

April 7, 2017

Ms. Amy Bassano
Acting Director
Center for Medicare and Medicaid Innovation
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: HealthyChildrenandYouth@cms.hhs.gov RFI

Dear Ms. Bassano:

We the undersigned organizations are pleased to submit comments on CMS' Request for Information on Pediatric Alternative Payment Model Concepts. We commend CMS for its interest in developing new pediatric health care payment and service delivery models focused on high-risk, high-need youth. We also appreciate CMS' focus on integrated service delivery models that address long-standing eligibility, delivery system, and payment impediments.

We urge you to consider the population of Medicaid and CHIP-insured adolescents and young adults with behavioral health conditions, intellectual/developmental disabilities, and/or complex medical conditions who are between the ages of 16 and 25 and moving from pediatric to adult service systems. This group of youth and young adults consistently experience poorly managed transitions, which result in adverse complications, gaps in receipt of primary/behavioral/specialty care, excessive emergency room use, and preventable costs. The linkages between pediatric and adult medical and behavioral service systems are weak, with few examples of shared accountability for successful transition planning, transfer, and integration into adult care.

Complicating this transition process, eligibility for public insurance and social supports for young adults becomes more restrictive and, in certain cases, disappears altogether. Medicaid, State Title V Programs for Children with Special Needs, State Mental Health Block Grant Programs, and State Developmental Disabilities Programs are all examples of publicly funded systems where eligibility disruptions occur between the ages of 18 and 21. Further, the bifurcation of pediatric and adult systems combined with these program eligibility changes presents severe challenges for transition-age youth and their families. This is a vulnerable time where the alignment of pediatric and adult medical and behavioral service systems and public program eligibility should be the most robust. Recognizing this need, the Institute of Medicine, in its 2014 report on young adults, called for "more thoroughly incorporating pediatric to adult transition of care into the current health care reform movement."

Professional recommendations on the content and timing of health care transition were published in 2011 by the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians. This clinical report calls for transition planning to begin at age 12-14, an adult model of care at age 18, and transfer into adult care before age 22. The clinical report also call for recognition of young adults as a unique patient population requiring careful integration into adult care. These recommendations do not call for young adults to be retained in child health systems.

To effectively implement these professional recommendations, stability in insurance and public program eligibility are key. Moreover, financial incentives that promote shared accountability between pediatric and adult systems of care, adherence to transition delivery system recommendations, and linkages between medical/specialty and behavioral health and associated public program services are much needed.

We recommend that CMS consider extending public insurance and program eligibility for youth and young adults until age 26, at which point high-risk, high-need young adults will be situated with appropriate adult care providers. This has already been put in place in Medicaid for young adults in foster care and for dependent children whose parents have private health insurance. The following are specific suggestions for eligibility changes to insurance and public programs to recognize transition-age youth and young adults as an underserved, high-need population:

- Under Title XIX of the Social Security Act, establish a new eligibility group to include adult children until age 26.
- Under Title V of the Social Security Act, expand the target population of children with special needs to include adult children under age 26.
- Under Title XIX of the Public Health Service Act, expand the population of children with serious emotional disorders to include adult children under age 26.
- Under Title 1 of the Developmental Disabilities Assistance and Bill of Rights Act, expand the population of children with developmental disabilities to include adult children under age 26.

There are several potential structures that could be options under a payment model, including:

- Pay-for-performance models, where pediatric and adult medical/specialty/behavioral health practices receive a bonus payment for successfully transferring their patients before age 22 with complete medical/behavioral records and evidence of communication with adult providers/systems of care. Similarly, adult providers could receive a bonus for accepting a certain volume of new young adult patients, communicating with the referring pediatric providers/systems of care, and ensuring an adult medical/specialty/behavioral visit within 1-3 months of the last pediatric visit.
- Capitation models, where both pediatric and adult medical/specialty/behavioral health practices receive a monthly capitation fee for the year before and after transfer, recognizing the added time to prepare youth and their families for transfer, completing transfer documents, ensuring coordination and communication between pediatric and adult providers/systems of care, and implementing outreach, engagement, and follow-up strategies for new young adults.
- Bundled payment models, where multiple transition-related services are provided by pediatric and adult physicians and other qualified health professionals over a defined period before and after transfer. These face-to-face and non-face-to-face services can include an assessment of self-care skills, self-care education, development/updating of transition plan of care, development/updating of medical/behavioral summary, communication and coordination between pediatric and adult clinicians and systems of care, outreach, and follow-up.

A new CMS innovation on transition from pediatric to adult care has the potential to foster the development of a lasting, sustainable connection to care and coverage for high-need populations. Such an innovation aligns well with the medical home model of care, Medicaid's health home provisions, integration of mental health and primary care, patient engagement, and shared decision-making. It also builds on the cost-effective experience from Medicare's hospital readmission reduction program. We welcome the opportunity to discuss these recommendations in greater

detail. Please do not hesitate to contact Peggy McManus, the Co-Director of Got Transition, the federally funded health care transition resource center at mmcmanus@thenationalalliance.org.

The National Alliance to Advance Adolescent Health
American Association on Health and Disability
American Foundation for Suicide Prevention
American Psychiatric Association
Campaign for Trauma-Informed Policy and Practice
Child Neurology Foundation
Children and Adults with Attention-Deficit Hyperactivity Disorder
Children's Dental Health Project
Cleveland Clinic
Eating Disorders Coalition
Lakeshore Foundation
National Alliance on Mental Illness
National Association of Pediatric Nurse Practitioners
National Association of Social Workers
National Association of State Directors of Special Education
National Federation of Families for Children's Mental Health
Quality Trust
Sickle Cell Disease Association of America
Society for Adolescent Health and Medicine
University of Rochester Medical Center