THE HOSPITAL & HEALTHSYSTEM
ASSOCIATION OF PENNSYLVANIA

Statement of The Hospital & Healthsystem Association of Pennsylvania

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Before the
House Health Committee

Presented by:

Paula A. Bussard
Senior Vice President, Policy and Regulatory Services
The Hospital & Healthsystem Association of Pennsylvania (HAP)

Harrisburg, PA
June 21, 2011

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Representative Baker and members of the committee, I am Paula A. Bussard, senior vice president, policy and regulatory services, for The Hospital & Healthsystem Association of Pennsylvania (HAP). HAP represents and advocates for the nearly 250 acute and specialty care hospitals and health systems across the state and the patients they serve. Joining me today is Ronald J. Butler, president and chief executive officer, Laurel Health System, located in Tioga County.

We appreciate the opportunity to present the views of hospitals and health systems from across the commonwealth on House Bill 1480—The HealthChoices Act. We will provide the hospital community's view on Medical Assistance managed care, as well as a perspective from a rural health system.

Background

Pennsylvania hospitals and health systems have historically supported enrollment of Medical Assistance recipients in managed health care plans as a means of improving continuity of care through access to cost-effective, quality care. Designed and implemented appropriately, managed care programs for Medical Assistance patients enable a focus on primary and preventive care, offer opportunity to improve continuity and integration of care, promote individual recipient responsibility for health care choices, help to control program costs, and help to improve the efficiency and effectiveness of Pennsylvania's Medical Assistance program.

HealthChoices

House Bill 1480 would require the Department of Public Welfare to expand the HealthChoices

program to the remainder of the state. Currently in southeastern, southwestern, south central, and the eastern portion of the state, more than 70 percent of Medical Assistance recipients are enrolled in the HealthChoices program. HealthChoices is the state's mandatory managed care program requiring Medical Assistance recipients to enroll in, or to be assigned to, a managed care organization (MCO), which is a state licensed health maintenance organization (HMO) that contracts with the Department of Public Welfare to provide physical health services. Medical Assistance recipients residing in nursing homes are exempt from enrollment. The intent of House Bill 1480 is to require the commonwealth to expand the existing HealthChoices program to northeast, northwest, and central Pennsylvania, which are the more rural areas of the state.

Under the HealthChoices program, the MCOs contract with health care providers to serve their enrolled population. Successful managed care programs recognize that the MCO and its provider network need to work together to ensure that the right care is delivered in the right setting and at the right time. An essential concept underlying the Medical Assistance managed care programs is that recipients will be afforded better access to primary and preventive care, resulting in a reduction of inappropriate utilization of emergency rooms and hospitalizations as compared to a population receiving care under a more traditional fee-for-service program. It should be noted that the areas in this bill that call for an expansion of HealthChoices are currently served by the state's AccessPlus program, which is a primary care case management program that requires recipients to use primary care physicians to coordinate their health care needs, so there already is a familiarity with case management, an essential component of managed care, in the northwest, northeast, and central portions of the state.

Effective MCOs establish provider networks and employ other education, recipient incentives, and care review strategies to improve appropriate health care use while also reducing inappropriate health care use by improving care management. MCOs contract with health care providers and use an array of provider contracting strategies to align the incentives of the providers and the plan to achieve the objective of providing high quality, cost-effective care. The commonwealth allows MCOs latitude in provider contracting, and MCOs use a variety of ways to reimburse contracted providers, including use of fee schedules, per diem, per case, and/or prospective payment systems as are used in Medicare and the existing Medicaid fee-for-service program. In addition to using a variety of contracting methods, MCOs may use other strategies to improve the effectiveness of health care delivery, such as medical homes that work closely with the plan to coordinate care for individuals with chronic medical conditions, such as asthma, congestive heart failure, or diabetes. MCOs also may use quality incentive payments that reward providers for achieving certain quality indicators, such as vaccination rates, reduced health care-associated infections, etc. Additionally, MCOs use a variety of care review strategies to assure that care is medically necessary and provided in an appropriate and timely manner, including prior authorization, precertification, as well as concurrent and retrospective review. MCOs may also deploy discharge planning staff to work directly with hospital discharge planning staff to enable more effective care transitions following hospital inpatient care stays.

As a result of the ability of MCOs to deploy an array of contracting strategies, the design of the Medical Assistance MCOs—which enables MCOs and providers to negotiate contracts—has afforded both hospitals and doctors the opportunity to negotiate rates that reimburse per case/visit better than the rates under the traditional program, without increasing overall Medical

Assistance costs to the commonwealth, because the health care providers are working collaboratively with the managed care plan working collaboratively to provide cost-effective health care.

The Department of Public Welfare operates the HealthChoices program under a federal waiver that is required because recipients can be restricted in their choice of health care services given that they must use health care providers in the MCO's provider network. The federal government has established various requirements for mandatory Medicaid managed care programs, including, but not limited to:

- Consumer protections to ensure that Medicaid recipients have rights to appeal or file grievances to address particular health care needs.
- Provider network adequacy to ensure that Medicaid recipients have reasonable geographic and timely access to health care.
- Programs to address special health and other needs of Medicaid recipients.
- The ability of MCOs and providers to freely negotiate contracts provided that such contracts do not inappropriately limit the access of Medicaid recipients to timely and medically necessary health care.
- Establishment of a default rate—that is a rate that non-contracting providers receive in the event an enrollee in a Medicaid MCO needs emergency care and is unable to seek care at a provider in the MCO's provider network.

A key aspect of managed care, including commercial, Medicare, and Medicaid managed care, is that health care providers freely negotiate contracts. This includes rates and other contract terms that enable the parties to work together to meet the needs of patients. Therefore, there should not be provisions that would interfere with the ability of health care providers to fairly and freely negotiate a contract with a Medical Assistance MCO as would be the case with Section 7 of House Bill 1480. This section would interfere and even negate any incentive for the MCO to negotiate contract rates and other contract provisions with hospitals. As such, this provision conflicts with the intent of managed care which is for MCOs and providers to work collaboratively to improve the cost-effectiveness of care.

The hospital community cannot support House Bill 1480 with the inclusion of Section 7. The HealthChoices program has worked effectively in the commonwealth for more than a decade and has resulted in improved access to primary and preventive care, care coordination for individuals with complex medical needs, and the delivery of cost-effective care to Medical Assistance recipients. In all existing regions of HealthChoices, MCOs and health care providers have freely negotiated contracts, and the program has achieved the objectives envisioned by the commonwealth. Therefore, while the hospital community would support state efforts to expand HealthChoices, it must be done in a way that would not hinder the ability of health care providers to negotiate contracts that enable the provider to serve the health care needs of its patients.

At this time, Ron Butler will provide a brief perspective from a rural health care system.

Conclusion

Managed care can be expanded throughout the state in a way that assures efficiencies, improves quality and access, fairly pays for health care services, and affords public accountability. Pennsylvania's rural communities and most vulnerable citizens deserve no less. The hospital community urges the committee to amend House Bill 1480 by deleting Section 7.

We appreciate the opportunity to present the hospital community's views on expanding Medical Assistance managed care statewide, and would be happy to answer any questions you might have. Thank you.

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