



Pennsylvania  
**MEDICAL SOCIETY**

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# The State of Medicine in Pennsylvania

An Overview of Pennsylvania's Physician Marketplace

Critical Action Steps to Ensure Access to  
Health Care for Pennsylvania Citizens

# Executive Summary

## Critical Action Steps to Ensure Access to Health Care for Pennsylvania Citizens

### Introduction

In light of the recent passage of the federal Patient Protection and Affordable Care Act (PPACA), which is expected to extend health care coverage to hundreds of thousands of additional Pennsylvanians beginning in 2014, the commonwealth has an urgent need to act now to begin to prepare Pennsylvania's health care delivery system to meet the increased demand for services. Prior to the passage of PPACA, Pennsylvania had a pressing need to address health care reform. As a result of the federal reform legislation and the anticipated increase in demand, Pennsylvania may soon face a crisis.

Without an adequate network of primary care and specialist physicians, newly insured patients will flood already crowded emergency rooms or continue not to receive care, further driving up spending and costs. The Medicaid Program (referred to in Pennsylvania as the Medical Assistance or "MA" Program), with its low provider reimbursement levels, will find it difficult to attract and retain enough physicians and other service providers to adequately meet the demand of the nearly 500,000 new Medicaid eligibles that will likely participate in the program by 2019. In addition, the rest of the health care delivery system will struggle to provide services for individuals eligible for federal subsidies who will purchase insurance through what are known as "Health Insurance Exchanges." The Rendell Administration's Governor's Health Care Reform Advisory Committee recently concluded, based on analysis of models formulated by the Lewin Group and the RAND Corporation, that 1.3 to 2.1 million Pennsylvanians will purchase health insurance through the Health Care Exchange. The participation of individuals within this exchange will represent an enormous increase in the number of insured individuals within Pennsylvania. It is important to recognize that insurance coverage does not equal access to or quality of care.

In order to effectively address this anticipated crisis, the commonwealth must implement the following three policy responses:

- Identify and implement strategies to increase physician supply and in particular primary care physician supply.
- Aggressively implement approaches and initiatives to ensure the financial viability of the Medicaid Program.
- Adopt strategies to increase Medicaid physician participation rates by providing positive incentives to ensure that Pennsylvanians who will be newly-eligible for Medicaid and other insurance will have access to care.

Below, this issue brief will provide some general background information relating to Pennsylvania's health care landscape, provide a brief snapshot of the state of medical practice in the commonwealth, and briefly describe the anticipated impact of PPACA on Pennsylvania. Following this background information, this issue brief will provide a series of options and recommendations to address the policy imperatives identified above.

### Pennsylvania's Health Care Landscape

Pennsylvania residents, like those of all other states, receive their health care through a variety of private and government programs. Most people are covered by private insurers, and the vast majority of individuals with private insurance receive coverage through their employers. A survey conducted by the Pennsylvania Department of Insurance (DOI) in 2008 found that 89 percent of those with private insurance received coverage through their employers, 6.3 percent purchased the insurance themselves, and the remainder, 4.7 percent, had insurance through some other entity, such as college or a retirement plan.

According to the survey, over 25 percent of the commonwealth's residents are uninsured or receive their health care through state government sponsored

programs. The following table shows the results of the survey:

Type of Insurance	Percent of Population	Numbers Eligible
<b>Private Health Insurance</b>	62.1	7,828,000
<b>Medicare</b>	16.8	2,118,000
<b>State Sponsored</b>		
• <b>Medicaid</b>	16.0	2,223,000
• <b>CHIP</b>	1.4	193,000
• <b>adultBasic</b>	0.4	46,000
<b>Military</b>	1.8	227,000
<b>Uninsured</b>	8.2	1,034,000

**Note:** The percentages will add to over 100 percent since many people are eligible for more than one type of coverage. The numbers of people listed as eligible in each category were determined by applying the percentages in the 2008 survey to the current population and by inserting actual numbers, if known.

The primary state government sponsored programs include Medicaid, CHIP, and adultBasic. The Medicaid program is a joint state/federal program that pays for health care services for about 2.2 million Pennsylvanians with limited income. Depending upon the eligibility category, covered services may include physician and clinic visits; inpatient hospital care; home health care; medical supplies and equipment; nursing facility care; inpatient and outpatient psychiatric and drug and alcohol services; prescription drugs; and dental and other medically necessary services. The Medicaid program is administered primarily by the Department of Public Welfare (DPW).

CHIP is an acronym for the Children's Health Insurance Program, Pennsylvania's program to provide health insurance to all uninsured children and teens that are not eligible for or enrolled in Medicaid. CHIP has expanded to cover all uninsured kids and teens up to age 19 that are not eligible for Medicaid. Families with incomes above the free CHIP limits will pay low monthly premiums and co-pays for some services. CHIP is administered by private health insurance companies that are licensed and regulated by the

Pennsylvania Insurance Department and have contracts with the Commonwealth to offer CHIP coverage.

Finally, adultBasic<sup>1</sup> was designed to provide health insurance for adults age 19 through 64 who need coverage but cannot afford it. The program was intended to provide transitional health insurance for adults who either have incomes below 200 percent of the Federal Poverty Guidelines, who may have jobs that do not include health benefits, or who are between jobs. It is also administered by the Pennsylvania Insurance Department through contracts with insurers throughout the state. It is not an entitlement program and is limited by the amount of state dollars available.

## Physician Supply and the Decline of Primary Care Physicians

Current Pennsylvania Physician Data from the Pennsylvania Department of Health (DOH), the Association of American Medical Colleges, and the Pennsylvania Medical Society's 2010 "State of Medicine in Pennsylvania" report provide insight into the issue of physician supply in Pennsylvania. Given the overall supply trends, Pennsylvania demographics and the looming increase in demand, this data illustrates that Pennsylvania will be facing significant challenges in the years ahead as it begins to prepare for national health care reform.

- The average age of physicians engaged in direct patient care in the commonwealth is 48.9 years.
- Nearly 12 percent of direct care physicians are younger than 35 (but most are clustered in Southeastern Pennsylvania, greater Pittsburgh, and a few other counties)
- About one of every four physicians in Pennsylvania is 60 years or older; only one of every five physicians in Pennsylvania is under the age of 40.
- According to a 2008 DOH survey, nearly 20 percent of physicians who practice primary care say they will leave Pennsylvania in five years or less.

<sup>1</sup> As of February 28, 2011, the adultBasic insurance program will exhaust its funding. As a result, adultBasic enrollees and those on the waiting list will not have coverage beyond this date. As an alternative, enrollees will have access to another health care coverage option (with higher premiums and fewer benefits) known as the "Special Care" program offered by Blue Cross/Blue Shield insurers.

- Despite being home to almost 12 percent of the state's population, only about 7 percent of the state's physicians practice in rural counties.
- There are statewide physician shortages, especially in family practice, internal medicine, ob/gyn, general surgery, orthopedic surgery, radiology, cardiology, emergency medicine, and pediatrics.
- Pennsylvania has a smaller percentage of primary care physicians than the United States in general.
- Only one of every three physicians who completed their medical degree in Pennsylvania remained in the state to practice, ranking Pennsylvania 32nd among all the states.
- Only about two of every five physicians who completed their graduate medical education (GME) in Pennsylvania remained in the state to practice, ranking Pennsylvania 35th among all the states. (Although physician retention rates have improved in Pennsylvania over the last three years, the state is still losing ground to the rest of the country.)

As demonstrated by the above data, Pennsylvania must do more to attract physicians from other states as well as foreign medical graduates, and ensure that our institutions make maximum effort to recruit, train, and place as many Pennsylvania residents into primary care residencies and practices as possible.

## Impact of National Health Care Reform

While PPACA provides a major opportunity for Pennsylvania to provide additional insurance coverage for its neediest citizens and most underserved communities, the increased demand that will be experienced by the health care delivery system could overwhelm the existing system and jeopardize access to care for all of Pennsylvania's citizens.

In summary, PPACA, signed into law on March 23, 2010, will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- Medicaid will be significantly expanded to cover low-income adults under the age of 65 without dependent children who are currently not eligible for the program. The new law bases eligibility for Medicaid on income for individuals under age 65 and establishes a national floor for Medicaid coverage at 133 percent of poverty (\$14,404 for an individual or \$29,326 for a family of four in 2009) in 2014.
- Other individuals who do not have access to affordable employer coverage will be able to purchase coverage through a "Health Insurance Exchange" with premium and cost-sharing credits available to individuals with incomes between 133 percent and 400 percent of poverty to make coverage more affordable. Individuals eligible for Medicaid will not be eligible for subsidies in the state exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the exchange, with exceptions for small employers.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.

The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million by 2019. Of this number, approximately 16 million will be covered by the Medicaid program, according to a number of organizations and entities that have evaluated this issue.

The Kaiser Commission on Medicaid and the Uninsured issued a report in early 2010 providing "state-by-state" estimates of the likely effect of national health care reform on the Medicaid program. Because of the variation across states, there is a range of implementation scenarios that will affect the number of people who sign up for coverage. In light of this variation, the study authors identified two models (the "standard participation scenario" and the "enhanced outreach scenario"). Under the "standard participation scenario," the report estimates that an additional **482,366** individuals will be enrolled in the Medicaid program in Pennsylvania by 2019. Under the "enhanced outreach scenario," the report estimates

that an additional **682,880** individuals will become newly enrolled within the same period. Regardless of the outcome, the impact on Pennsylvania's Medicaid program will be substantial.

In summary, the impact of national health care reform will be enormous. A significant number of uninsured Pennsylvanians will receive health coverage through the new Health Insurance Exchange, and the Medicaid program will experience an unprecedented expansion. The new Medicaid eligibles and other newly insured individuals will have high-medical needs and will add a disproportionate stress on the delivery system. Absent aggressive action by policy makers, this shortage will become a crisis that will negatively affect all Pennsylvanians who rely on the system for their health and well-being.

## Critical Pennsylvania Policy Responses

The situation faced by Pennsylvania demands urgent and aggressive action by relevant state policy makers. Unfortunately, this need for urgent action is coming at a time when the commonwealth is facing enormous budgetary challenges and a funding shortfall as it struggles to emerge from the debilitating effects of the economic downturn. Despite this challenge, there are opportunities to implement novel reforms in the areas of workforce development, Medicaid cost containment, and physician participation in government health care programs that have been adopted with success in other states. While many of these reforms will be difficult and will face opposition from powerful interest groups, the current situation and the change in administration provide a unique opportunity for necessary changes to the health care delivery system.

Below, we will provide a summary of what we believe are core policy goals that must be adopted in order to address the upcoming crises, and suggest possible options and recommendations.

### Policy Response #1: Identify and implement strategies to increase physician supply and in particular primary care supply.

In order to provide adequate care to the enormous number of Pennsylvanians who will become eligible

for health insurance beginning in 2014, policy makers must take steps to increase the number of physicians practicing in the commonwealth. It will be particularly important to ensure an adequate number of primary care practitioners, and to take steps to increase physician supply in existing health professional shortage areas. Failure to address these issues will result in increased waiting times for appointments, inappropriate utilization of emergency room services, lack of preventative care, and adverse health outcomes. It is also worth noting that in assessing the current status of the ability of the system to provide adequate primary care, the supply of nurse practitioners and physician assistants must also be evaluated and addressed. These groups—which serve as key members of physician-led care teams—are experiencing many of the same supply and demand issues as physicians.

## Options and Recommendations

- 1) **Create a Health Care Workforce Interagency Workgroup and Public/Private Partnership for Strategic Health Care Workforce Development.** In light of the serious nature of the physician supply issue, there is a pressing need to establish a broader entity to develop an overarching strategy and governance in order to leverage and create synergy with the many assets Pennsylvania has to address comprehensive workforce needs. There are several models that can be reviewed by the governor and his staff that may provide some insight for a path forward to create a structure or process for developing the strategic guidance for health care workforce issues and to guide the planning and implementation of many of the recommended actions outlined in other sections of the report. Examples of such structures include New Jersey's Center for Health Workforce Planning, Massachusetts' Healthcare Workforce Center, Utah's Medical Education Council, and Georgia's Board for Physician Workforce.

The public/private partnership should include the establishment of (or designation of an appropriate existing) 501(c)(3) entity that could facilitate and accelerate an aggressive search, application for and implementation of federal funds, foundations, business, and other resources to augment or

leverage other funds and programs to carry out strategic initiatives and activities.

2) **Implement Health Insurance Oversight, Leadership and Collaborative Activities.**

One of the most critical policy tools available to the governor to ensure an adequate workforce is the statutory and regulatory authority vested within the Departments of Health and Insurance to regulate health insurers. Options available to the governor include the following:

- **Hold Insurers Accountable for Meeting Network and Provider Panel Requirements.** The governor should announce that he intends to hold insurers accountable for ensuring that their *coverage provides access to quality care*. Insurers should work with other stakeholders, including the Pennsylvania Medical Society, to define measures of quality care. He should also direct the Insurance Commissioner, Secretary of Health, and the Secretary of Public Welfare (and other appropriate officials) to ensure that health care regulators and purchasers vigorously enforce state and federal primary care provider network and quality requirements.
- **Convene All Health Insurers to Discuss Successor to and Broadening Participation in Community Health Reinvestment Fund (CHR) and Discuss PPACA Implementation Issues.** The governor should initiate discussions with all payors (Blue Cross/Blue Shield plans, commercial insurers, MCOs, businesses, self-insured funds and third party administrators) to establish a statewide health workforce fund or trust (that includes insurer controlled funds) that can be used to strategically target health care workforce issues.
- **Utilize Non-Profit Conversions to Address Strategic Health Workforce Priorities.** The governor should pursue legislation or other authority with the Office of the Attorney General to mandate a contribution from future non-profit conversions to address strategic health workforce priorities directly or contribute

to a statewide health workforce trust/ foundation that would invest in these activities.

3) **Explore Opportunities to Reform Graduate Medical Education (GME).**

Another critical component to increase physician supply and encourage the provision of primary care in health professional shortage areas is to explore reforming graduate medical education. Possible elements of a reform strategy include the following:

- **Evaluate and Implement Recommendations of the Council of Graduate Medical Education (COGME).** In 2009, the COGME made several suggestions for statutory changes to re-align graduate medical education training priorities. The administration should convene a broad-based statewide coalition to examine these recommendations, and suggest appropriate changes with or without federal participation.
- **Identify and Exploit Federal Funding Opportunities.** The Administration should direct the Medicaid program to aggressively identify federal match opportunities for primary care physician training and recruitment and retention strategies in urban and rural underserved areas/populations/facilities. Federal funding opportunities to demonstrate, evaluate, or implement accountable care organizations, patient centered medical homes, and/or the Chronic Care Commission initiative should also be explored.
- **Improve Use of Medicaid Revenues.** The Administration should review the feasibility of improving the use of Medicaid revenues to pay for a portion of physician graduate medical education. For example, Medicaid revenues could perhaps be used as subsidies to teaching hospitals and clinics, could support clinical education programs, and support teaching costs incurred by hospitals and community health centers.

4) **Implement Department of Health Policy Reforms.**

The Department of Health (DOH) must continue to play a primary role in addressing

physician supply and recruitment issues. Several reforms can be implemented to improve their efforts:

- **Re-institute Primary Care Practitioner's Program Advisory Committee.** The Primary Care Practitioner's Program currently exists within the DOH. The Administration should re-institute and revitalize the defunct advisory committee mandated in legislation establishing this program, and utilize this advisory committee to serve as a focal point to develop and manage current and future physician recruitment/retention needs, opportunities, and strategies.
  - **Accelerate Shortage Area Assessments.** The DOH should seek resources and accelerate a complete assessment of the commonwealth to identify new and renewed designations for Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs), including primary medical, mental health, and dental. Federal funding opportunities are conditioned on these designations.
  - **Pursue Matching Funds for Primary Care Community Challenge Grants.** The DOH should permit and actively pursue matching funders of Primary Care Community Challenge Grants and consider a public-private partnership for this purpose to expand both the number and scope of grants to expand the primary care physician workforce. This may require a new governance and decision making mechanism.
  - **Provide Proactive Support for Use of the National Health Service Corps (NHSC).** These activities will include early communication with federally qualified health centers, certified rural health clinics, and other safety net providers regarding NHSC opportunities, creation of a "tickler database" in the primary care office to assist NHSC opportunities, and strengthen the NHSC site review process at the state level to assure appropriate utilization of obligated clinicians.
  - **Address Barriers to the Use of International Medical Graduates.** The DOH should improve the coordination with provider recruitment/retention services, address concerns regarding quality and long term retention of foreign providers, and improve coordination with the state Board of Medical Examiners.
- 5) **Reform the Commonwealth Loan Repayment Program.** The commonwealth's Loan Repayment Program, developed in the early 1990s, is in need of significant changes to keep pace with patient and provider needs and the competitive loan repayment environment. The typical medical school debt for a new physician is between \$180,000 – \$225,000. This is a significant debt burden for young physicians, and loan repayment or forgiveness programs are an attractive option for new graduates. Pennsylvania's program does not compare favorably to programs in place in other states. For example, programs in Maryland, New Jersey, and Virginia provide nearly double the loan repayment amount (\$120,000) than Pennsylvania (\$64,000). New York's program is even more generous. Pennsylvania should also explore novel public relations efforts to encourage young physicians to practice in our state.
- 6) **Promote the Provision of Volunteer Medical Services.** Another approach to address the physician supply issue is to actively encourage volunteer service by retired (and active) physicians and other primary care practitioners and disseminate information on the statutory changes and other efforts which have already been made to encourage this service. Professional liability issues, which often serve as a barrier to volunteer services, should be carefully evaluated and addressed.
- The commonwealth and the Administration will face enormous challenges to increase physician supply and encourage the provision of primary care in health care professional shortage areas. To address these challenges, new governance structures must be created, and aggressive and coordinated actions must be implemented that are commensurate with the size and scope of the problem.

## **Policy Response #2: Aggressively implement approaches to ensure the financial viability of the Medicaid Program.**

The Medicaid Program is Pennsylvania's primary vehicle for providing health care coverage to low-income and high-need populations, and the program serves as the foundation for expanded coverage under PPACA. By 2014, it is estimated that over 2.5 million Pennsylvanians will receive health insurance through this program. In addition, Medicaid currently constitutes 20.8 percent of the state's General Fund budget (the second largest component behind education), and this percentage is likely to grow as medical costs increase. Absent ongoing efforts to contain costs, the program will continue to crowd out other important spending priorities.

It is important to remember that, over the past decade, the Medicaid Program has been under immense pressure to contain the growth of the program and cut costs. As a result of this pressure, the program has implemented a wide array of initiatives, both large and small, to contain costs and/or reduce expenditures. Many of the remaining cost-savings opportunities involve complicated and controversial initiatives that will require a significant amount of effort, commitment, and expertise in order to effectively implement. These challenges also come at a time when DPW—which has been subject to salary and hiring freezes (since January 2008)—has been asked to “do more with less.” While perhaps not debilitating, these challenges will certainly make it more difficult for the commonwealth to implement many of the initiatives necessary to ensure the financial viability of the program.

### **Options and Recommendations**

#### **1) Implement Managed Long-Term Care Models/Improved Coordination of Dual-Eligibles.**

Medicaid is the largest funder of long-term care services (LTCS), providing 40 percent of the cost of this care to the elderly, developmentally disabled, and physically disabled. It is estimated that over 65 percent of the elderly will require some type of LTCS during their lifetimes. As a result, there is a significant incentive for states to better manage the long-term care needs of Medicaid beneficiaries, including those who are also eligible for Medicare (the “dual eligibles”). These options include

programs that manage long-term care supports and services only, those that integrate acute and long-term care, and those that integrate Medicaid and Medicare. Managed long-term care programs appear to improve quality, cost effectiveness, and community placements in several states, including Arizona, Florida, Texas, and Wisconsin. Pennsylvania should aggressively investigate the implementation of these models.

- 2) **Enhance Physical Health and Behavioral Health Integration.** It is well established that mental illness and substance abuse are diagnoses that are prevalent among Medicaid patients. Many of these persons also have a variety of chronic diseases. According to a study in 2009, of the highest cost 5 percent of Medicaid patients, over 40 percent had a psychiatric illness and cardiovascular disease and 28.6 percent had a psychiatric diagnosis along with a pulmonary condition. Diabetes is also common in this population. In spite of this situation, very little has been done to effectively coordinate behavioral health care and physical health care among Medicaid patients. Also, people with both serious mental illnesses (SMI) and drug and alcohol disorders along with chronic conditions present additional challenges.

This is an enormously complex issue, but it must be addressed. The Administration should carefully evaluate the program design to determine if it appropriately aligns incentives to ensure coordination of care. Existing pilot care management programs should be evaluated and expanded, and incentives for behavioral health and physical health providers to coordinate care should be developed and explored.

- 3) **Continue Development of “Medical Home” Models.** In January 2007, the commonwealth implemented what is known as the Chronic Care Commission. This initiative recognized that chronic diseases account for about 80 percent of health care costs, 76 percent of visits to physicians and 90 percent of prescriptions, but that only 56 percent of chronic disease patients receive the recommended plan of care for their conditions. Pursuant to this initiative, the commonwealth has been working with 900 primary care practitioners

and major payers to transform primary care in those practices to patient-centered medical homes, and to change payments to encourage the use of interdisciplinary teams, patient registries, assistance with patient self-management and embedding care coordinators. The ability of this initiative to bend the cost curve is currently being evaluated. If this study demonstrates promising results, this initiative should be continued and perhaps expanded throughout the commonwealth.

- 4) **Reform of County-Based Behavioral Health HealthChoices Program.** DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the behavioral health (BH) component of the HealthChoices program, which provides behavioral and substance abuse services to Pennsylvania's Medicaid population statewide. Unlike the Physical Health Program, where MCOs provide services within a geographic zone, only one BH-MCO provides behavioral health care in a given county. The counties are offered what is known as the "right of first opportunity" with regard to operating the behavioral health care program. Under this option, counties can choose to run the program directly (as Philadelphia County has done) or can subcontract with a BH-MCO. The counties can also join together to form an oversight entity to contract with a BH-MCO. Most counties have chosen to subcontract with a BH-MCO, although six counties in the southwest region and many counties in the north/central county region operate "joinder" programs. In the north/central region, DPW (rather than the individual counties) has a contract with a BH-MCO to provide services in the region's 23 counties. Five different BH-MCOs operate in Pennsylvania: Community Behavioral Health (CBH), Community Care Behavioral Health Organization (CCBHO), Community Health Network of Pennsylvania (CBHNP), Magellan Behavioral Health (MBH), and Value Behavioral Health (VBH).

The existing structure is administratively complex, and creates what could perhaps be considered an unnecessary network of contractual agreements and administrative tasks. It is also possible, if not likely, that DPW has less leverage to negotiate payment rates with county governments, than it would if it were to directly negotiate with BH-

MCOs. The Administration should carefully evaluate the existing program and determine whether it would be more appropriate to eliminate the county right of first opportunity model, and permit DPW to contract directly—perhaps by geographic zone—with BH-MCOs. This approach would streamline the administrative structure, allow more rigorous rate negotiations, and perhaps lead to reductions in the capitated rates paid to BH-MCOs.

- 5) **Ongoing Utilization and Enhancement of Pay-for-Performance Payment Methodologies.**

Over the past several years, pay-for-performance (P4P) programs have emerged as a strategy promising to improve the quality and cost-effectiveness of care in the Medicaid program. These strategies have been applied at both the health plan level (rewarding health plans or disease management vendors that meet defined targets) and the physician level (linking physician reimbursement to improved quality of care). Pennsylvania's Medicaid program has been a national leader in implementing these innovative programs, and the HealthChoices MCOs and the ACCESS Plus program have demonstrated improved outcome results due, in part, to these programs.

Despite the success of these programs, funding for these initiatives may be in jeopardy as a result of the enormous financial pressures. Any reductions to this program would be short-sighted, and serve to reduce the incentives for Medicaid MCOs and contracted providers to continue to implement and maintain innovative programs to improve outcomes and contain costs long-term. In addition, as these programs continue to evolve, the Administration should continue to work closely with physicians and the Pennsylvania Medical Society to ensure that the programs are appropriately designed to improve quality.

- 6) **Payment Re-design Efforts.** Several types of payment reforms have been discussed in the context of health care reform. Two of these are bundled payments and Accountable Care Organizations (ACOs).

In a bundled model, different provider payments for an episode of care for a particular condition are lumped together in a “global” payment.

It has been described as a middle ground between a purely fee-for-service system and a totally capitated system. Under a bundled payment system, one entity receives and disburses payment to the providers who have mutual agreements to be involved in the episode of care. In theory, they all need to work together to provide services in the most efficient manner. The elimination of duplication of services and unnecessary care should lead to savings to be shared among all care providers.

ACOs are organizations of health care providers that agree to be accountable for the quality, cost, and overall care of its patients, and meet quality performance measures. Each is eligible to share realized savings. Health care providers typically cannot get together to determine what they will be paid by health care payors because of anti-trust laws, but an exception exists if the state convenes and supervises the discussions. In addition, provisions in the recently passed health care law allow the Medicare program to share savings if specific requirements are met.

The Administration, in conjunction with applicable stakeholders including the Pennsylvania Medical Society, should carefully evaluate both of these models and test them to evaluate their effectiveness within Pennsylvania’s government health care programs and marketplace.

- 7) **Evaluation of Alternative Delivery Models for Medicaid Dental Services.** According to a recent study issued by the University of Pittsburgh’s Medicaid Policy Center, the Medicaid Program spent about \$124.9 million on dental services for children, or about \$109 per enrolled child (which is relatively low, compared to the national average for all children across all payors of about \$284). Although Pennsylvania implemented a number of initiatives to improve dental provider participation in Medicaid, participation and payment rates remain low. The Pew Center on the States reports that in 2008, Pennsylvania’s Medicaid reimbursement rates were only 53.2 percent of dentists’ median

retail fees, compared to the national average of 60.5 percent of retail fees. In addition, of the 6,659 Pennsylvania practicing dentists in 2009, only 1,723 dentists (or 26 percent) treated at least one Medicaid patient during that time period.

The low participation rates (due, in part, to low payment rates), is troubling, in light of the mounting evidence of the connection between an individual’s dental health and their overall physical health and well-being. In order to address this issue, Pennsylvania could consider implementing an Administrative Services Organization (ASO) model for dental services paid by the commonwealth’s FFS system. An ASO model could provide the commonwealth with greater program and cost control, and would permit the Medicaid program to reinvest program savings in improved dental rates. In an ASO arrangement, a private contract would perform prior authorization and utilization review and the State would retain all financial risk for dental costs. A key advantage of implementing an ASO model is the enhanced utilization management that can be provided, and the ability to reinvest program savings in increased reimbursement rates and outreach efforts to improve dental participation.

- 8) **Improved Coordination Among State Government Programs.** In Pennsylvania, governmental health care programs are operated by the Department of Health (drug and alcohol, chronic renal disease, and traumatic brain injury), DPW (Medicaid, mental health and substance abuse services, developmental disabilities), the Department of Aging (PACE, home- and community-based waivers), the Department of Insurance (adultBasic, CHIP), and the Pennsylvania State Employees Benefit Trust Fund (health insurance for state employees and retirees.) Each program operates independently and, while efforts are continually made to better coordinate activities, the reality is that government managers barely have time to run the programs for which they are responsible, let alone taking time to work with staff in other departments or within a department. The Administration should consider appointing a “Health Care Czar” responsible for ensuring coordination and administrative efficiencies among the programs. Efforts to combine programs (e.g.

Medicaid, CHIP, and adultBasic) should also be considered.

9) **Reform of Medical Assistance Transportation Delivery System.**

In 2007, the Pennsylvania General Assembly directed the Pennsylvania Department of Transportation (in association with other agencies and offices) to perform a study of the Pennsylvania Human Services Transportation System in Pennsylvania.<sup>2</sup> The study concluded that the commonwealth's current system is severely fragmented and results in unnecessary complexity and inefficiencies; that program costs have increased and that current economic conditions will generate more demand while threatening revenue; and that regional consolidation of management and service delivery offers the greatest opportunity for increased service, quality, and availability. Consistent with these recommendations, the commonwealth should consider several "market-based" approaches that have been adopted by a number of other states to help control costs and improve service delivery. The most common of these approaches is the adoption of statewide or regional brokerage approaches, in lieu of the existing county, cost-based approach, which provides few incentives to control costs. Under this model, DPW would conduct competitive procurements (by zone or state-wide), and choose an at-risk broker to provide transportation services. Quality and access could be rewarded through appropriate performance-based contracting approaches and program management.

10) **Selective Contracting for Durable Medical Equipment (DME) and Home Health Care.**

Presently, Pennsylvania pays for DME and home health services on a fee-for-service basis to a large number of providers that are willing to participate in Medicaid. Because of this, the state may be spending more for DME and home health than it otherwise would if providers were chosen through a competitive bidding process and required to conform to set pricing parameters.

Using a competitive bidding approach would reduce the number of providers, ensure they are willing to commit to a fee schedule, and help reduce fraud, abuse, and waste of these services. A similar selective contracting approach was adopted by DPW through the establishment of the Specialty Pharmaceutical Drug Program, where DPW utilized a competitive bidding process to select two providers to provide selected high-cost specialty drugs to Medicaid consumers enrolled in the FFS program. Pursuant to this initiative, the department could establish specified geographic regions, and perhaps choose two vendors for each region for both DME and home health services.

It is important to note, however, that these initiatives could result in substantial savings but will be extremely controversial, as they could serve to displace small, independent DME suppliers and home health providers. Many DME providers, for example, may be unable to compete with the large national providers.

**Policy Response #3: Adopt strategies to increase Medicaid physician participation rates to ensure that Pennsylvanians who will be newly-eligible for Medicaid and other insurance will have access to care.**

While Pennsylvania physicians continue to see Medicare and Medicaid patients at a higher rate than many other states, participation rates are not high. To the extent that physician payment rates remain stagnant, it is likely that the nearly 500,000 new Medicaid consumers will find it difficult to access care. While access to primary care will be particularly difficult, as Pennsylvania has a smaller share of primary care physicians compared to the United States in general, and there are several "pockets" within the commonwealth where shortages are acute, access to specialist physicians is also limited. The Pennsylvania Medical Society 2010 "State of Medicine in Pennsylvania" report showed that one third of primary care physicians were not able to obtain specialty referrals for at least one of their Medicare, Medicaid, or privately insured patients.

<sup>2</sup> This system consists primarily of the Medical Assistance Transportation Program (MATP), which provides transportation to medical services for consumers eligible for the Commonwealth's Medicaid program, and the Shared Ride Program for seniors and persons with disabilities, which reimburses providers 85 percent of the fare for persons 65 years or older and for persons with disabilities.

Federal law does not set specific requirements for the reimbursement of medical services, and states have significant flexibility in setting Medicaid physician payment rates. Generally speaking, Medicaid rates are lower than those for Medicare rates, which in Pennsylvania are also typically less than rates paid by private insurance. Nationwide, the average Medicaid reimbursement rate is 72 percent of Medicare reimbursement. For primary care services, it is 66 percent of Medicare. In Pennsylvania, all physician services are about 73 percent of Medicare, slightly higher than the national average. However, for primary care services, Pennsylvania's percent of Medicare is 62, below the national average. While this difference may not seem as large as one might expect, it is important to note that many Medicaid patients have severe and continuing chronic medical problems, disabilities and behavioral health issues.

Studies have demonstrated that participation is driven, in significant part, by reimbursement rates. In order to ensure access, the commonwealth will have no choice but to identify savings from its current Medicaid program, and redeploy these savings into initiatives that would make access to primary and specialist physician care for newly-eligible Medicaid consumers a reality. These initiatives will also be aided by the Administration's efforts to address professional liability reforms.

## Options and Recommendations

### 1) **Increase Physician Reimbursement Rates.**

There are several methods that could be used to increase reimbursement to physicians. One option is to expand physician Pay for Performance incentives in both the HealthChoices and the ACCESS Plus programs. Expansion of these programs would ensure that physicians are rewarded for improved outcomes and quality.

A second possibility is to raise fees for providers who treat Medicaid patients in rural and urban areas where there is a shortage of primary care physicians. This could be similar to Medicare's Incentive Payment (MIP) program, which provides a 10 percent bonus payment to (i.e. HPSAs and Physician Scarcity Areas, or PSAs.). A corollary could be to designate a small fund to target bonus payments to physicians in areas experiencing

crises, and provide the "interagency workgroup" discussed previously with discretion to target these funds. Another method that could be considered is to fashion a "disproportionate share payment" for physicians. While CMS does not recognize this type of a payment as disproportionate share (since they are reserved, by law, for hospitals), such an additional payment would likely be approved by the Federal government. It would provide higher reimbursement to those physicians who treated a disproportionately large number of Medicaid patients. Such payments would incentivize physicians to treat additional Medicaid patients.

Finally, the department can begin a process to develop internal consistency among fees. For example, a study could be done to determine what the fees would be and what it would cost to move to a fixed percent of Medicare fees. Fees should, at a minimum, be set at 100 percent of the Medicare fee schedule. The Medicaid program could develop a plan, over several years, to move to that fixed percent. No fees would be reduced and there may need to be exceptions for certain procedures, such as primary care and obstetrical services. Finally, the \$1,000 reimbursement limit that is now in place for a period of hospitalization and the \$500 limit during an outpatient visit could be increased or eliminated. Regardless of the approach, it is critically important to address current Medicaid reimbursement levels to ensure adequate access to primary and specialist physician care.

### 2) **Ensure the Financial Viability of Medicaid Managed Care.**

HealthChoices began in 1997 in the Southeast region of Pennsylvania. Today, HealthChoices extends to 25 of the state's 67 counties, including some of the most populous and some of the most rural. HealthChoices is the primary service delivery model in Medicaid, covering 1.2 million of the commonwealth's 2 million Medicaid consumers. Under HealthChoices, DPW contracts with managed care organizations (MCOs) to provide a complete package of benefits to Medicaid consumers who enroll in their plan. The MCOs are paid capitated fees for each enrolled member each month. The plans are at financial risk and must provide all contracted services to their members as well as

the administrative and quality structure for those services within that fixed amount. The MCOs, in turn, contract with providers to provide care and services to Medicaid consumers.

The rates paid to the MCOs over the past several years have been very low, and yearly rate increases have been well below the trend of increases in medical costs. DPW has made the decision to pay the MCOs the lowest rates possible under federal law. While there were significant budgetary issues that drove these policy decisions, the rate pressure placed on the HealthChoices MCOs serve, in turn, to place pressure on provider rates. In light of the expansion of the Medicaid program that will result from PPACA, and the associated physician supply issues that will be the inevitable result, it is important for all providers that contract with Medicaid MCOs for the HealthChoices program to be adequately funded.

3) **Enforce Network Access Requirements.**

Within the HealthChoices program, DPW requires participating MCOs to meet explicit provider network standards, many of which have been strengthened in recent years. In developing their networks, the MCOs are contractually required to take into account the anticipated enrollment, the expected utilization of services, the number of providers who are not accepting new patients, and the location of the providers.

While MCOs can seek to meet provider network standards through active recruitment and friendly contracting policies, the issue of participation revolves primarily around the adequacy of payment rates. Although it is important to appropriately fund the HealthChoices program, it is also critical for DPW to enforce access and network standards. Absent aggressive enforcement of these requirements, MCO rate increases will not always be passed on to participating providers.

4) **Create Dedicated Funding Stream to Increase and Sustain Physician Payments (e.g. soda tax, beauty tax, tobacco tax, fast food tax, etc.)<sup>3</sup>** When a state imposes a tax, it decides how

the revenues are to be used. The funds raised can be deposited into a general account, called the General Fund in Pennsylvania, where it can be used for any purpose. An alternative is to place these revenues into a separate account, where the funds must be used for a specific purpose. Pennsylvania has about one dozen special funds from the Fish Fund (with revenues from fishing licenses and fines and used to protect aquatic life) to the Lottery Fund (with monies from the sale of lottery tickets which is used to benefit older Pennsylvanians.) Gas taxes in several states fund the maintenance of highways.

Dedicated taxes on a service or product can be imposed to change behavior. The most vivid examples are taxes on cigarettes. At both the state and federal levels, taxes on cigarettes have been steadily increasing for many years. According to the Campaign for Tobacco Free Kids, Pennsylvania ranks 20th in the country in the state excise tax on cigarettes. Of the states surrounding Pennsylvania, including New York, Maryland and New Jersey, all have higher taxes, West Virginia and Ohio lower, and Delaware the same.

Other assessments, with the proceeds dedicated to the Medicaid program, or to a specific purpose within Medicaid, such as maintaining or increasing physician fees at a specific level or percentage of Medicare, could be levied or increased on cosmetic dentistry, alcohol, smokeless tobacco (Pennsylvania is the only state that does not tax smokeless tobacco), fast food, and others. In the current political and economic environment, persuading the General Assembly to pass a tax of any kind will be extremely difficult. But it may be something to consider promoting as part of an overall strategy to adequately fund the Medicaid program and establish physician reimbursements at a reasonable level. This will be absolutely necessary for there to be access to necessary medical services. Since many physician practices are small businesses, perhaps providing tax breaks to physicians who serve Medicaid patients can also be evaluated.

<sup>3</sup> It is understood that the Corbett Administration has made a commitment that it will not raise taxes and/or fees in order to raise revenue. As a result, these proposals may not be a viable option for the commonwealth.

- 5) **Reducing Administrative Burdens Relating to Medicaid Participation.** Providers across the country have typically contended that the “hassle factor” relating to participation in Medicaid has discouraged physicians and other providers from treating patients who are covered by Medicaid. These issues typically relate to slow payments, difficulties in correcting claims, patient “no-shows,” paperwork requirements, frequent changes in policies or procedures, and other red tape associated with program participation. Although the Pennsylvania Medicaid program has focused on this issue over the past several years, more can certainly be done to address these concerns. The Administration should continue to work with the Pennsylvania Medical Society to address these issues moving forward.

## Conclusion

In light of the recent passage of PPACA, the commonwealth has an urgent need to act now to begin to prepare Pennsylvania’s health care delivery system to meet the increased demand for services. Absent reform, the Medicaid program, with its low provider reimbursement levels, will find it difficult to attract and retain enough physicians and other service providers to adequately meet the demand of the nearly 500,000 new Medicaid eligibles that will likely participate in the program by 2019. In addition, the

rest of the health care delivery system will struggle to provide services for individuals eligible for federal subsidies who will purchase insurance through what are known as “Health Insurance Exchanges.”

In order to effectively address these challenges, the commonwealth must identify and implement strategies to increase physician supply (and in particular primary care physician supply) and encourage the provision of primary care in health professional shortage areas; aggressively implement approaches and initiatives to ensure the financial viability of the Medicaid Program; and adopt strategies to increase Medicaid physician participation rates to ensure that Pennsylvanians who will be newly-eligible for Medicaid and other insurance will have access to care.

It is hoped that this document will provide useful suggestions and recommendations that can be adopted by the commonwealth as it prepares to address the enormous challenges ahead.





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