medical, behavioral, and social needs. Further, there is a need to streamline administrative burden for authorization, reauthorization, and the extension of services if needed.

- **Remove barriers to integration of social services with medical services**

Integrating clinical care services and non-medical services, such as housing and food, into social services has great potential to achieve better outcomes, reduce inequality, and increase cost savings. For example, through proper funding support, Medicaid managed care plans could coordinate with social and community interventions that are proven effective in improving outcomes and reducing costs.<sup>2</sup> In recognition that children and youth often receive services from an array of programs, it is critical that care coordination encompasses the full constellation of services and supports that contribute to the desired functional and financial outcomes of pediatric APM implementation.

- **Remove access barriers and promote effective telehealth tools**

Telehealth technologies can increase patient access to medical care, particularly in remote or underserved areas. State regulatory barriers that inhibit the adoption of telehealth should be reduced. These barriers include reimbursement ineligibility, and variations and restrictions in state licensure rules.

Audiologists and speech-language pathologists have demonstrated the capability to provide effective care through telehealth technologies for more than a decade and in various work settings. Telehealth venues include medical centers, rehabilitation hospitals, community health centers, outpatient clinics, universities, patients' homes, and residential health care facilities. There are no inherent limits as to where telehealth can be implemented as long as the services comply with national, state, institutional, and professional regulations and policies. Telehealth is being used in the assessment and treatment of a wide range of clinical

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<sup>2</sup> Dzau, VJ, McClellan M, et al. Vital Directions for Health and Health Care. *National Academy of Medicine*. <https://nam.edu/wp-content/uploads/2017/03/Vital-Directions-for-Health-Health-Care-Priorities-from-a-National-Academy-of-Medicine-Initiative.pdf>

disorders, including articulation disorders, autism, dysarthria, fluency disorders, language and cognitive disorders, dysphagia, and voice disorders.

- **Ensuring access to providers through funding and reimbursement**

Sufficient Medicaid reimbursement is necessary to achieve access to care. The adequacy of Medicaid payments should be based on the true costs of delivering care. For example, payments could be adjusted for case-mix differences based on chronic conditions. ASHA opposes block granting proposals for Medicaid that would limit federal matching funds. Block granting and per capita caps based upon federal poverty census data within states would have a dramatic negative effect on children and youth in states where Medicaid has expanded and where optional populations are covered.

### **Challenges in Existing Pediatric-Focused APMs**

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- **Accountable Care Organizations (ACO)**

No one definition for Medicaid ACOs exists and its parameters vary from state-to-state. However, there appears to be common characteristics in that they promote patient-centered care and care coordination. According to an analysis conducted by Leavitt Partners on Medicaid ACOs, one area in which states need assistance in implementing ACOs is integrating long-term services and supports.<sup>3</sup> For ACOs to become more meaningful from a patient and cost-saving perspective, states will need to consider implementing post-acute and long-term services and supports—these services are critical in order to provide comprehensive episodes of care. If states can more effectively incorporate long-term services and supports into their ACOs, then they could potentially enhance chronic disease management, reduce unnecessary emergency room visits, develop more efficient care transitions, and facilitate the proactive diagnosis and prevention of post-discharge conditions. Other areas in which states need assistance are (a) understanding how to deploy population health analytics to improve care and (b) integrating behavioral health for children, in particular.

- **Patient-Centered Medical Homes (PCMH)**

Currently, 26 states have Medicaid PCMH initiatives underway. Under this model, patient treatment is coordinated through the primary care physician to ensure patients receive care by employing care coordination and enhanced communication. ASHA is aware that pediatricians who participate in Arkansas' Medicaid PCMH program have elected to modify operational processes by focusing on therapy and behavioral health. Specifically, the clinic requires newly referred therapy patients to choose one therapy provider for their initial evaluation and a different therapy provider for their therapy services. The goal of this process is to adopt a “checks and balances” approach for patients so that the evaluation is independent of subsequent therapy services. Unfortunately, this requirement has created a barrier to therapy services in instances where access to participating Medicaid therapy

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<sup>3</sup> Leavitt Partners. The Rise and Future of Medicaid ACOs: themes, trends and takeaways. Available at: <http://leavittpartners.com/2015/09/the-rise-and-future-of-medicaid-acos-2/>.

providers is limited, particularly in rural areas. In addition, it is problematic for ensuring the most effective clinical treatment of patients.

Thank you for your consideration of ASHA's comments on the Pediatric APM RFI. If you require further information or clarification, please contact Daneen Grooms, MHSA, ASHA's director of health reform analysis and advocacy, at 301-296-5651 or [dgrooms@asha.org](mailto:dgrooms@asha.org), or Laurie Alban Havens, ASHA's director of private health plans and Medicaid advocacy, at 301-296-5677 or [lalbanhavens@asha.org](mailto:lalbanhavens@asha.org).

Sincerely,

A handwritten signature in cursive script that reads "Gail J. Richard".

Gail J. Richard, PhD, CCC-SLP  
2017 ASHA President