Health Care Reform Recommendations

PRESENTED BY THE INTERAGENCY HEALTH REFORM COUNCIL
TO GOVERNOR TOM WOLF

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Contents

Introduction

Prior to the COVID-19 pandemic, cost, access, and equity warning signs already existed in Pennsylvania's health care system. Thirty-six percent of Pennsylvanians find it hard to pay their medical bills, ten percentage points above the national average.[i] The Commonwealth's health care costs have been growing annually at a rate that is significantly above the annual statewide growth in gross domestic product (GDP), making Pennsylvania families and businesses pay a larger percentage each year towards health insurance premiums and out-of-pocket costs.[ii] Health care access is becoming more difficult, as large providers close their doors after changes in ownership. Pennsylvanians are also experiencing tangible health disparities with life expectancy varying by more than 20 years in adjacent neighborhoods.[iii]

The COVID-19 pandemic has magnified these existing issues in Pennsylvania's health care system. Even for those with insurance, rising unemployment may mean much greater difficulty paying out-of-pocket costs. In addition, state revenue reductions now and in the future have made finding efficiencies in our health care system more important than ever. COVID-19 has also exacerbated the preexisting inequities that certain disadvantaged neighborhoods face, disproportionately hitting Pennsylvanians of color.

Recognizing the importance of affordable health insurance coverage, in recent years Pennsylvania has worked to moderate premium increases and pursue initiatives that will increase affordability without sacrificing quality or comprehensiveness of coverage. In particular, in 2020, Pennsylvania implemented a reinsurance program alongside the launch of its own state-based exchange, Pennie, that lowered premiums for individuals and families that buy comprehensive coverage on their own. However, long-term trends such as continual increases in health care costs and the shifting of these costs to employees through higher cost-sharing, particularly deductibles, necessitate efforts aimed at curbing these broader trends over time.

Moreover, industry analysts predict that healthcare provider and payer merger, acquisition, and changes in ownership will accelerate as a result of the pandemic as distressed organizations seek stable partners.[iv] Currently, this merger and acquisition activity happens with little transparency regarding the effect that these changes will have on our communities, including the cost of health care coverage for the Commonwealth's businesses and residents.

The Wolf Administration is implementing a Whole-Person Health Reform Package that strives to make health care more affordable, support transformation within health care corporations and state government, and tackle health inequities. Whole-Person Health Reform means focusing on every aspect of a person that contributes to their health—both physical and behavioral health across the lifespan, addressing the social determinants of health and eliminating health disparities, and promoting the affordability, accessibility, and value of health care.

A core piece of this Whole-Person Health Reform Package is the creation of the Interagency Health Reform Council ("IHRC" or "the Council"), which was created via executive order on October 2nd, 2020. The purpose of the Council is to evaluate the potential alignment of health care payment and delivery systems to provide efficient, whole-person health care that also contains costs, reduces disparities, and achieves better outcomes. The Council consists of 7 members: Meg Snead, the Governor's Secretary of Policy and Planning, Teresa Miller, the Secretary of Human Services, Dr. Rachel Levine, the Secretary of

Health, Jessica Altman, the Insurance Commissioner, John Wetzel, the Secretary of Corrections, Robert Torres, the Secretary of Aging, and Jennifer Smith, the Secretary of Drug and Alcohol Programs. The Council is Chaired by Alison Beam, Deputy Chief of Staff in the Office of the Governor.

The Council's first charge was to develop this report, which includes proposals for the development and implementation of health care reform and identifies policy and legislative changes needed to effectuate the Council's proposals. The Council compiled this report after reviewing and evaluating contributions from agency leadership and staff across the commonwealth. This report is arranged by topic areas, with one or more recommendations in each topic area.

This report is one of the first steps to embarking on the path of Whole-Person Health Reform. By collectively moving towards care that addresses every aspect of a person, we can give every Pennsylvanian the best opportunity to live a long, happy, and fulfilling life. Pennsylvanians deserve nothing less.

Create Health Value Commission to Institute Health Care Cost Growth Benchmarking

Background: Health care affordability has become a crisis in Pennsylvania. Even before the pandemic, 1 in 2 Pennsylvanians struggled to afford health care in the past year. The price of health care causes Pennsylvanians to make extremely difficult choices. Four out of 5 Pennsylvanians are worried about affording healthcare in the future. This leads to many families taking actions that are jeopardizing their health, such as delaying care (29%), avoiding care altogether (21%), skipping a test or treatment (24%), failing to fill a prescription (19%), or cutting pills in half or skipping doses (17%).[v] It's no wonder that across party lines, 9 out of 10 Pennsylvanians believe lawmakers should take action to remedy the situation. [vi]

Unchecked provider consolidation can worsen the problem for those who struggle with health care costs. The Medicare Payment Advisory Commission reviewed a large body of literature and concluded that the preponderance of evidence suggests that provider consolidation leads to higher prices.[vii] For example, when two hospitals merge, there is a price increase of 7-9% on average, and price increases of 20-30% are not uncommon.[viii] Hospital acquisitions by private equity firms reported larger increases in hospital charges than hospitals not acquired by private equity firms, by $407 per inpatient day.[ix] And while this would all perhaps be justified if consolidation improved the quality of care, the evidence in this regard is decidedly mixed, with some studies suggesting that horizontal consolidation can actually lead to lower quality care[x] As COVID-19 is expected to speed up provider consolidation,[xi] transparency is sorely needed to provide more accountability for these changes before they happen.

Recommendation #1: Pass Legislation to Establish the Health Value Commission

The Council recommends that the General Assembly pass legislation to establish the Health Value Commission. The Health Value Commission would be led by a team of commissioners, including the Secretaries of Human Services, Health, Drug and Alcohol Programs, Aging, and the Insurance Commissioner, in addition to appointments by the Governor and the General Assembly.

The Commission will improve affordability by establishing a health care cost growth benchmark for the Commonwealth and monitoring and enforcing payor and provider performance relative to the benchmark. If payors and providers exceed the benchmark, the Commission may require a performance improvement plan to increase accountability. This is a proven approach that has worked in other states, such as Massachusetts.

With the establishment of the Commission, health care expenditures in the commercial market is modeled to be reduced between $2.7 billion and $3.2 billion between 2022 and 2026. With

full participation of self-insured employers, these savings could be doubled: up to $6.4 billion dollars could be saved within the Commonwealth. This will directly translate into higher savings for Pennsylvania businesses and families and may even improve state revenue. In turn, the savings for businesses and families translate into personal and business income, which is modeled to generate an increase in net tax revenue of up to $122 million for the Pennsylvania state budget between fiscal years 2022 and 2026.

Whole-person care means more than improving affordability—it's about making sure we have a health care system that addresses the needs of every Pennsylvanian. That's why the Commission will also develop spending targets to support primary care, behavioral health, and value-based payments. We know that primary care, behavioral health, and paying for value are the foundation of a well-functioning health care system, but spending has not always reflected this. For example, in Pennsylvania only 4.2% of our health care dollars are spent on primary care— less than the national average of 5.6%-- even as we know that primary care should serve as the foundation for a well-functioning healthcare system. Increasing investment in these areas will improve long term health outcomes and reduce potentially preventable emergency department visits and hospital admissions.

The Health Value Commission will be a partner for the legislature and the public by identifying the core drivers of health care costs. The core drivers of health care cost invariably change over time. That's why the Commission will monitor for trends in health care cost growth and bring transparency to the core drivers of health care cost growth in the Commonwealth. The Commission will create an annual report of the core drivers in health care cost growth that will serve as a foundation for future legislation and policymaking.

Lastly, the Health Value Commission will add increased transparency to large provider mergers, acquisitions, corporate affiliations, and changes in ownership. The Commission will have the ability to perform public interest reviews of these changes, analyzing such factors as health care cost, quality, access to care, and the role of the provider in serving at-risk, underserved or low-income populations. The final report of a public interest review will be posted publicly and sent to the Office of the Attorney General. The merger, acquisition, affiliation, or change in ownership could only be finalized 30 days after completion of the public interest review—after Pennsylvania communities can know what to expect.

Address Health Equity

Background:
The Centers for Disease Control and Prevention (CDC) describes that health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.[xii] The Robert Wood Johnson Foundation defines health equity as meaning that everyone has a fair and just opportunity to be healthier. Achieving health equity

requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care.[xiii]

Unfortunately, like many states across the nation, a Pennsylvanian's life expectancy is heavily dependent on the zip code where they are born. A baby born in certain areas of North Philadelphia has a life expectancy of only 63 years. But just a few miles to the South, newborns are expected to live to 86 years.[xiv] These areas with profound inequities, and poor life expectancy, are the same neighborhoods that have been historically redlined. We can do better. We must do better. The following provides recommendations of how we can improve health equity across the commonwealth.

Recommendation #1: Develop Responsive Supports and Services for Individuals and Communities Experiencing Trauma

There is a lack of trauma awareness and cultural responsiveness within community health and support systems which often results in poor health outcomes. Communities of color are at high risk, in part due to higher rates of childhood trauma, ongoing historical or institutional trauma and secondary/vicarious trauma. This lack of understanding within healthcare systems is a problem as these systems are often the safest place for individuals experiencing trauma to obtain resources to help.

The commonwealth should develop additional responsive supports and services for individuals and communities. These supports and services should include a multidisciplinary leadership team and the implementation of trauma-informed education for providers that treat Pennsylvanians. The commonwealth should support community trauma conversations with people living in poverty hosted by community action agencies. The intent is to empower people living in poverty to identify trauma and chronic stress, establish existing community action agency as locations to access support, and increase access to services and delivery of trauma-informed care.

Recommendation #2: Cultivate Transformational Systems Change in Health Care, Including the Adoption of New Equity Incentives

Health care delivery systems, health care policy and health care data and data analyses need to engage people of color and consider equity and cultural traditions, nuances and distinctions.

As part of its transformational change, the Department of Human Services (DHS) has created the first equity incentive in the commonwealth to reduce inequities. In the Physical HealthChoices

Managed Care Organization Pay-for-Performance Program in 2020, this equity incentive includes both quality measures for the access to well-child visits and the timeliness of prenatal care amongst Black members. This equity incentive is $26 million dollars, or a full 10% of the program, and is expected to grow over time.

To help expand these efforts, it is recommended that agencies across the commonwealth also adopt a statewide definition for "health equity" across health care delivery programs and policies. In addition, it is recommended that health care programs administered by DHS and throughout the commonwealth stratify the quality, health outcome, behavioral health, and trauma measures they collect by race and ethnicity, if they have not already done so, to determine and measure whether there are disparities in the provision, access, and utilization of health care.

When disparities are identified, it is recommended the commonwealth explore the creation of aligned quality incentive programs designed to help eliminate the disparities. Alignment of quality and equity measures and incentives will be important to consistently and maximally reduce disparities, insofar as similar disparities exist across program areas.

Recommendation #3: Create Health Equity Zones

The interaction between race and place is extreme and is well-illustrated with a measure called the childhood opportunity index. In Philadelphia, 53 percent of black children are born into neighborhoods with a very low opportunity index, compared to only 2 percent of white children.[xv] Three percent of black children are born into an area with a very high opportunity index, compared to more than 30 percent of white children.[xvi]

Creating Health Equity Zones— which are areas with profound inequities in health outcomes— will establish the beginning pieces of an infrastructure to focus on access to care and healthy living options for our most vulnerable populations, which will ultimately address chronic disease and improve health outcomes. This concept is an extension of the Health Enterprise Zone in Northern Philadelphia, whereby DHS has targeted grants to the neighborhood with the highest number of Medical Assistance beneficiaries in the commonwealth. Under this recommendation, DHS and the Department of Health (DOH), along with payors, providers, and community-based organizations (as part of the Regional Accountable Health Councils, discussed elsewhere in the report), will partner to identify health equity zones, by examining Medical Assistance claims data, community health needs assessments, and social determinants of health data throughout the commonwealth.

Once identified, grant programs could be better targeted to these neighborhoods, and DHS could grow its equity incentive to promote improved outcomes in these areas, connecting incentives in the delivery of health care to community inequities for the first time. DOH, DHS,

and agencies throughout the Commonwealth could target grants to health equity zones to target the most vulnerable communities. This process can begin to tackle some of the inequities in our commonwealth and restore the opportunity to live a long and fulfilling life no matter where a person is born.

Recommendation #4: Review and Revise Predictive Analytics and Algorithms Used by Payors and Providers.

Many insurers and providers use algorithms to target their services to patients that are expected to be "high utilizers" of healthcare. Unfortunately, these algorithms may inaccurately predict the need for additional medical services because the algorithm predicts need based on the cost of health care, instead of the level of illness. In one seminal nationwide study, the authors of the study examined the use of a commercial algorithm and reported a growing concern that algorithms may reproduce racial disparities and bias. For the examined commercial algorithm, whereas almost half of Black members should have gained access to a service, the authors found that only 17% did.[xvii] DHS has partnered with the authors of this study to team up with Medical Assistance Managed Care Organizations (MCOs), to review the use of predictive algorithms in order to remove any bias that may exist and improve the identification of patients with the greatest health care needs.

This partnership has attracted the attention of the National Committee of Quality Assurance, who is interested in following along with Pennsylvania's leading efforts to tackle a nationwide problem, and better understand how to address bias and improve predictive analytics in the health care industry.

Recommendation #5: Promote Culturally and Linguistically Sensitive Services in the Commercial Insurance Market

DHS has required that all Physical Health, Behavioral Health, and Community HealthChoices MCOs, work towards or achieve the National Committee for Quality Assurance (NCQA) distinction in multicultural health care. This distinction recognizes those organizations that are leading the market in providing culturally and linguistically sensitive services (CLAS) and working to reduce health care disparities. The NCQA evaluates how well an organization complies with standards for collecting race, ethnicity, and language data, providing language assistance, cultural responsiveness, quality improvement of CLAS, and reduction of health care disparities. The first MCO in the nation to receive this distinction is from Pennsylvania, and most of the Physical Health MCOs in the Commonwealth are expected to achieve the distinction this year.

To the extent MCOs have achieved NCQA multicultural health care distinctions, the applicable standards could be applied across all lines of business, including the commercial lines. This would

help to ensure that insurers in the commercial market are providing culturally and linguistically appropriate services and in turn, potentially reduce health disparities.

Recommendation #6: Establish Regional Accountable Health Councils

In Erie, there is a 20-year life expectancy difference in neighborhoods just separated by a few minutes' walk.[xviii] The profound inequities based on the block where someone is born are simply unacceptable. And they are bigger than any one insurer, provider, or even any one agency can manage alone. That is why Pennsylvania is creating the Regional Accountable Health Councils (RAHCs) as a core part of Governor Wolf's Whole-Person Health Reform Package. The Regional Accountable Health Councils are being established through the Medical Assistance Program. The purpose of the RAHC will be to serve as a forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes across each region of the state. This planning will be focused on areas of high burden of disease, such as the health equity zones.

The RAHCs goals are to 1) to promote health equity and eliminate health disparities, 2) address regional needs related to social factors that affect health, such as food or housing, 3) bend the cost curve by aligning value-based purchasing initiatives, 4) support and steer population health improvement processes, and 5) center health improvement efforts in the communities where people live.

The first duty will be to officially form the RAHCs before February 28, 2021. Then, each RAHC will seek to develop a Regional Health Transformation Plan before June 30, 2021, and as part of this effort, work with DOH and DHS to identify health equity zones (Recommendation #3). This Regional Health Transformation Plan will be based on community health needs assessments, Medical Assistance data, and social determinants of health (SDOH) data, and will identify coordinated strategies for improving health outcomes across the region, with a particular emphasis on addressing the root causes of disparities. In addition, the RAHCs will help provide technical assistance and learning network for community-based organizations to support their administrative functions.

Integrate Social Services into the Delivery of Health Care

Background: Although the United States spends far more on medical care than any other nation, the U.S. consistently ranks at or near the bottom among affluent nations on key health indicators, such as life expectancy.[xix] One often-cited study found that medical care was only responsible for about 10-15% of preventable mortality.[xx] Additionally, studies have demonstrated that states with a higher ratio of social spending to health spending had

significantly better subsequent health outcomes across both physical health and behavioral health outcomes measures.[xxi]

Agencies across the commonwealth are increasingly focused on how to advance a holistic approach to health and well-being through their programs and services. If we do not consider the whole person – how they present in the moment, the conditions they live in, and the environment they grew up in – we are only treating a small portion of what influences their health and well-being. Social determinants of health (SDOH) greatly influence physical and mental health. SDOH can take many forms, including access to nutritious food, employment status, access to affordable transportation, safe and affordable housing, access and utilization of regular health services, environmental conditions, and social cohesion in communities, among other factors. These determinants do not exist in silos, but they often interact and build off each other and can be barriers to physical and mental health and economic well-being.

Individuals also face barriers in accessing information on how to obtain the services that may address SDOH needs. They are often provided with a phone number, card, brochure, or website. In many cases, no mechanism for follow-up on referrals exists and social agencies have no way to track if an individual's needs are met. DHS is in the process of finalizing the procurement and begin implementation of a person-centered, statewide resource and referral tool (R&RT) to assist individuals with obtaining meaningful information and access to the services they need to achieve overall wellbeing, positive health outcomes, and financial self-sufficiency.

Recommendation #1: Utilize the Newly Procured Resource and Referral Tool, Align the Mandatory SDOH Domains, and Utilize a Statewide Scale for Measuring Unmet Need within each Domain

The Department of Human Services is seeking to implement a person-centered, statewide resource and referral tool (R&RT) to assist individuals with obtaining meaningful information and access to the services they need to achieve overall wellbeing, positive health outcomes, and financial self-sufficiency. This tool harnesses the potential to be an asset across agencies, as the Administration envisions a statewide solution that builds on a multi-sector collaborative model for health care and social services delivery that will ultimately improve the health outcomes for the most vulnerable Pennsylvanians, while creating efficiencies for health care providers and social services organizations assisting individuals and families. The tool can provide for resource mapping across the Commonwealth—connecting health providers to the social service organizations in their area—and also allow for a closed loop referral system. A provider who refers a patient to the local food pantry, for example, would be able to check to see that the individual was able to receive the food assistance needed.

This R&RT must be available to residents of the Commonwealth through a public portal that can be accessed online, or via mobile phone or tablet. In addition to having a client portal with a comprehensive statewide social services resource database, the R&RT must be available to entities serving individuals and families throughout Pennsylvania. The R&RT will be used by entities regulated by DHS and voluntarily adopted by community-based organizations (CBOs), health care systems and physical and behavioral health providers throughout the commonwealth. DHS's vision is a person-centered system with a no-wrong-door approach that will assist state and local governments, social service agencies, healthcare organizations and CBOs to seamlessly work together to provide whole person care. Due to the large scope of this project, DHS will implement the R&RT utilizing a regional approach that will seek to align with the physical health MCOs regions. Pre-implementation work has already started in some counties through sharing information about the tool, identifying potential leaders for county-based steering committees, seeking early adopters and identifying potential existing opportunities and barriers. The counties to participate in the first phase will include: Dauphin, Cumberland, Perry, Adams, Lebanon, York, Lancaster and Berks. Cross-agency discussion is already underway about how to utilize the R&RT Administration-wide, including DOH, Pennsylvania Department of Education, Department of Aging, Department of Military and Veteran's Affairs, Department Of Corrections, Department of Labor & Industry, and the Department of Community and Economic Development, among others.

The Department of Human Services has also engaged stakeholders to define a vision for SDOH assessments in order to identify the priority domains. Having a set of consistent, mandatory domains is important for ensuring a whole-person approach no matter where the assessment is taking place to realize a statewide screening of SDOH in a wide variety of settings ranging from health care providers to food bank operators. Achieving this wide range of use means the assessment has to address a limited number of priority domains and the number of questions asked needs to be reasonable to fit in with existing work processes and staffing resources. Additionally, having consistent domains allows for interregional and setting comparisons. Through consensus building exercises, stakeholders have identified nine major domains that are priorities and can be assessed by the wide range of agencies targeted to use the R&RT system. These domains include:

1. Food Insecurity
2. Health Care/Medical Access/Affordability
3. Housing
4. Transportation
5. Childcare
6. Employment
7. Utilities: Emergency Assistance
8. Clothing: Emergency Assistance
9. Financial Strain

In order to align SDOH work across agencies and sectors, DHS is utilizing these nine domains as the framework for any SDOH initiatives moving forward. Every agency, entity or organization utilizing the R&RT is required to assess for these nine domains at a minimum, but may add additional domains as desired.

Lastly, while assessing for unmet SDOH needs is important, having a way to track on an individual-by-individual basis how these needs are being addressed is extremely important. This information will allow a local community-based organization, for example, to understand the impact their housing-related services are having on the relative housing security of the population they are serving. This is also a way for local and state government to better understand which social service interventions are working and which are not.

Fortunately, in Lancaster County this exercise is not just hypothetical. A coalition of over 50 nonprofit organizations is currently sharing a web-based data system and using an assessment designed by Franklin and Marshall College and the coalition's leadership organizations (Community Action Partnership of Lancaster County, Lancaster County Homeless Coalition, United Way of Lancaster County, and Penn Medicine Lancaster General Health). The "Strengths Matrix" examines 17 life areas for social service customers on a 5-point scale from "in crisis" to "thriving." It serves both as a baseline for new customers as well as a way to track progress over time. The data system, called "Empower Lancaster" puts a flag on any file that has gone six months without a reassessment so the next provider they see can administer the tool. In order to ensure maximum objectivity and correct for varying degrees of assessor training and education, Franklin and Marshall also helped create a question and answer tree that would drive scoring on each question in a way that eliminates subjectivity. In its first two years of use, this system led to real-time data of a significant sample size for Lancaster County that both allowed providers to know the top strengths and challenges of people receiving services as well as what was improving due to service delivery and what remained unaffected or got worse.

The Commonwealth will build on the success of Lancaster County and adopt a statewide system for measuring relative strengths and challenges across each domain to better track them over time.

Recommendation #2: Develop Resources for Local Braiding of Funding to Support a Whole-Person Approach

Pennsylvanians may experience disjointed social services due to fragmentation in funding streams. For example, if an individual's circumstances change because of receipt of assistance from one program, the individual may no longer qualify for funding from another source that was helping them get by or succeed, leading to an immediate relapse and voiding the success of

the first funder. Likewise, these funders may not be working together in any way because federal, state, or local policies have created silos among government programs that persist into service provision. An individual's needs are interwoven so the solutions must be as well. Using the examples given above, workforce development services should be braided so that additional support services lead to ultimate success: self-sufficiency. Withholding any of these supports or pulling them away based on income thresholds instead of strategy, means that we are wasting our efforts and our resources in many cases only save the luckiest service recipients.

Many of these funding streams are consistent across the Commonwealth. As such, it is recommended that the commonwealth create flexibility and incentives for providers to braid funding and offer resources to outline how to do so to support a whole-person approach.

Recommendation #3: Include Community-Based Organizations that Provide Social Services in Value-Based Contracts

Value-based purchasing (VBP) describes payment arrangements based on the value of care provided rather than the volume of medical care provided. The Behavioral HealthChoices and Physical HealthChoices programs are newly requiring in 2021 that moderate and high-risk arrangements between MCOs and providers include Community-Based Organizations (CBOs) that are addressing SDOH. Moderate and high-risk VBP arrangements, by definition, reward providers for reducing the total cost of care. And, because social interventions can reduce the total cost of care, both payors and providers can benefit from addressing social needs. The milestone for how many of these arrangements must include a CBO increases over time.

Additionally, increasing financial resources for CBOs would enhance their ability to manage the increased referrals expected from the deployment of the R&RT and the flood of additional social needs that have resulted from the pandemic. In turn, the R&RT would allow MCOs to know which CBOs are most effective at addressing different SDOH domains, which could guide efficient investment and scaling of the most effective interventions.

DHS has spearheaded a comprehensive body of work addressing the SDOH, including through leveraging MCO contracts. It is recommended that the Pennsylvania Insurance Department should explore what work commercial insurers are undertaking to address the SDOH and identify opportunities to align with the MCOs' practices and DHS's initiatives.

Recommendation #4: Utilize an Education and Case Management Approach to Prevent the Benefits Cliff

DHS conducted an analysis of how different household variations move on and off public assistance programs as their wage increases. The goal was to identify where cliffs exist and how they affect a household's gross resources based on their income. This analysis identified childcare as the most prominent benefit cliff a household will face as their income increases. The more children in a family, the more significant the cliff. The cliff occurs at 235% of the federal poverty level, which equates to about $50,000 of income for a family of three. While the childcare cliff is an issue for some, this analysis highlighted the fact that the bigger issue is that we have a lot of working people on public assistance, working full-time and receiving benefits, and still not able to make ends meet. Most people who can work want to work, but they have to be able to find employment that pays enough to cover costs like childcare, transportation as well as maintain housing. Often the employment that we are placing individuals in is not providing a wage that would enable them to sustain the other necessary supports that enable them to continue working. Even before families reach the childcare benefit cliff, many households experience a period of stagnation where, because of the loss of benefits as their wages increase, their overall financial picture does not improve even as their income is increasing. At the current minimum wage, families can work full-time and still struggle to afford safe and suitable housing, food, childcare, transportation, and other necessities.

It is recommended the commonwealth invest in programs and services that will address the whole person and invest in their long-term success and well-being. For too long, we have focused on addressing people as they present in that moment – both in health care and social services. But this ignores the causes and factors that contribute to a person's present situation. DHS and United Way are working on developing a proposal for a pilot program that will educate individuals about the benefits cliff, help develop a plan prior to reaching the cliff, and providing resources to help them through the cliff into financial self-sufficiency.

DHS also worked with consultants to develop a tool/calculator that calculates the value of after-tax income plus benefits toward meeting basic household needs across various household configurations. Developed using 'What-if' scenarios, the authors determine the point at which a household is able to achieve a break-even between gross income and core household expenses by adding the value of the following benefits to the after tax-income: Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Low Income Home Energy Assistance Program (LIHEAP), Child Care Works, Modified Adjusted Gross Income (MAGI) Medicaid, and the Children's Health Insurance Program (CHIP).

The analysis tool measures benefit composition dependent upon household demographics, such as number of adults and number of children in the household, and childcare needs to determine a benefits cliff. Even though household earnings increase, they often have not increased enough to allow families to cover existing expenses and expenses associated with the loss of benefits. Either stagnation or the benefit cliff may negatively impact a family's progression to financial stability in the absence of financial literacy or other supports. And, because eligibility criteria are

highly unique to household configuration, recipients need more coaching or case management to understand how stagnation and benefit cliffs impact their personal situation.

The IHRC is recommending implementation of a pilot program in collaboration with United Way to test the tool/calculator using an existing and trusted network of community agencies, employers, and individuals to ensure that it is effective and user-friendly. The goal is to for these agencies to provide feedback on the impact the tool has on the conversations, budget development, and planning process with their clients. Furthermore, case managers will use this tool to develop a timeline and expectations so recipients can anticipate the potential change in benefits as they move up their career pathway with increased income. With this plan, recipients will be able to anticipate the shift in benefits and develop a budget that avoids a negative impact of the increase in income, or the benefits cliff.

Drive Quality Improvement

Background: For this topic area, the IHRC focused on measuring essential physical health (PH), behavioral health (BH), opioid use disorder (OUD), Skilled Nursing Facility (SNF), and long-term care support service (LTSS) quality metrics across four agencies (Department of Aging, Department of Drug and Alcohol Programs (DDAP), DHS, and DOH). The populations served are Medical Assistance (HealthChoices and Community HealthChoices MCOs) enrollees, CHIP beneficiaries, dual eligibles (Medicare and Medicaid), older adults participating in Department of Aging programs (OPTIONS, PACE), individuals living with OUD, and the under or uninsured. Many of these quality metrics can be applied to commercial insurance and Medicare Advantage plans.

These metrics can be used to drive clinical quality improvement, assure access to care, develop incentive programs, and close equity gaps. They can also be used to assess value-based purchasing programs (VBP).

Many of the following recommendations include developing public dashboards for assessing these metrics at the state, regional, and manage care organization (MCO) level. Incentive programs can be developed to drive improvement. It is specifically recommended to develop an incentive program for SNFs, LTSS and integrated behavioral health services. It is also recommended to coordinate with the health information exchange to leverage the gathering of electronic quality measures. All quality metrics need to focus on identifying and eliminating potential health disparities.

Recommendation #1: Measure the Quality of Opioid Use Disorder Treatment and Prescribing Stewardship

The Council identified standardized quality metrics used at the national level to assess progress in opioid prescribing stewardship and access to treatment of opioid use disorder. Several metrics of opioid prescribing stewardship (measures 5-8 below in Table 1) are currently being used within DHS in the HealthChoices program, Aging's PACE program, and by the DOH's Prescription Drug Monitoring Program (PDMP). Many commercial carriers and Medicare Advantage plans also report these metrics. These metrics could be expanded to the Community HealthChoices (CHC) program. These quality measures could be evaluated at the county level via a dashboard using PDMP, Medicaid and PACE data to help improve opioid stewardship by working with providers and other stakeholders at the county level.

In addition, four metrics were identified (see Tables 1-4 below) to assess OUD treatment being used by the HealthChoices program, commercial carriers, and Medicare Advantage plans. The Medicaid quality outcome data could be stratified by county to help DDAP and their single county authorities (SCAs) assess the access and duration of OUD care within their counties. Additional non-Medicaid data may be available to supplement the Medicaid data.

An annual dashboard of these metrics can be developed for reporting by organizations that include: HealthChoices, Community Health Choices, Medicare Advantage plans, and commercial insurance plans.

Table 1

Opioid Use Disorder Measures
1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
2. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
3. Use of Pharmacotherapy for Opioid Use Disorder
4. Pharmacotherapy Duration for Opioid Use Disorder
5. Use of Opioids from Multiple Prescribers
6. Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
7. Concurrent Use of Opioids and Benzodiazepines (COB-AD)
8. Risk of Continued Opioid Use

Recommendation #2: Measure the Quality of Care in Long-Term Services and Supports and Skilled Nursing Facilities (SNFs) and Develop a Quality Improvement Incentive for Community Health Choices Managed Care Organizations and SNFs.

Four standardized LTSS quality metrics, the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience survey, and the Health Plan CAHPS patient experience survey are used at the national level to assess the quality of services within the Community HealthChoices (CHC) and Aging programs (Table 2). The Council recommends adding two waiver

assurance measures to assess network adequacy and missed shifts for personal care services. An annual dashboard can be developed to report these metrics statewide by CHC MCO and by CHC region. A CHC MCO incentive program could be developed using these measures to reward benchmark and incremental year-to-year performance. The incentives paid to MCOs can be based on statewide benchmarks and year to year incremental improvement for performance in CY 2021 versus CY 2022. Incentive payments would occur in FY 2023-2024.

Table 2

LTSS MCO Measures
1. LTSS Assessment/Update
2. LTSS Care Plan/Update
3. LTSS Shared Care Plan w PCP
4. LTSS Reassessment/Update after inpatient stay
5. LTSS CAHPS Health Plan survey
6. LTSS CAHPS HCBS survey
7. Waiver assurances (missed shifts and network adequacy)

Eleven standardized quality metrics were identified to assess the quality of care within skilled nursing facilities (Table 3). Most of these metrics obtained from the Minimal Data Set (MDS) are already collected annually by DHS and DOH for each licensed skilled nursing facility. A dashboard can be developed to publicly report these metrics at the state and facility level, compared to national benchmarks. Three-year trended data could be published for 2016-2019. DHS and DOH could develop a quality improvement incentive program at the CHC MCO level as well as the facility level based on these metrics. The incentives paid to facilities and MCOs can be based on statewide benchmarks and year-to-year incremental improvement for performance in CY 2021 versus CY 2022. Incentive payments would occur in FY 23-24.

Table 3

Skilled Nursing Facilities Measures
1. Number of hospitalizations per 1,000 long-stay (LS) resident days
2. Outpatient emergency department visits per 1,000 LS resident days
3. Rate of successful return to home and community from a SNF (short-stay residents)
4. Percentage of LS residents who received an antipsychotic medication
5. High-risk residents with pressure ulcers
6. Percentage of LS residents experiencing one or more falls with major injury
7. Percentage of LS residents who needed and received a flu shot

8. Percentage of LS residents who needed and received a vaccine to prevent pneumonia	
9. Rate of successful return to home and community from a SNF (short-stay residents)	
10. Facility staffing ratios	
11. Nursing home resident satisfaction survey- Core Q or other	

Recommendation #3: Measure the Quality of Behavioral Health (BH) Care Services across Multiple Agencies; Develop a Behavioral Health-Physical Health Integrated Care Incentive Program in the Community HealthChoices Program

Description

Behavioral health measures have been identified that assure access to services and appropriate follow-up care especially after hospitalization or emergency department use. The Council recommends that specific attention be focused on the delivery of behavioral health services within skilled nursing facilities. The BH measures listed below also include the opioid metrics from the first recommendation. Many of these measures are being used by DHS to assess the quality of care in the physical and behavioral health HealthChoices program.

The IHRC recommends developing these metrics using available Medicare data within the DHS Community HealthChoices and Aging programs. It is further recommended that a dashboard of these metrics be developed to reflect statewide, regional, MCO and primary behavioral health contractor performance. Currently, the HealthChoices program has an Integrated Care Program that incentivizes the BH contractors and PH MCOs to collaborate and improve care. A similar integrated care program can be developed to incentivize the BH primary contractors to work with the Community HealthChoices MCOs. This incentive program could be implemented with measurement in CY 22 versus CY 23 and payment in FY 24-25. Many commercial health insurance and Medicare Advantage plans report many of these metrics.[xxii] A statewide report card of these metrics can be developed by collating these results by health plan.

Finally, the Behavioral HealthChoices program is adopting a new "Transitions to Community Program." This model seeks to standardize quality measures that link inpatient and outpatient mental health and substance use disorder treatment across primary contractors and behavioral health MCOs. It is recommended that DDAP and DHS align these quality measures where feasible, such that providers have similar incentives across agencies.

Table 4

Behavioral Health

1. Follow-Up After Hospitalization for Mental Illness: Ages 6-17
2. Follow-Up After Hospitalization for Mental Illness: Ages 18 and older
3. Follow-Up After Emergency Department Visit for Mental Illness
4. Adherence to Antipsychotics for Individuals with Schizophrenia
5. Behavioral Health Services in Skilled Nursing Facility
6. Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
7. Initiation and Engagement of Alcohol and Other Drug Dependent Treatment
8. Use of Opioids from Multiple Prescribers
9. Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
10. Concurrent Use of Opioids and Benzodiazepines (COB-AD)
11. Use of Pharmacotherapy for Opioid Use Disorder
12. Pharmacotherapy Duration for Opioid Use Disorder

Recommendation #4: Measure the Quality of Physical Health Care Services across Multiple Agencies

Physical health measures have been identified that assure access to high quality services for children, adults, and pregnant women. These metrics also look at the quality of care associated with highly prevalent chronic conditions (asthma, diabetes, hypertension). These metrics are currently being used in the HealthChoices MCO and provider incentive programs. Many of the pediatric metrics will soon be used to incentivize improvement in the CHIP program. With the use of Medicare data, similar quality measures for adults can be used to assess quality of care in the Community HealthChoices and Aging programs. Many commercial health insurance and Medicare Advantage plans report these metrics publically.[xxiii] It is recommended that a statewide report card of these metrics be developed by collating these results by service line health plan.

Table 5

Physical health
1. Prenatal and Postpartum Care Rate: Timeliness of Prenatal Care
2. Prenatal and Postpartum Care Rate: Postpartum Care
3. Well-child Visits ages 0-20
4. Developmental Screening in the First 3 Years of Life
5. Lead Screening in Children

6.	Plan All-Cause Readmission
7.	Asthma Medication Ratio: Ages 5 to 18, 19-64
8.	Controlling High Blood Pressure
9.	Comprehensive Diabetes Care: HbA1c Poorly Controlled
10.	Breast Cancer Screening

Recommendation #5: Maintain access to telehealth

The unprecedented pandemic has significantly improved access to telehealth and telehealth visits have risen sharply starting in March 2020.[xxiv] This was particularly important because COVID-19 made in-person visits risky for both staff and patients. Over the course of the pandemic, telehealth has become a vital means of service delivery and health care consumers have mostly appreciated being able to access health care services from the comfort of their own home. Even after the public health emergency period is over, it is recommended that the Commonwealth seek to maintain access to telehealth for all Pennsylvanians. To accomplish this, it is also recommended that the Commonwealth pursue policies that also reduce inequities that create limited access to the internet or devices such as smartphones, tablets, or computers.

Align Value-Based Purchasing

Background:

The Commonwealth is attempting to change the financing of our health care system from a fee-for-service model, which pays according to the volume of medical services provided, to a more value-based approach. Paying for value means that providers are rewarded for delivering high quality care and reducing total cost. Because our health care system is fractionated into multiple payors, alignment behind unified value based purchasing (VBP) models is important to drive quality outcomes. In fact, national guidelines of VBP recommend multi-payer alignment as a key way to influence provider's behavior and improve the quality of care delivered.[xxv] As such, alignment behind a value-based approach and in certain value-based models is important across state agencies.

Recommendation #1: Align VBP terminology across Commonwealth programs

Alignment of certain terminology is important for a consistent, statewide approach to oversight of VBP. DHS has developed definitions for VBP payment arrangements, payment strategies, and models. Payment strategies include performance-based contracting, shared savings, shared risk,

bundled payments, and global payments. Alignment across these definitions makes it easier to also align VBP arrangements across multiple payors, such that providers can focus on key population health metrics.

Recommendation #2: Coordinate VBP reporting by payors to agencies

Information regarding each VBP arrangement is collected in different ways by different agencies. The Pennsylvania Insurance Department (PID) and DOH collect information involving components of commercial insurers' VBP arrangements. DHS collects information regarding each VBP arrangement separately through the Office of Medical Assistance Programs and the Office of Mental Health and Substance Abuse Services. It is recommended that these reporting templates be coordinated, such that relevant and systematized information is being requested of payors across state agencies. This would streamline the information that is collected, reducing the reporting burden on payors, while simultaneously allowing for comparison of VBP arrangements across lines of business.

Recommendation #3: Extend VBP Requirements from Medicaid into the Commercial Insurance Market

DHS currently sets flexible VBP spending targets for MCOs participating in the Medical Assistance Program and other requirements in VBP. For example, 50% of the Physical Health MCOs' medical spend must be linked to value, and a certain percentage of moderate and high risk VBP arrangements must incorporate a Community Based Organization to mitigate the SDOH barriers of Medicaid enrollees. Language was added to the current Physical Health MCO procurement that requires applicants to describe how VBP targets will be extended to all affiliated lines of fully-insured business operating in Pennsylvania. There is the opportunity to promote VBP targets across all lines of business, thereby increasing the amount of payments in our health care system linked to value, creating multi-payer alignment where applicable, and addressing the social needs of Pennsylvanians outside of Medicaid.

A starting place in aligning VBP models could be the new maternity care bundled payment model that DHS is rolling out in 2021. This maternity care bundled payment model is an innovative VBP model to improve the quality of maternity care and reduce costs. The bundled payment includes prenatal, delivery, and up to 60 days of newborn and postpartum services. If the maternity care team reduces costs relative to a pre-set benchmark, a pool of shared savings is created. The relative amount of shared savings received by the maternity care team depends on their performance on quality measures, including:

- Initiation of alcohol and other drug use or dependence treatment
- Timeliness of prenatal care
- Postpartum care
- Prenatal depression screening and follow up
- Postpartum depression screening and follow up
- Prenatal immunization status
- Receiving the appropriate number of well-child visits
- SDOH screening

In addition, providers will be measured on their performance in reaching national benchmarks in order to reduce pregnancy related mortality, especially among populations with a disparate rate of pregnancy related deaths.

This maternity care model was based on recommendations from the Pennsylvania Perinatal Quality Collaborative (PA PQC), which included participation from Medical Assistance MCOs, commercial insurers, regional business groups on health, and maternity care providers. PID will work with the commercial insurers to understand the delta between the commercials' bundle and the DHS bundle and work towards adoption of the elements that would promote aligned incentives and reduce administrative burden. PEBTF is requiring contracted insurers to adopt this value-based payment arrangement.

Recommendation #4: Explore a Global Budgets Model with Health Systems, Payors, and the Federal Government

The Pennsylvania Rural Health Model has recruited 17 hospitals for participation in a global budget model. This model has been run as a collaboration between the Centers for Medicare and Medicaid Services (CMS) and DOH. With the enactment of Act 2019-108, the Rural Health Redesign Center Authority was created to administer global budget methodology for rural hospitals.

Similarly, DHS applied for and was awarded technical assistance from CMS (called the "Innovation Accelerator Program") to explore a more urban and suburban global budget program. This suburban and urban model would have some key differences from the Pennsylvania Rural Health Model, in that it is focused on health systems and not hospitals, it attributes patients to health systems through their primary care providers, and part of the intent is to bend the cost curve and lead to savings for the state. This simulation was calculated for Medical Assistance only, and excluded fee-for-service payments (thereby not affecting the hospital assessment payments to hospitals). On average, the simulation found that for the base case, global budgeting would lead to savings of approximately $7 million annually, with potential savings as high as $20 million annually. The majority of health systems would benefit financially as well under a global budget system as they begin to transform care. Because this analysis was

done only in the Medical Assistance program, it did not include payments through Medicare or other commercial insurers.

The Council recommends that DHS, DOH, and the Rural Health Redesign Center Authority (RHRCA) explore a global budgets model with the Center for Medicare and Medicaid Innovation, payors, and providers that would extend to urban and suburban settings. If there are barriers to a statewide model, a more limited global budget pilot program could be pursued in Medical Assistance alone. This proposal could truly transform the way that care is delivered, and is particularly strategic because many of the health systems in urban and suburban settings are better positioned to switch from predominantly fee-for-service payments to a global budget model, because these hospitals are generally larger, and have more personnel and data infrastructure to manage the population that they serve. In turn, a global budget model would incentivize the provision of better care and improve health outcomes for Pennsylvanians statewide, and foster innovation approaches to addressing health equity and social determinants of health. COVID-19 has been a jarring reminder of how important funding stability is to hospitals—and how health systems could truly transform to improve the value of care provided.

Recommendation #5: Ensure Access to Data/ Information to Allow Providers to Assume Risk and Manage Population Health in Moderate or High Risk VBP Arrangements

Moderate or high risk VBP arrangements, such as shared savings, shared risk, bundled payments, and global payments, involve the total cost of care and transfer some of the risk that insurers normally carry onto providers. In order to provide high-quality, efficient care to their patients, providers need timely and actionable data, not all of which may come from their own electronic medical records. Combining clinical data and claims provides a more complete picture of the care that patients are receiving both inside and outside a health system.

As such, it is very important that providers are able to regularly obtain up-to-date, standardized, claims data from all payors. It is recommended that DHS, PID, or the newly established health value commission engage with payors and providers to better understand the core areas where timely and actionable data-sharing is necessary to best improve population health.

Leverage State Purchasing Power to Achieve Savings

Background: Leveraging state purchasing power can be an effective way to achieve new savings in health care. For example, Chapter 7 (relating to prudent pharmaceutical purchasing) of the State Lottery Law enables the Pharmaceutical Assistance for the Elderly (PACE) Program to collect rebates for drugs dispensed to PACE and Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET) beneficiaries. The rebate calculation is comparable

to the rebates collected by the Medical Assistance Program. It is estimated that the PACE Program collects 45% of the total drug spend in rebates. This rebate return far exceeds the rebates collected by private pharmacy benefit managers. Over the years, the statute has been amended to include not only the PACE and PACENET Programs, but the General Assistance Program in DHS, and Special Pharmaceutical Benefits Program and End Stage Renal Dialysis Programs in DOH. There are opportunities for other state taxpayer funded pharmacy programs to realize savings through inclusion in the drug rebate program.

Aligning state purchasing power to achieve savings in durable medical equipment (DME) is another option. DME is defined as, "an item or device listed in the fee schedule that can withstand repeated use; which are used primarily and customarily to serve a medical purpose; which are customarily not useful to a person in the absence of illness or injury and which are appropriate for home use".[xxvi] Examples of DME include canes, crutches, blood sugar monitors and test strips, walkers, wheelchairs and scooters, and patient lifts.[xxvii] DME is covered by most insurance, including Medicare and Medicaid, and more than $54 billion was spent across the United States in 2017 on DME alone.[xxviii]

The IHRC evaluated ways in which pharmaceutical and DME costs to the Commonwealth can potentially be reduced, without sacrificing quality or quantity.

Recommendation #1: Amend State-Funded Pharmacy Program Drug Rebates Statutes

It is recommended that the State Lottery Law be amended to require drug manufacturers to enter into and have in effect a drug rebate agreement with the Commonwealth in exchange for coverage of the drug by the state taxpayer-funded pharmacy programs. Proposed additional state-funded pharmacy programs include the Department of Corrections, Pennsylvania State Police, the General Assembly, Workers' Compensation, Intermediate Care Facilities for Persons with Intellectual Disabilities, Youth and Juvenile Detention facilities, the Children's Health Insurance Program (CHIP), and Department of Military and Veterans Affairs (DMVA) nursing facilities. Pharmacy programs that qualify for the Federal Drug Rebate Program, like the Medical Assistance Program or that qualify for 340B pricing would be exempt from the state-funded drug rebate.

Currently, each state taxpayer funded pharmacy program is administered differently by the individual agencies. The only requirement to support expansion of the drug rebate is for each program to send paid drug claims to a designated rebate program administrator. The administrator will then invoice drug manufacturers for the rebates on a calendar quarter basis and reconcile the collected rebates back to each program.

Recommendation #2: Compile and Analyze Pharmacy Data within State Agencies that Purchase Pharmaceuticals

One of the more common health care services provided by multiple Commonwealth agencies is prescription drugs. Based upon a preliminary survey, the compilation of prescription drug data across agencies will allow us to look at utilization and cost variations of the drugs between agencies. To the extent permitted by law, it is recommended that agencies enter into a data sharing agreement regarding pharmacy data. Compiling the data across the agencies will help inform what specific prescription drugs the Commonwealth may leverage to negotiate a lower price. In addition, the Commonwealth would better demonstrate efficiencies in drug purchasing and ability to control the cost of pharmacy drugs within and across agencies. Based upon current work being done, the PACE program can contribute immediately analysis of the aggregate prescription data across multiple agencies and prescription benefits.

Recommendation #3: Move towards a Single Purchase Provider and Major Retailers to Achieve Savings

The DOH and the Department of Aging would benefit from the use of a single or handful of key purchase provider(s) of DME and medical devices for programs administered by the Commonwealth. The use of a single purchase provider, or the utilization of a Request For Information (RFI) to determine a few providers, who can provide DME and medical devices at cost or below the Medicaid reimbursement rate, would both provide savings to the Commonwealth and foster direct purchasing relationships with providers with purchasing power to ensure continuous availability of products to consumers. This recommendation could be piloted with one or two of the most commonly requested DME, such as Personal Emergency Response Systems (PERS) or incontinence products.

Furthermore, the DOH and the Department of Aging would like to examine the option of using a major retailer to obtain DME at the lowest possible price. Often, staff in these departments find that DME is more accessible and at a lower price to consumers who visit large retailers. Allowing the Commonwealth and its program providers to utilize large retailers to purchase products of the same quality as traditional DME providers, but perhaps at a lower cost, would provide a cost savings. It is important to note that while Aging does permit direct reimbursement to the consumer, DHS does not, and only reimburses providers; however, if a provider is able to purchase DME products at large retailers, they would be eligible for a reimbursement. This recommendation could be piloted with one or two of the most commonly requested DME, such as Personal Emergency Response Systems (PERS) or incontinence products.

Recommendation #4: Create Consistency in the DME Review and Approval Process across State Agencies

The Council recommends aligning and expanding the process used by DHS to review DME and medical devices coverage approval and pricing, including measures to contain costs for basic and specialized DME and medical device requests across other state agencies. The alignment and expansion of this process could ultimately be referenced by other state programs when evaluating their own DME approvals and costs. The goal of expanding this process is to make pricing and approvals consistent across all agencies which provide DME and medical devices.

Recommendation #5: Pursue DME Rebates

It is recommended that Aging, DOC, and county jails, explore the opportunity to enter into agreements with DME manufacturers to receive rebates for DME purchases. In a study produced by the U.S. Department of Health and Human Services' Office of Inspector General, it was found that states can have significant cost savings when rebate agreements are established with DME manufacturers. In a prior Office of Inspector General report, it was found that Indiana and New York State Medicaid agencies had a combined savings of almost $18 million by utilizing rebates for a single DME product (diabetic test strips).[xxix]

Streamline Access to Medical Assistance to Reduce Recidivism

Background: In 2015, the Wolf Administration, spurred on by the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services and advocates, sought to develop a means to suspend, as opposed to terminating, the Medical Assistance benefits for recipients that become incarcerated. The Department of Human Services (DHS) also sought to develop a solution which supported Medical Assistance enrollment for eligible individuals who were not enrolled in Medical Assistance prior to incarceration to ensure services were available upon release. The administration's hope for this initiative is that it would improve the process of returning citizens' ability to receive necessary physical and behavioral health medical services and in-turn, reduce rates of recidivism.

This process was codified by Act 76 of 2016 which required the temporary suspension of benefits during incarceration. In 2017, a process to shorten the application and expedite the processing time for Medicaid benefits for individuals being released was developed. In 2018, the automated suspension and reopening of Medicaid benefits was completed through an agreement between DHS and DOC with support from the Office of Administration.

Currently, 70% to 75% of all inmates released from DOC facilities have their Medical Assistance benefits reinstated on the day they leave a correctional institution. Through the suspension process, DHS has increased average monthly savings in the Medical Assistance program and decreased case errors. The value of this process can still be expanded further to additional state agencies, counties and Medicaid recipients.

Recommendation #1: Increase State Savings by Billing Medicaid for Health Services upon Release of Inmates

Act 76 of 2016 and the ensuing process to automate suspension and opening/reopening of Medical Assistance benefits for citizens returning from state correctional institutions has enabled Medical Assistance benefits to be open for 75% of those individuals on the day they are released. Because date of their benefit opening coincides with the end of their institutionalization and freedom of movement, medical services and pharmaceuticals delivered to this population on that day may be billed to the Medical Assistance program.

In SFY 19-20, the DOC spent approximately $2.1M on release medications for inmates being released from DOC custody. These expenditures have been covered in the DOC budget through state appropriation. Through efforts between DOC and DHS, to bill Medicaid for the service provided to the 70% to 75% or greater number of inmates released with Medical Assistance, the majority of these expenditures can be shifted off of the Department of Corrections' state budget and onto the Department of Human Services' federally-matched Medical Assistance budget.

In addition to opportunity for cost savings by fully utilizing retuning citizens' Medical Assistance coverage, care coordination could be improved significantly by ensuring MCOs are aware of a participant's release from incarceration. The automation of suspension and reopening through DOC's partnership with DHS, as well as the shortened and expedited application process for individuals being released from county jails, has increased the universe of people which DHS is aware of that were recently released from incarceration. This population faces specific needs and risks when returning to society and their overall health and well-being would benefit from improved care coordination during this transition.

It is recommended that DHS make necessary system and agreement changes to ensure that its Physical, Behavioral, and Long-Term Care Managed Care Plans have information indicating which of their new Medical Assistance plan participants have recently been released from incarceration to improve care coordination.

Recommendation #2: Expand Automation of Medical Assistance Suspension and Opening

The partnership between DHS and DOC has proven to be successful in ensuring and maintaining Medical Assistance enrollment, reducing Medical Assistance case errors, and has potential to increase state savings. While the shortened and expedited application is available to serve county jail inmates, and DHS workers are manually able to suspend the benefits of individuals incarcerated in county jail, there are currently no counties that have agreements with DHS to utilize the automated system of suspending and opening/reopening benefits, despite the vast majority of the states' inmates being incarcerated in county jails.

Expansion of this service to county jails would constitute achieving the full benefit that the initiative offers. By reaching the broader population of inmates with efficient Medical Assistance enrollment, returning citizens will be more successful in their integration back into society, counties will save money in their jails by reducing health care costs and recidivism, Single County Drug and Alcohol Authority, and Mental Health Office budgets through the provision of medical services upon release and reduce recidivism, and the state will save money by reducing case errors.

Recommendation #3: Track the Health Care Utilization of Individuals Released from State Correctional Facilities

DOC has taken significant efforts to get inmates released from correctional facilities connected to health care resources. As provided above, DOC has worked with DHS to enroll individuals into Medical Assistance. DOC has also worked with the Department of Aging to enroll eligible individuals into the PACE program. With the ability to share data across the agencies, we can track the health care utilization and outcomes of recently released inmates. We can answer questions about whether inmates with behavioral health diagnoses are accessing necessary behavioral health services or if inmates with substance use disorder are getting ongoing treatment. Overall, the sharing of data between agencies can help demonstrate how improved coordination of the agencies may be assisting in recidivism. This can be done by comparing the rate of recidivism for those who received continuing health care (through Medical Assistance or PACE) to those inmates who were released who did not receive ongoing health care services. Data can also be used to help support inmates who have complex medical needs and will be released in the near future. Through the sharing of data between agencies, there can be better preparation for supporting the unique needs of these medically complex inmates upon their release.

Leverage Data Sharing and Health Information Exchange

Background:
The Health Care Reform Council Executive Order (Number 2020-05) calls for the potential alignment of Commonwealth health care payment and delivery systems to provide efficient,

whole-person health care that also contains costs, reduces disparities, and achieves better health outcomes for Pennsylvanians. The order, in Section 5(c), provides that: The Council member agencies may enter into agreements, as permitted by law, to integrate, review, and analyze existing Commonwealth data across agencies, including claims and encounter data, to support evidence-based decision making. In order to determine the potential to use data for this work, it is necessary to understand what data each agency has with respect to the delivery of health care. Once there is an understanding of the data that exists across the applicable agencies there will be discussions about how it can be used across the different agencies. The data can be used to help answer questions about the costs, outcomes, and utilization of health care services that fall under the Governor's jurisdiction. Data sharing across agencies, as legally permissible, can help identify opportunities as well as evaluate any new initiatives that are adopted by the Interagency Health Reform Council.

The Pennsylvania eHealth Partnership Program, established in DHS, operates the Pennsylvania Patient and Provider Network (P3N), a federated statewide health information exchange that allows providers connected to any of our five P3N Certified Health Information Exchange Health Information Organizations (HIOs) and DOC to instantaneously retrieve electronic clinical information about their patients from any other P3N participating providers. The P3N also pushes patient encounter information to the patient's home HIO when they are accessing health services outside of their home HIO. These P3N services arm health care providers and care coordinators with complete and actionable information to provide quality care to their patients.

DHS also works collaboratively with DOH to allow P3N participating providers to streamline their public health reporting and information retrieval requirements through their HIO and the state's Public Health Gateway (PHG). For example, more than 40 hospital labs are electronically reporting COVID-19 lab test results to DOH through the PHG.

DHS has used federal HITECH funding to make it easier for providers to onboard to HIOs and has used managed care contracts to require Medicaid payors to join HIOs. DHS has also used payment incentives to encourage hospitals and patient-centered medical homes to join HIOs. However, we have not reached our goal of ubiquitous provider and payor participation in robust health information exchange in Pennsylvania and the P3N does not share patient information with surrounding states when patients seek care across state lines, so there is still work to do.

Recommendation #1: Determine a Solution for Data Sharing Between Agencies

The Governor's Office of Administration (OA-OIT) has an established internal interagency data sharing and data governance process to facilitate the storage of data across multiple agencies to answer high level Commonwealth business questions through data sharing agreements among the participating agencies. This infrastructure provides a secure environment where data from

multiple agencies can be used for data analyses. The environment incorporates the most restrictive security, logging, auditing, and backup needs of regulated data types brought into the data sharing platform. Access to the environment is strictly managed and provided only to approved and authorized Commonwealth staff. The infrastructure also includes data governance processes for transferring data to the secure system and for removing the data at the conclusion of the engagement.   To ensure compliance with federal and state confidentiality and privacy laws, agency legal counsel will review initiatives and determine whether there is a possibility for a multi-agency data sharing agreement to be negotiated and executed. Data entered into the system is project specific and only those data elements needed to answer the applicable questions will be shared into the system. This centralized infrastructure and process will create an efficient means to compile and analyze data in a secure manner.

Recommendation #2: Increase Provider Participation Requirements and Incentives

The Council recommends increasing (Health Information Exchange) HIE participation through regulation or contractual arrangements, i.e. grants or cooperative agreements, that would require certain types of providers to participate with P3N HIOs or create additional incentives for participation. Provider participation with P3N Certified HIOs is voluntary in the Commonwealth. While we have made great advances in getting hospitals to join P3N HIOs, some general acute care hospitals and many specialty hospitals are not connected to P3N HIOs. Additionally, less than a third of nursing facilities are connected to P3N HIOs. Pennsylvania access to federal HITECH funds to underwrite HIO Onboarding Grants ends September 30, 2021. After several years of offering incentives and onboarding grants, it is recommended that DHS examine requiring key health care provider participation with P3N HIOs.

While statutory and regulatory authority may be utilized to require hospital and nursing facility participation, there is more work to be done to enable utilization by drug and alcohol (D&A) providers. Federal and state substance use confidentiality laws are more stringent than the federal Health Insurance Portability and Accountability Act (HIPAA). It would be helpful to explore how D&A providers could utilize HIE while remaining compliant with federal and state confidentiality laws. In addition, D&A providers who are not connected with a hospital may face additional barriers, such as technological barriers. It is important to communicate the benefits and uses of participating in HIE, including benefits to providers who do not have electronic medical records.

State confidentiality laws related to mental health treatment records (Act 148 of 1976) are also more stringent than HIPAA. Amendments to Act 148, in line with the changes in HIV-related information in Act 59 of 2011 and recent changes to 42 CFR Part 2, are needed to facilitate better coordination of care for BH patients.

Lastly, it is recommended that the above recommendations be coupled with a communications campaign to expand public and provider HIE awareness activities focused on why providers should participate with P3N HIOs and why consumers should seek participating providers. It would be important to develop simple, consistent and coordinated core messaging to be used by agencies. The key message across both providers and patients is that it is good to have health information shared to improve care, wellbeing, and effectiveness.

The Council also recommends that the Commonwealth invest in a grassroots provider campaign, which focuses on existing relationships with provider groups and associations to be sure providers are aware of the robust health information exchange that we have in Pennsylvania.

The Council recommends the provider campaign be paired with a patient campaign, focusing on helping patients understand that health information exchange is critical to their health, that we have robust health information exchange in Pennsylvania, and they should seek out providers who participate in P3N HIOs (or encourage their providers to participate in P3N HIOs).

Recommendation #3: Integrate Health Information Exchange with MMIS

The Council recommends that the Commonwealth prioritize the replacement of the P3N infrastructure procurement and its integration with the DHS Medicaid Management Information System (MMIS). Act 76 of 2016 requires DHS to host an interoperability platform for Pennsylvania. The Pennsylvania eHealth (Pa eHealth) Partnership Program, under the leadership of the Department of Human Services (DHS) Office of Medical Assistance Programs (OMAP), is replacing the legacy Pennsylvania Patient & Provider Network (P3N) with a new and improved system. The legacy P3N system is hosted by IBM Watson Health and the contract with DHS is nearing its expiration date. IBM has decided it will no longer participate in providing the Health Information Exchange (HIE) services. This new, improved P3N system will reuse all the data and current business processes from the legacy system and will be tightly integrated with the MMIS 2020 Platform services and processes.

In order to implement a replacement P3N system by April 2022, it is recommended that a new P3N procurement be released. The Commonwealth's current IBM P3N contract was for five years with up to five one-year renewals (option-years). We are in Option-Year 3 with the IBM P3N Contract (May 1, 2020 to April 30, 2021). The RFP requires CMS approval prior to posting. CMS approved our request to integrate the new P3N infrastructure into MMIS2020 and we will enjoy a 90 percent federal match for the first year and 75 percent federal match for ongoing operating costs. The current IBM P3N contract has no federal match. CMS must approve the P3N procurement before it can be released for bid.

Recommendation #4: Expand the P3N Alerting Service across States

The Council recommends that the commonwealth enable the sharing of alerts with neighboring states when patients seek care across state lines. In order to provide greater opportunities for care coordination for patients who seek care outside of their home state and for the mutual benefit of the members of P3N HIOs and the members of out-of-state health information exchanges (HIEs) that share patients with Pennsylvania, it is recommended that DHS work with the P3N Health Information Exchange Trust Community Committee (HIETCC) to expand the P3N Admission Discharge Transfer (ADT) Service to out-of-state HIEs that share patients with Pennsylvania.

The Chesapeake Regional Information System for our Patients (CRISP), The Delaware Health Information Network (DHIN), and West Virginia's Health Information Exchange (WVHIN) are in active discussions with PA eHealth to participate in the P3N ADT Service. CRISP has proposed a simple Health Information Exchange Agreement and an Exchange of ADT Feeds Use Case Addendum for our consideration.

The current IBM P3N infrastructure will allow for the onboarding of neighboring state HIEs to the P3N ADT Service and can accommodate the interstate routing of ADT messages based on the patient's state of residence identified in the ADT message. However, the current P3N infrastructure does not allow individual P3N Certified HIOs to opt-out of the interstate sharing of ADT messages if another state's HIE is participating in the P3N ADT Service. This creates an all or none acceptance of the Interstate Expansion of the P3N ADT Service by the P3N HIOs.

Conclusion

The Council's recommendations highlight the potential alignment of Commonwealth health care payment and delivery systems to provide efficient, whole-person health care that also contains costs, reduces disparities, and achieves better health outcomes for Pennsylvanians.

As the recommendations are broad and far-reaching, the Council recommends that next actions include drafting a timeline over which the recommendations can be achieved and narrows in on the recommendations that can be achieved in the short-term while investing in long-term strategies to secure the remaining recommendations. Further, the timeline will account for partnering with the legislature on the recommendations with require statutory authority for successful implementation.

The Council will continue to convene to facilitate accountability of the short-term recommendations, while perpetually crafting the Wolf Administration's legacy of reforming health care.

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