The Hospital + Healthsystem Association of Pennsylvania

REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

December 10, 2020

The Honorable Tom Wolf
Office of the Governor
Commonwealth of Pennsylvania
225 Main Capitol Building
Harrisburg, PA 17120

Dear Governor Wolf:

We are writing on behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP) and the Rehabilitation and Community Providers Association (RCPA) to provide preliminary input with regard to the commonwealth's Whole-Person Health Reform Plan for Pennsylvania. We seek to provide recommendations to the Interagency Health Reform Council (IHRC), which has been tasked with exploring opportunities for efficiencies, utilizing data across agencies, and aligning value-based purchasing programs. We understand that the council is required to develop recommendations by December 30, 2020.

These recommendations are derived, in part, on the findings of the recent Joint State Government Commission (JSGC) report titled, "Behavioral Health Care System Capacity in Pennsylvania and its Impact on Hospital Emergency Departments and Patient Health." The report was the result of House Resolution 268 of 2019, which directed the JSGC to appoint an advisory committee to conduct an assessment of the commonwealth's current behavioral health needs and the impact that the behavioral health care system's capacity has on hospital emergency departments and patient health.

The advisory committee consisted of experts across the spectrum of behavioral health care and included physicians, public health authorities, behavioral health professionals, hospital administrators, and patient advocates. The report, in general, strongly validates that emergency department boarding is a serious problem for patients and hospitals, and that it results from underfunded and fragmented behavioral health and substance abuse treatment delivery systems.

Specifically, we offer the following recommendations that could reduce unnecessary costs, and improve overall health and care outcomes:

Telehealth—COVID-19 has accelerated the use of telehealth unlike any other recent event. This progress, specifically in increasing access and flexibility, should not be squandered. Telehealth will continue to be a vital means of service delivery, and one likely to be demanded by health care consumers. While we certainly expect that the health care delivery system will return to some type of new "normalcy", health care consumers likely will be less willing to engage in in-person care for services they were able to receive within the ease and safety of their own homes just weeks before.

Ensuring that we continue to provide an environment that allows both physical and behavioral health care practitioners to meet their patient' needs will require continuing many of the provisions that were created for the COVID-19 situation. Examples include allowing for telephonic visits in the event that a patient does not have the means to connect via video, paying for the service at the same rate that would be paid for a similar in-person visit, and continuing to allow for non-traditional telemedicine platforms.

We strongly urge the commonwealth to continue these policies following the COVID-19 crisis to address patient concerns and maintain access to care for both physical and behavioral health care services.

Behavioral Health Crisis Capacity—In the state's 2012–2013 budget, county-based mental health funding was cut by a full 10 percent. Further, there has not been an increase in this budget line item since 2009, and for many more years behavioral health funding has faced a pattern of chronic underfunding.

The lack of adequate mental health funding has led some counties to reallocate mental health dollars to other health and human service programs and hindered the delivery of quality community-based mental health services. The results of mental health budget cuts and the continued lack of any cost of living increases has impacted the system in many ways, but specifically in a reduction in crisis services. The mental health funding cuts continue to plague the commonwealth's mental health system and undercuts a state goal to serve Pennsylvania's vulnerable populations.

We understand that funding gravitates to where the crisis of the moment lies. During February 2020—just prior to the COVID-19 crisis—RCPA testified before the Pennsylvania House about this issue. **We ask that adequate funding be provided to ensure behavioral health crisis service capacity.**

Mental Health Parity—Parity laws and regulations have changed nationally and in Pennsylvania during the last several years. In theory, there is a realization that behavioral health services (mental health and drug and alcohol treatment) should be approached the same as with physical medical services. This includes benefit coverages, payment rates for like services, authorization practices (including managed care), and claims payment policies and procedures.

Yet despite this realization, differences and gaps continue to exist between physical and behavioral health, and across Medicaid and commercial coverage.

We have seen examples of this during the COVID-19 crisis where there was an immediate recognition of the significantly increased costs that medical facilities experienced, but less so with mental health and drug and alcohol facilities, which had the exact same needs and

increased costs without any like recognition of staffing shortages and personal protective equipment (e.g., increased sanitation, gloves, masks).

We ask that the commonwealth set forth an active process to systematically address this issue of "true parity." We need to collectively ensure that parity is not just in name and on paper, but in practice.

Post-Acute Treatment—Patients experience significant difficulties finding appropriate post-acute placements, which has severe negative consequences for patient care and financial implications for hospitals. These difficulties have become even more acute during the COVID-19 crisis. Prolonged and unnecessary hospital stays have a range of effects on patients, including increased dependency, loss of confidence in their ability to cope, depression, risk of infection, and other adverse consequences. Prolonged stays also make long-term institutionalization more likely. From a system perspective, delays in discharge negatively affect the efficient use of health care resources and cause other patients to wait longer for care elsewhere in the system.

HAP staff had been working collaboratively with the Pennsylvania Department of Human Services (DHS) to facilitate placements for patients who require behavioral health treatment and establish a process to allow hospitals to elevate problematic cases to DHS. This process will, in effect, ensure that contracted managed care organizations meet their obligation to ensure adequate provider networks and access to care for Medicaid consumers. As you can imagine, these discussions were hampered with the onset of COVID-19, but we are very interested in continuing work on this issue.

While this effort was initially focused on issues placing patients with behavioral health needs, delays also are caused by factors other than insufficient behavioral health capacity. In a 2016 survey, 65 of 70 Pennsylvania hospitals (93%) were unable to find timely placement for patients who required long-term care following an emergency department admission. Nearly 50 percent reported that treatment delays occurred more than ten times per year. Other hospitals report that insufficient funding for personal care homes is a contributing factor for low-income citizens who do not need nursing home or medical care. We are also aware that people with intellectual and developmental disabilities have also experienced difficulties finding placements after an emergency department admission or inpatient stay.

We strongly recommend the implementation of an escalation policy that would enable hospitals to engage counties, managed care organizations, and the department when a difficult placement situation is occurring in programs administered by the Office of Mental Health and Substance Abuse Services, the Office of Long-term Living, and the Office of Developmental Programs. We ask for your support in these efforts.

We also understand that DHS will add requirements to form five Regional Accountable Health Councils (RAHC) across the state into its agreements with physical health Medicaid managed

care organizations. RAHCs will be required to develop regional transformation plans to improve access and care delivery. We believe that the RAHCs could serve as a vehicle to implement recommendations made by the Interagency Health Reform Council, including the recommendations included in this letter. DHS could, for example, require the RAHCs to work collaboratively to develop regional plans that promote telehealth, behavioral health crisis capacity, mental health parity, and post-acute treatment.

Thank you for the opportunity to provide these recommendations. We would be happy to meet with you to discuss any of these suggestions further, and look forward to working with you and other members of the administration to successfully implement innovative health system reforms in Pennsylvania.

Sincerely,

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The Hospital and Healthsystem
Association of Pennsylvania

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c: Meg Snead, Secretary of Policy and Planning for the Office of Pennsylvania Governor Tom Wolf
Teresa Miller, Secretary of the Pennsylvania Department of Human Services
Dr. Rachel Levine, Secretary of Health for the Pennsylvania Department of Health
Jessica K. Altman, Commissioner of the Pennsylvania Insurance Department
John Wetzel, Secretary of Corrections for the Pennsylvania Department of Corrections
Robert Torres, Secretary of the Pennsylvania Department of Aging
Jennifer Smith, Secretary of the Pennsylvania Department of Drug and Alcohol Programs