The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

September 28, 2020

TO: Members of the Pennsylvania House Health Committee

FROM: Stephanie Watkins, Vice President, State Legislative Advocacy

SUBJECT: Oppose House Bill 2476

The Hospital and Healthsystem Association of Pennsylvania (HAP), on behalf of its members—more than 240 acute and specialty hospitals and health systems—appreciates the opportunity to provide comments on the proposed legislation directing the Commonwealth of Pennsylvania to create hospital and Medicaid managed care organization (MCO) outcome programs, House Bill 2476.

HAP opposes the bill and urges a no vote.

While moving towards value-based reimbursement models is certainly a laudable goal, HAP believes that the legislation is duplicative and, if implemented, will undermine the financial viability of hospitals for the following reasons:

- **The programs established by the bill are duplicative.** Pennsylvania's Medicaid program includes an overlapping array of contract incentives, requirements, and programs designed specifically to reduce avoidable admissions, unnecessary readmissions and other improper payments. For example:
    - HealthChoices has implemented a value-based purchasing program over the past several years, which requires approximately 50 percent of Medicaid spent to be delivered through value-based contracts that discourage inappropriate admissions and reward outcomes in 2020 (increasing to 70 percent in 2021)
    - HealthChoices includes an MCO pay-for-performance program that rewards (or sanctions) MCOs relating to their performance in selected outcome measures
    - The Medicaid MCO rate setting process—through the use of "efficiency adjustments"—calibrates payments downward to account for inappropriate readmissions
    - The Department of Human Services (DHS) has implemented a Hospital Quality Improvement Program which is designed to target and incent hospital improvement in addressing avoidable admissions
    - Federal law and DHS policy already precludes payment for health care acquired conditions, and Medicaid policy precludes payment for hospital readmissions within 30 days. MCOs establish utilization review protocols to ensure compliance
    - Hospitals are already subject to the federal Hospital Readmission Reduction Program, which penalizes hospitals for unnecessary readmissions

- **The legislation is likely inconsistent with federal law and the program design is impractical.** The Medicaid managed care rate setting process is governed by federal law that requires state Medicaid programs and their actuaries to establish "actuarially sound rates" developed using generally accepted actuarial principles and practices. Rates must also be approved on a yearly basis by the Centers for Medicare and Medicaid Services (CMS). See 42 CFR Section 438.4. The attempt by this legislation to dictate Medicaid rate setting approaches (and reduce rates) in a way that is inconsistent with rate setting principles and federal law could jeopardize federal approval and lead to possible litigation.

  In addition, the program design and savings targets are impractical based on the timing of the managed care rate setting process. For example, while the legislation targets $40 million in savings for FY 2020–21 and $55 million in savings for FY 2021–22, DHS and the Medicaid MCOs are—after months of rate development work and negotiations—currently working to finalize proposed rates for the calendar year (CY) 2021 contract year. These negotiations must be finalized quickly, and contracts must be shepherded through the lengthy contract approval process in the very near future to ensure that payment rates are in place within a reasonable time period. As a result, it does not appear possible at this late date to revise the rate setting process to affect rate development for CY 2021 and, subsequently, meet the targeted savings for FY 2020–21 and FY 2021–22.

- **The legislation is designed to decrease Medicaid payments during a pandemic, which could further undermine the financial viability of the health care delivery system.** The goal of the legislation is to reduce Medicaid outlays, regardless of the range of safeguards and protections already in place. This goal is misguided, not only due to the fact that the Medicaid program only pays 81 percent of costs for inpatient admissions, but especially due to the fact that hospitals have suffered billions in losses due to COVID-19 (as demonstrated by a recent HAP commissioned study). As we move into the winter, losses will continue and many hospitals will struggle to maintain financially viable. Additional, not less, Medicaid funding is necessary to address the financial impact of COVID-19.

Finally, even if the legislation was necessary, appropriate, and consistent with federal law, establishing an appropriate methodology to reward or penalize both hospitals and MCOs is incredibly complex and should not be unilaterally imposed without additional discussion and deliberation. Performance based programs are notoriously complex, and must contain appropriate risk adjustment approaches to account for regional differences and other relevant factors. In addition, the massive disruption to hospital utilization caused by the COVID-19 pandemic would undermine year-to-year comparisons and must be carefully evaluated and addressed.

Please vote no on House Bill 2476.