The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

November 24, 2020

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

Dear Governor Wolf:

I am writing on behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, to provide preliminary input relating to the Governor's "Whole-Person Health Reform Initiative."

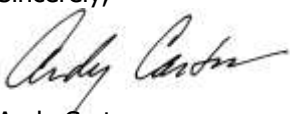
HAP in particular seeks to provide input to the Interagency Health Reform Council (IHRC) tasked with exploring opportunities for efficiencies, utilizing data across agencies, and aligning value-based programs. We understand that the Governor has directed the IHRC to develop recommendations by December 30.

We developed the attached document that includes specific policy recommendations relating to the following areas:

- Reducing the impact social determinants of health have on whole-person health
- Aligning measures among state, federal, and commercial payors
- Ensuring provider access to data/information to allow providers to assume risk and manage population health
- Determining and implementing opportunities to further integrate physical and behavioral health
- Partnering with providers, payors, and the Centers for Medicare & Medicaid Services (CMS) to identify funding to support the implementation of recommendations and reduce short-term risks
- Retaining innovations related to telehealth services and the workforce
- Reducing delays in post-acute placement
- Enhancing the health care workforce
- Addressing prior authorization obstacles and other troubling payor practices

We would be happy to meet with you to discuss any of these recommendations further, and look forward to working with you and other members of the administration as these health reforms are implemented in Pennsylvania.

Sincerely,



Andy Carter
President and Chief Executive Officer

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

HAP
Leading for Better Health

HAP Recommendations

The Wolf Administration's Whole-Person Health Reform Initiative

Background

In October, the Wolf Administration announced a new health care plan aimed at reducing the cost of health care and tackling health inequities resulting from systemic racism.

The plan has three main components. One of these components is the establishment of an Interagency Health Reform Council (IHRC) composed of agencies involved in health and the governor's office.

The IHRC is tasked with the responsibility to develop recommendations by December 30 to find efficiencies in the health care system by aligning programs where feasible, including aligning value-based purchasing (VBP) models, and using data across state agencies to promote evidence-based decisions.

HAP offers the following to the IHRC for possible inclusion in its recommendations report.

Recommendations

1) Reduce the impact social determinants of health have on whole-person health

The hospital community across Pennsylvania continues to focus on reducing health disparities within the communities they serve.

HAP's quality improvement initiatives include supporting the hospital community by sharing best practices in opioid care through our Learning Action Network (LAN). This two-year initiative convenes hospital clinicians on the frontlines dealing with the opioid epidemic and provides networking opportunities for sharing best practices and learning opportunities for improving opioid treatment.

For the past eight years, HAP has supported hospitals in quality improvement through the CMS Hospital Engagement Network and Hospital Improvement Innovation Network programs. Most recently, harm reduction efforts by participating hospitals have recognized an estimated 3,735 harm events avoided, a cost savings avoidance of $73,402,276, and an estimated 503 lives saved. The next evolution of that work, entitled the Hospital Quality Improvement Contract, is designed to support rural and critical access hospitals, as well as those hospitals that are challenged with serving vulnerable populations.

Act 52 calls for the Department of Health to provide annual reports for Healthcare-Associated Infections (HAIs) reported across the commonwealth. The most recent annual report available is the 2016 Healthcare-Associated Infection Report. Updating this report more often will assist the hospitals with valuable real-time benchmarking.

Another collaborative underway in Southeast Pennsylvania focuses on food insecurity and trauma informed care. These areas of focus were identified as common needs during the latest community health needs assessment. This initiative brings the hospital, public health, and community organizations together to maximize the efforts for achieving the greatest impact.

HAP encourages the commonwealth to seek opportunities to support local and regional initiatives across the commonwealth by engaging hospitals and other community organizations to address the social determinants of health impacting their community. HAP also recommends annual updates for the Healthcare-Associated Infection Report.

2) Align Measures and Value-Based Program Designs among State, Federal, and Commercial Payors

The shift towards value-based purchasing (VBP) is occurring in rapid fashion. Private and public payors alike are instituting VBP programs—each with a unique set of measurement characteristics. The proliferation of quality metrics and resulting administrative burden threatens to undermine the overall goal of providing efficient, high-quality care to the people of Pennsylvania.

For example, a provider that is contracted with four major commercial payors, Medicaid, and Medicare may be managing upwards of 150 measures, 20 of which may be related to diabetes care but each using different methodologies for measurement. This creates undue administrative burden to the provider and distracts them from focusing on what will actually create better outcomes at lower costs for the patients they serve.

Pennsylvania's Department of Human Services (DHS), which administers the state's physical health managed care program known as "HealthChoices," has established specific value-based contracting goals for participating managed care organizations. For the state to move forward in pursuing transformation in the health care delivery system in any meaningful way, it is critically important that DHS is actively engaged in the process to align measures.

HAP believes that there must be a coordinated effort in structuring aligned measures and design for multi-payor VBP programs. It is critical that we drive toward collaboration among payors to create a focused list of measures that promote positive outcomes and are not overly administratively burdensome.

As a first step in this effort, HAP recommends that the commonwealth develop a comprehensive inventory of measures utilized by payors within their value-based purchasing programs. This inventory, which can be updated over time, will help all parties identify the scope of the problem, identify common measures, and serve as a starting point for discussions relating to the development of a common data set. We also recommend that efforts be made to align with federal efforts related to measure consolidation.

HAP also is supportive of ongoing efforts to develop new value-based payment models.

As the commonwealth moves forward to promote these models, however, it should ensure that the models:

- Create opportunities for both providers and payors to share savings if benchmarks are achieved
- Are flexible and scalable to allow all providers to participate
- Reward improved performance as well as continued high performance
- Allow for a flexible, multi-year phase-in to recognize administrative complexities
- Financially reward, rather than penalize, providers who deliver high-quality care

3) Ensure Access to Data/Information to Allow Providers to Assume Risk and Manage Population Health

Access to data and information about the populations that our hospital and health system partners will be accountable for in these value-based programs is paramount. 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. The marriage of clinical data and claims provides a more complete picture of the care patients are receiving both inside and outside of a health system, as well as providing the pharmaceutical data.

Significant cultural challenges exist for both providers and payors to share information, which promotes resistance to sharing the necessary data to manage populations. Specifically, the risk of transparency for providers is the potential of losing their competitive edge if they are identified as a high-cost provider. The risk of transparency to the insurer is that providers will use this information to attempt to negotiate increased payment. However, access to the cost of care for patient populations is critical for both hospitals seeking success under risk-based contracts and for insurers to realize savings in the total cost of providing care.

There are several concrete steps that the commonwealth can take in order to promote the sharing of information between and among insurers and providers. The broadest solution would be to explore legislation that would require insurers to provide specific information to providers to allow them to effectively implement value-based payment arrangements.

Other less comprehensive solutions could include implementing stronger contract requirements in instances where the commonwealth is a payor. These programs include the Physical Health (PH)-HealthChoices, Behavioral Health (BH)-HealthChoices, Pennsylvania Employee Benefit Trust Fund (PEBTF), and Children's Health Insurance Program (CHIP). The contract requirements could specifically require insurers to share designated information in a specific format with providers to advance value-based payment objectives.

As the payment environment shifts to value, and then further to global budgets and capitated arrangements, payors and providers must commit to providing the appropriate level of actionable and timely information and data to manage populations.

We encourage the commonwealth to adopt a public-facing data analytics platform/data-processing software to give consumers access to analyzed (not just raw) data, researchers timely access to raw data, and clinicians access to the reporting necessary to manage their patients and monitor their performance. We also recommend thoughtful consideration of the 30 plus years of experience in data collection and reporting that has been accomplished by the Pennsylvania Health Care Cost Containment Council (PHC4) as the commonwealth moves forward with these efforts.

It also is important for the state to take steps to modernize the Pennsylvania-specific super-protected data regulations to align and be consistent with the existing Health Insurance Portability and Accountability Act (HIPAA).

4) Determine and Implement Opportunities to Further Integrate Clinical and Behavioral Health

Behavioral health issues have been featured prominently in the news, and in health care policy discussions at the local, state, and federal levels. Issues include emergency room boarding of patients due to the lack of inpatient beds, access to appropriate community-based services, the integration of behavioral health and physician health services, and high-end utilizers of hospital services.

The Affordable Care Act (ACA) provides a number of opportunities to provide mental health and drug and alcohol services to a population of individuals previously uninsured or under-insured. As the state and health care providers seek to improve the overall health of Pennsylvanians and reduce health care costs, there are a number of issues plaguing the behavioral health care system in Pennsylvania that need to be addressed. These issues include inadequate funding, the fragmented delivery system, access to care issues, and provider shortages.

Potential ways to alleviate some of these issues include leveraging telehealth/ telepsychiatry by supporting efforts to provide reimbursement and reducing regulatory and policy barriers to the services (including Pennsylvania-specific, super-protected data regulations which hinder providers' ability to care for the whole patient), ensuring enforcement of behavioral health parity legislation, and pursuing payment strategies and policies across CMS, DHS, and private payors that promote integrated behavioral and physical health care.

5) Partner with Providers, Payors, and CMS to Identify Funding to Support Implementation of Recommendations and Reduce Short-term Risks

Provider and payors are voluntarily willing to investigate and test value-based purchasing strategies. In some cases, these strategies require significant up-front financial investment in people and infrastructure, while at the same time putting core revenue streams at risk for certain providers. CMS has demonstrated a willingness to support up-front costs (and offset risk) of payment and delivery system reform through waivers, such as the Delivery System Reform Incentive Program (DSRIP).

If additional funding is not available for the implementation of the plan through the CMMI State Innovation Model program, the commonwealth should consider other funding opportunities to support providers and payors as it is implementing the plan.

6) Retain Innovations Developed During the COVID-19 Pandemic

In response to the COVID-19 pandemic, the commonwealth has waived several regulations and provided other administrative flexibilities that should be continued and maintained following the lapse of the Governor's disaster declaration.

Telemedicine Advancements: COVID-19 has dramatically accelerated the use of telemedicine. This progress should not be squandered. Telemedicine will continue to be a vital means of service delivery, one that is likely to be demanded by the consumers of health care. While we certainly expect that the health care delivery system will return to some type of new normalcy, our patients will likely be less willing to engage in in-person care for services they were able to receive with the convenience and within the safety of their own homes just weeks before.

Ensuring that we continue to provide an environment that allows health care practitioners to meet their patient's 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 inperson 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.

Workforce Flexibilities: As hospitals worked around the clock to prepare for and respond to the COVID-19 outbreak, significant regulatory flexibilities were provided to the hospital community with regard to the utilization of their health care workforce. As these flexibilities were put into place, our members found that some of their new flexibilities and innovations provided for a better patient experience and better patient outcomes.

These flexibilities allowed health care practitioners to practice at the top of their licenses. Continuing to permit provider enrollment flexibilities to streamline participation and reimbursement, allowing for less stringent supervisory requirements among practitioners, and permitting ongoing expanded scope of practice for advance practice providers was extremely valuable and led to more creative ways to address workforce shortages.

HAP strongly urges the commonwealth to continue these policies following the COVID-19 crisis to address patient concerns and maintain access to care.

7) Strengthen the Commonwealth's Health Care Workforce

HAP released a workforce report entitled "Addressing Pennsylvania's Health Care Workforce Challenges." This report is the culmination of a year-long process by HAP's Health Care Talent Task Force that guided the development of strategies to support HAP's goal in assisting members to enhance their health care team talent pool and transform their health care workforce.

With the onset of the COVID-19 pandemic, developing a strong, robust and diverse health care workforce has become more important than ever. While many of the recommendations included in our report require legislative action, many others can be implemented by action of the administration. Specifically, the report recommends that Pennsylvania:

- Devote resources to ensure that licensure and other practice applications processed by the Department of State's licensing boards can be completed in a timely manner. The current backlog of applications receiving approval hinders a practitioner's ability to practice as well as hinders patients' access to care

- Strengthen the focus of the Keystone Workforce and Economic Development Command Center on the health care workforce, by creating a Health Care Workforce Committee within the command center

- Expand and develop supply/demand studies for more categories of health care professionals to improve the data available to make policy and funding decisions

- Develop strategies to devote additional staff resources and/or creating administrative flexibility for the Pennsylvania Department of Health to better administer the ARC J-1 VISA and Conrad 30 programs

- Revise state loan repayment programs to enhance awards and increase length of service commitments to compete with contiguous states

- Develop opportunities that support efforts to expand current physician and advance practice provider (APP) residency programs targeted to rural and underserved areas

HAP believes that there must be a coordinated effort to address the commonwealth's health care workforce needs. HAP is eager to collaborate with the Wolf administration to implement these strategies, and will be sending correspondence in the coming weeks with specific recommendations and priorities.

8) Establish Appropriate Contract Standards and Escalation Protocols to Ensure Appropriate Post-Acute Placements

Hospitals 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. 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. HAP also has been advocating for behavioral health access, which culminated in a Joint State Government Commission (JSGC) effort to perform a behavioral health access study.

While HAP 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 percent) 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.

HAP strongly recommends the implementation of an escalation policy that would enable hospitals to engage counties, BH-HealthChoices managed care organizations, and the department when a difficult placement situation is occurring by both the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Long-term Living (OLTL). We ask for your support in these efforts.

9) Take Steps to Address Prior Authorization Obstacles and Other Troubling Payor Practices

Even before the COVID-19 pandemic, Pennsylvania hospitals for the past several years have experienced a steadily increasing pattern of insurers creating artificial barriers to significantly delay provider reimbursement for medically necessary services, and in some cases, to prevent it completely.

Many of these barriers stem from the prior authorization process. Prior authorization (PA) is a requirement that a provider obtain approval from a patient's health insurance plan to perform select medical tests and/or procedures, prescribe a specific medication, or admit a patient to the hospital. However, in addition to ensuring that patients get the care that they need, PA can also be used as a technique for minimizing insurer costs, wherein benefits are only paid if the medical care has been pre-approved according to certain rules defined by the insurance company paying the claim.

There is a place for prior authorization when used appropriately—unfortunately, inappropriate authorization practices have many negative impacts, including delays in patients receiving medically necessary care, increased administrative burden for providers which simultaneously takes staff away

from direct patient care, and increased health care costs for businesses, consumers, and payors, including the government.

Prior to the public health emergency, HAP was working with other stakeholder groups and proposed amending Act 68 to implement common sense legislative protections against inappropriate payor practices such as:

- Insurers downgrading inpatient admissions to "observation" status thereby underpaying hospitals for medically necessary services for patients
- Denying payment for medically necessary services based solely on administrative errors on the claim with limited to no process to remedy the errors (e.g. wrong date of service, performed by a physician partner instead of the one that is on the authorization, slightly different but commonly and appropriately substituted procedure code, etc.)
- Failure of an insurer to communicate reasons for denials limiting a provider's ability to effectively appeal the denial
- Failure of an insurer to indicate a service attempting to be pre-authorized is an uncovered service and will result in non-payment
- Failure of an insurer to update online tools in a timely fashion when they require providers to use the tool for patient eligibility
- Denying a claim after prior authorization was obtained based on information that was not available at the time of obtaining the prior authorization
- Denying a claim for a service which is medically necessary, but was not pre-authorized because it was identified during the course of treating patient for an authorized service
- Failure of an insurer to provide timely determinations especially after hours and weekends

A recent example in the pattern of unilateral and troubling payor practices comes from United Healthcare (UHC). Hospitals are now pushing UHC to abandon a proposed policy change that will require in-network, freestanding, and outpatient laboratory claims to contain a laboratory specific, unique code for the overwhelming majority of laboratory testing services. These codes will be required *in addition* to the internationally-adopted standard Current Procedural Terminology (CPT) codes. In order for laboratories to be paid for these services, they must register each test code with UHC. This policy will apply to UHC's commercial, Medicare Advantage, and Community Plan health plan products starting January 1, 2021.

Hospitals expressed significant concerns about the UHC policy during March 2020, when it was first announced as an upcoming policy change. There had been no previous conversation with providers about this upcoming change. In an August 14, 2020 letter, the American Hospital Association (AHA) strongly urged UHC to forgo the new coverage policy because it is overly burdensome for hospitals and it will negatively impact patient access to care. In addition, they stated that "UHC has not provided a rationale for this decision, nor has it justified the potential negative consequences."

The new policy also contains several unresolved programmatic flaws that may make reporting of the lab test code impractical and noncompliant with the Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set Standards for institutional claim data. Even if there were some substantive reason driving this action, which to date UHC has not been able to articulate, the

timing for implementing changes of this magnitude is certainly not in the midst of a national public health emergency. Again, UHC's new laboratory policy will divert staff from patient care and require financial resources to implement this change which many hospitals do not have.

These are just two examples of the many payor challenges that hospitals face. Any relief during these especially challenging times should be fully explored and pursued.

The Pennsylvania Department of Human Services (DHS) could add provisions to the HealthChoices physical health agreements requiring the Managed Care Organizations (MCOs) to:

- ***notify providers of administrative reasons for downgrades or denials and work with them to resolve these issues within a defined period of time so appropriate payment can be made***
- ***engage in good faith conversation with providers before implementing policy or program changes that are likely to result in reduced provider reimbursement***

The Pennsylvania Insurance Department could define criteria and timeframes for commercial payors to make policy /program changes outside of the contracting process, and require good faith conversation with providers before implementation.

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