



July 20, 2015

Dear Colleague:

On May 29, 2015, the Department of Human Services released a request for information (RFI) to help guide us as we plan for the release of a new procurement for the provision of managed care services for physical health. As noted in the RFI, the Department is interested in making changes to these contracts that will encourage managed care organizations to adopt practices that support quality outcomes.

We are grateful for the number of thoughtful responses that we received to the RFI. They have been an enormous help to us as we continue to develop the new procurement.

In order to continue our effort to be transparent during this process and to provide an opportunity for additional comment, I have attached a summary of some of the most frequently provided comments in the responses to the RFI and some of the changes that the Department is considering for the new procurement. Please note that this list is not meant to be final – it is merely some of the ideas that are being considered at this time.

If you would like to comment on the concepts included in the attachment or an area that is not listed in the document, please send the comments to RA-PWHCRFIResponses@pa.gov by August 10, 2015.

Thanks again for your participation in this process.

Sincerely,

A handwritten signature in black ink, appearing to read "Theodore Dallas". The signature is fluid and cursive, with a long horizontal stroke at the end.

Theodore Dallas

Section 1 – Major Comments/Themes from RFI Responses

The Department of Human Services (DHS) issued a Request for Information (RFI) to obtain information and assist with the development of a procurement for the HealthChoices Physical Health program, and to generate ideas and strategies for improving DHS' mandatory managed care program, including the provision of both physical and behavioral health services. Major themes and comments from the RFI responses include the following:

Care Coordination and Collaboration

- Care coordination among Physical Health Managed Care Organizations (PH-MCOs) and Behavioral Health Managed Care Organizations (BH-MCOs) should be improved.
- Care coordination is critical. DHS should institute more combined BH/PH pay for performance (P4P) opportunities similar to the State Innovation Model (SIM) grant program.
- Lower numbers of PH-MCOs would reduce the administrative workload and would improve continuity of care and collaboration.
- More intensive, in-person care management as part of the care team/community care modeling will work to improve outcomes.
- Co-location of various providers at health clinics/centers - including physical, behavioral and dental with social navigators comprising care management teams - could help with better care coordination and integration.
- MCOs should consider offering incentives to providers for pursuing certification/recognition of patient-centered medical home status.

Data Sharing

- PH- and BH-MCO data sharing improvement is necessary for better collaboration and coordination.
- DHS should consider issuing explicit direction regarding exactly what data and information can be shared among providers/insurers that is compliant with confidentiality regulations.
- Conservative interpretation of confidentiality regulations by entities inhibits the flow of necessary care data.

Payment Models and Pay for Performance

- MCOs should move away from the common reimbursement method of fee-for-service and encourage other payment formats that work toward quality outcomes.
- More P4P opportunities for quality of care should be allowed, but not require excessive administrative demands that outweigh the fees available.

Access/Provider Issues

- Improved access to providers and services is essential—particularly in underserved areas. MCOs need to participate in community care teams and recognize and pay for “Health Navigators” and health care provider extenders.
- Dental access is critical; MCOs should work to improve access overall, but particularly among pediatric dental providers.
- DHS should provide more intensive monitoring of MCO network development and on-going access.
- Recognition and payment of physician extenders would allow more access and better health outcomes.
- Provider enrollment and credentialing should be streamlined among MCOs and Medical Assistance (MA), including the possibility of a common HealthChoices process for all plans.
- DHS should consider incenting the MCOs to make investments in telehealth and participate in the development of more community-based health care and health education programs.

Section 2 – DHS Proposed Changes/Objectives and Measures

From the information submitted through the RFI process, DHS plans to make a number of adjustments and clarifications to the Medicaid and HealthChoices program. Major themes and comments from the RFI responses include the following:

- Promote the achievement of the Triple AIM (better health, better care, lower cost);
- Improve care coordination between physical and behavioral health services;
- Promote the expansion of value-based purchasing of health care services;
- Promote the expansion of team-based approaches to care delivery (for example, patient-centered care medical homes);
- Promote community-based public health initiatives;
- Increase consumer access to needed services, especially in rural and underserved areas of the commonwealth;
- Improve the efficiency of the HealthChoices program; and
- Improve the provider experience with the HealthChoices program.

To help address these goals, the Department is considering the following changes to existing MCO agreements:

- Setting targets for value-based payments;
- Use of Accountable Care Organizations (ACOs);
- Increasing value-based purchasing and pay for performance;
- Encouraging patient-centered medical homes;
- Improving access to quality care; and
- Streamlining the provider experience

Setting Targets for Value-Based Payments

The Department is considering setting targets or requirements for value-based or outcome-based payments as a percentage of total contract value. Targets would be phased in over time and increase over the terms of the contract. Respondents would submit plans as part of their response to the procurement detailing their strategy for achieving these targets.

Use of Accountable Care Organizations (ACOs)

Accountable Care Organizations (ACOs) are voluntary networks of hospitals, doctors and other providers that work together to provide coordinated care to patients. All network participants share medical and financial accountability in the arrangement. Quality and cost targets are set and the ACO partners share in agreed upon savings which result from improved quality and efficiencies. The Affordable Care Act (ACA) incentivized the establishment of ACOs for Medicare

patients to improve the quality of care and reduce health care costs. States are now implementing this initiative in Medicaid programs. Alabama, Colorado, Maine, Massachusetts, Minnesota, Oregon, Texas, Utah and Vermont are all preparing or implementing ACO models. Commercial payers have also adopted this payment and delivery model.

The Department is considering instituting a requirement that MCOs develop value-based contracts with large volume health systems to move towards becoming ACOs that focus on key efficiency and quality metrics. The quality metrics will be aligned with the existing MCO P4P program, a proposed hospital P4P program and health home quality metrics.

Key quality and efficiency measures may include: reducing preventable admissions and readmissions, reducing unnecessary Emergency Department visits, increasing adult and pediatric access to care, improving diabetes care, increasing prenatal and post-partum access to care, reducing C-sections and early induction of deliveries, and reducing the percent of NICU stays.

Value-Based Purchasing and Pay for Performance

DHS is exploring value-based purchasing strategies such as gain sharing, risk sharing, episodes of care, centers of excellence, bundled payments and accountable care organizations. PH-MCOs have the flexibility to negotiate payment arrangements with the providers in their networks that includes fee-for-service, capitation and other models for payment.

For example, DHS may institute episode of care (EOC) payments for PH- and BH-MCOs. Initial EOC payments could address: perinatal care, asthma, diabetes, hypertension, and SUD treatment. Providers that meet defined volume thresholds for each EOC would be measured on cost and quality metrics. As another example, the Department could develop a pay for performance (P4P) program focused on issues such as preventable admissions and readmissions.

Additionally, DHS will continue to provide funding for the MCOs to develop P4P programs with their providers. DHS will take into consideration the administrative burden as well as the fees the providers can earn when reviewing the MCOs proposals for expenditure of these funds.

Encouraging Patient-Centered Medical Homes

The patient-centered medical home (PCMH) model has proven effective for many states at reducing costs, while providing an innovative approach to health care delivery, and improving quality and efficiency through comprehensive patient-centered preventive and primary care. The PCMH model is designed around patient needs and tries to aim for the following goals:

- Improved access to care (e.g. through extended office hours and increased communication between providers and patients via email and telephone);

- Increased care coordination;
- Reduced costs; and
- Enhanced overall quality.

The medical home relies on a team of providers (i.e. physicians, pharmacists, nurses, etc.) to meet all of the person's health care needs. Research demonstrates that the attention a PCMH provides to the whole person and the integration of all aspects of health care offer the potential to improve physical health, behavioral health, access to community-based social services and management of chronic conditions.

DHS will most likely encourage the PH-MCOs to make use of alternative contracting strategies such as the use of traditional, primary care provider-led, PCMHs and Health Homes (HH), which provide for more flexibility. DHS will be working closely with recommendations that will be forthcoming from the Patient-Centered Medical Home Council. Some of these initiatives potentially include:

- Pursuing the SAMHSA opportunity for Certified Community Behavioral Health Clinics (CCBHCs).
- Developing contract requirements and payments for focused PCMH or HH for PSMI and SUD as recommended by the Patient-Centered Medical Home Council.

Improving Access to Quality Care

Access to quality providers is essential to maintaining a successful HealthChoices program. DHS is exploring a number of options to increase consumer access to needed services, especially in rural and underserved areas of the commonwealth. These include:

- Expanded use or incentives to increase use of telemedicine and telehealth.
- Inclusion in MCO provider networks of all Federally Qualified Health Centers and rural health clinics located within its regions that are willing to accept the fee-for-service provider prospective payment rates as payment in full.
- Expanded use of physician extenders. DHS launched the MCO Community-Based Care Management (CBCM) Program and provided an additional \$17.5 million in funding in this past fiscal year's budget for MCOs who submitted a plan for the use of community-based care approaches and activities, including the use of social workers, RNs, community health workers and other peer support workers to improve outreach and management of members. Research has shown that face-to-face approaches are more successful in helping patients to navigate and adhere to treatment regimens, and a report assessing

CBCM programs is due in November 2015 to help create “best practice” approaches to be implemented to improve outreach and management of members.

- DHS will continue to work with the MCOs and provider community to improve access to dental providers including pediatric dentists.

Streamlining the Provider Experience

DHS understands that a significant part of improving care for consumers is to streamline the process for providers and DHS is striving to improve the provider experience within the HealthChoices program. To enhance this, DHS is working on reducing or eliminating barriers for providers to participate in the Medical Assistance (MA) program including the following:

- DHS is instituting efficiency improvements for provider MA enrollment which will in turn improve turnaround times for the PH-MCO credentialing process.
- DHS is developing HealthChoices agreement language that will require PH-MCOs to begin credentialing concurrently while providers await MA enrollment. DHS is also considering convening workgroups to identify barriers and explore development of a common credentialing process for HealthChoices.
- DHS is committed to reducing or eliminating barriers for providers to co-locate services, and is working to clarify policies related to providers who are sharing space and co-located.
- As part of the HealthChoices re-procurement, DHS will also explore and carefully consider the number of MCOs per zone to promote competition, innovation and viability along with consideration of administrative workload.