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Testimony of the Pennsylvania Health Law Project to the House Health Committee of Pennsylvania June 21, 2011

Good morning. My name is Kyle Fisher, and I am a Staff Attorney with the Pennsylvania Health Law Project. Thank you for this opportunity to testify about House Bill 1480, which would expand mandatory managed care state-wide.

The Pennsylvania Health Law Project (PHLP) provides free legal services and advocacy to Pennsylvanians who rely on publicly funded health insurance, like Medicaid. Our statewide Helpline receives more than 2,000 calls a year from people who are either uninsured, or whose insurance is not covering a medically necessary service. While providing free legal assistance to these individuals, we also work on health policy changes that maximize health coverage and access to care.

Speaking in our capacity as consumer advocates, we want to highlight three areas of concern, all of which center on access to care. Access to care is critically important for the low-income and at-risk populations that Medicaid serves: children; seniors; and adults with disabilities. Each of these concerns is specific to managed care, and is not a concern in ACCESS Plus, the state's primary care case management care delivery system.

I. Managed Care Has Failed in Rural Counties

First, we are concerned that risk-based managed care simply does not work well in Pennsylvania's rural areas. The managed care plans already have the ability to operate in the state's rural areas, and the majority have chosen not to. (To provide context: 25 counties are currently in mandatory managed care, another 25 counties have voluntary managed care & ACCESS Plus, and 17 counties have ACCESS Plus alone.) Those managed care organizations (MCOs) that do operate in rural areas struggle to attract members and the providers needed to serve those members. Gateway Health Plan's recent experience showed this clearly. In September of last year, Gateway withdrew from 17 of the 19 voluntary counties in which it was operating, citing revenue losses for three straight years. Gateway's withdrawal affected over 14,000 consumers, some of whom were forced to find new doctors. We fear a repeat of this: new MCOs coming in, discovering that they cannot make a profit, and pulling out, leaving consumers in the lurch.

When given the choice, consumers overwhelmingly reject managed care plans and enroll in ACCESS Plus, the state's fee-for-service and primary care case management system. The few MCOs that operate in rural counties as voluntary managed care plans typically enroll less than 10% of the county's consumers. This is often because the MCOs, in rural areas, cannot attract doctors and have limited provider networks.

The poor fit of managed care in rural areas is not limited to Medicaid. In our Medicare advocacy, PHLP discovered that few Medicare managed care plans operate in Pennsylvania's rural counties, and that some of those that have tried to later withdrew.

Expanding mandatory managed care statewide would, in the short term, disrupt care for the more than 300,000 consumers currently in ACCESS Plus, without, in the long term,

guaranteeing adequate access to care. In the past ten years there have been multiple attempts, and half-starts, at expanding managed care. Our concern is that these past attempts failed, and MCOs have failed to thrive in the voluntary counties, because the dispersed consumers and providers in Pennsylvania's rural counties are a poor fit for risk-based managed care.

This concern is only heightened by the fact that it is now routine for Medicaid MCOs and hospital systems to part ways. Next month, for example, HealthPartners will terminate its contract with the Mercy Health System in the Southeast, forcing the 6,600 members who use the Mercy system to change either their doctor or their health plan. The type of adversarial business negotiations that lead to ruptures like this, and subsequent disruptions in care for consumers, does not occur on Medicaid's fee-for-service side, where hospitals and other providers either accept the Medicaid fee schedule, or don't. (Let me add that no one thinks the fee schedule rates are too high; Pennsylvania's payment rates are among the lowest in the country.) Attracting enough doctors into the Medicaid system is already a problem, especially in rural areas. Adding rate negotiations and this type of hospital system/MCO rupture to the mix could make the provider shortage problem only worse.

II. Access to Care Could be Compromised by Inadequate Provider Networks

There is another dimension to our concern about meaningful access to doctors. For many types of provider, the current HealthChoices rules require only a choice of two providers in the whole zone. In reasonably contained areas, this is usually enough. HB 1480, however, would create zones that are much larger than the existing HealthChoices zones. To apply the current rule of two providers per zone to the new zones would likely create very long travel times for many consumers. The proposed Central zone stretches from the state's northern border to its southern border. If an MCO's two in-network cardiologists are located near the southern border,

a consumer in Tioga County would have to travel nearly four hours to see his heart doctor. Even a travel time of two hours could raise an insurmountable barrier to care, especially for consumers dependent on the Medical Assistance Transportation Program, for which inter-county travel poses real challenges.

In contrast, a consumer in ACCESS Plus and on fee-for-service can, with a referral, see any specialist enrolled in the Medicaid program. There are no network limitations. That Tioga County resident could even cross into New York to see a cardiologist, assuming the doctor accepts the Medicaid rate. For consumers to have meaningful access to care in zones as large as the proposed Central and Northwest zones, the provider choice rules will need to take into account travel distances.

III. Inappropriate Denials are an Ever-Present Danger in Risk-based Managed Care

Lastly, we are concerned that managed care plans will inappropriately deny medical care. As one egregious and known example, a number of current managed care plans were inappropriately denying shift nursing and home health aide services for children on the basis of a behavioral health diagnosis. This was not a case of conflicting medical opinions. The plans were denying the prescribed service on an improper basis – the fact that the child had a behavioral health diagnosis, often autism. Because of this, the Department of Public Welfare put four managed care organizations (MCOs) in "corrective action." One managed care plan had to overturn its original denials and approve services for 92 children. This means 92 children were wrongly denied shift nursing or home health aide services. Going without needed services causes obvious harm for sick children. To the extent that it makes those sick children sicker, it also increases health care expenditures.

The ability of the state to maintain control over the managed care plans is a related concern here. As the MCOs consume an ever larger share the state Medicaid budget, it is increasingly difficult for DPW to exercise effective oversight, especially where one plan becomes dominant in a zone (like Keystone Mercy in the Southeast). This problem was seen in the shift nursing correction action context I described earlier. The plan that had to overturn denials for 92 children was placed in corrective action in December 2009. Because of repeated violations –either inappropriate denials of care or legally-insufficient denial letters – that plan, and three others, remain in corrective action today. That a managed care plan has been in corrective action for nearly a year and a half raises serious accountability concerns. Why has it taken 18 months for DPW to get a managed care plan to comply with program requirements?

Unlike with fee-for-service utilization review, where any savings realized go to the state treasury, any savings that result from an MCO denying care turn into MCO profit. This financial incentive, which is inherent in risk-based managed care, will almost certainly lead to inappropriate denials of care; the state has to retain the authority, and the actual ability, to prevent such abuses.

Thank you again for this opportunity to share our concerns.