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**MEDICAL SOCIETY**

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2011 edition

# 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

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## An Overview of Pennsylvania's Physician Marketplace

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### Note Regarding Sources/References:

This is not an academic report and the authors have chosen not to include footnotes or endnotes within the text to improve the readability of the document. Some of the narrative has been incorporated, in a general way, from other sources, with the goal of consolidating a large amount of information regarding this very broad topic in one comprehensive document. That said, a list of sources is included at the end of the report.

# 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 up to more than 1 million 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.

It has often been said, and it is certainly true, that "insurance coverage does not ensure access to or quality of care." Unless aggressive action is taken to address the challenges identified in this report, the expansion of coverage to a large percentage of Pennsylvania's uninsured population will cause serious disruptions to the health care system.

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 (also referred to in Pennsylvania as the Medical Assistance or the "MA" Program), with its relatively 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 to purchase insurance through what are known as "Health Insurance Exchanges."

Another factor that must be noted is that Pennsylvania is in a dire fiscal situation. The economic downturn has led to more people needing services from state government, especially through the Medicaid program. At the same time, revenues are below what is needed

to fund the increases necessary to provide additional care to the newly eligible. Additionally, federal monies that were designated to assist states to deal with the recession will cease on June 30, 2011.

Current estimates are that the commonwealth will face a deficit of \$4 billion as the fiscal year 2011-2012 budget is debated. With an annual expenditure of \$28 billion, the governor and General Assembly will face a considerable challenge crafting a budget. The options available to balance the budget and make up the magnitude of the predicted deficit are quite limited.

With the governor's pledging not to raise taxes, it is anyone's guess what will eventually be resolved in the governor's budget, which must be balanced, even though it was presented to the General Assembly in March 2011. Since eligibility for Medicaid may not be allowed to be more restrictive than it is currently, some options the governor will likely consider are eliminating optional services, reducing payment rates for providers, placing additional limits on the number of services provided and increasing patient copayments and deductibles. These changes produce immediate and measurable savings.

Other possible ways to save funds are harder to measure and have longer timelines to produce savings than the options mentioned above. These include improving care coordination for dual-eligibles, individuals needing long-term care services, those with both behavioral health and chronic conditions, and other high cost consumers, all of which are discussed in this report. Also, many of the efficiencies, benefits and innovations that are predicted to occur with health care reform will not happen for several years.

The purpose of this report is to generally describe the scope and extent of these challenges (with a specific focus on the Medicaid Program),<sup>1</sup> and then outline three specific policy responses that should be considered by state policy makers in order to address the upcoming challenge to provide adequate access to care. Specific initiatives will be suggested, where appropriate.

<sup>1</sup> The Medicaid program is particularly relevant for state policy makers. Although the commonwealth has the ability to influence the provision of health insurance in the commercial market through its regulatory power, its power is limited. In the Medicaid program, the commonwealth is the payor and regulator, and has the discretion, consistent with the provisions of state and federal law, to alter the design of the program, experiment with novel payment methods, and otherwise implement initiatives to control costs.

General policy responses outlined in this report can be grouped into the following three categories:

- 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.

This report is organized into several major sections. A brief summary of each section is outlined below:

**Section 1 – Pennsylvania’s Health Care**

**Landscape.** This section provides an overview of how health care is financed in Pennsylvania, with a specific focus on the Medicaid Program. This overview also provides some general background on current reimbursement rates, as well as emerging trends in Pennsylvania to reform the system through improved management.

**Section 2 – Physician Supply and the Decline of Primary Care Physicians.**

This section provides a brief snapshot of the state of medical practice in the commonwealth, as well as the current problems relating to access to care. Pennsylvania’s ability to recruit and train Pennsylvania citizens to attend local medical schools, encourage them to practice in Pennsylvania, and train in core primary care specialties is discussed. The effectiveness of Pennsylvania’s current approach is also evaluated.

**Section 3 – Impact of National Health Care**

**Reform.** This section provides a general overview of the major provisions of national health care reform, and the anticipated impact of these provisions on Pennsylvania. The stresses that the enormous expansion of the Medicaid program will impose on Pennsylvania’s delivery system are discussed.

**Section 4 – Critical Pennsylvania Policy Responses.**

This section briefly identifies the aggressive policy responses that must be adopted by Pennsylvania in order to meet the anticipated explosion of demand for services and provide access to primary health care for Pennsylvania’s most vulnerable citizens. These responses include implementing strategies to increase physician supply and encouraging the provision of primary care in health professional shortage areas, aggressively implementing approaches to ensure the financial viability of the Medicaid Program, and adopting strategies to increase Medicaid physician participation rates to increase the likelihood that Pennsylvanians who will be newly-eligible for Medicaid and other insurance will have access to care.

**Sections 5, 6 & 7 – Options and**

**Recommendations.** These sections identify specific initiatives that can be adopted by Pennsylvania policy makers to effectively implement or “operationalize” the three identified policy responses. Evidence and best practices from other states are presented where applicable and relevant, and observations relating to the challenges and viability of each initiative are provided. Specific recommendations are also offered, where appropriate.

It is hoped that this report will serve as a resource for health care stakeholders, for the new administration, and the Pennsylvania legislature.

# 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>2</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>2</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>3</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

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<sup>3</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.

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.

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>4</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

<sup>4</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.

to physicians who serve Medicaid patients can also be evaluated.

- 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.

# Section 1

## 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 more than 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 census bureau recently reported that more than 50 million people were uninsured last year, almost one in six U.S. residents or 16.7 percent of the population. Thus, Pennsylvania has a relatively low number of uninsured, compared to the rest of the country. Some possible reasons include the strength of unions in the

commonwealth (resulting in more employed individuals having their health insurance covered by their employers), higher income and asset limits for persons to be eligible for state sponsored programs, including Medicaid, CHIP, and adultBasic, and better outreach to enroll those eligible into state sponsored programs.

Additional information about the state government health care programs and the uninsured follows.

### Medicaid

#### General description and history

Congress enacted both the Medicare and Medicaid programs in 1965, as part of President Lyndon Johnson's Great Society Program. As these two programs celebrate their 45th anniversary this year, their importance to the health and well-being of many Americans cannot be overstated.

Nationwide, there are approximately 107 million people eligible for and enrolled in one of these two health care programs. That represents over one-third of the population of the United States. Without the coverage provided by Medicare and Medicaid, the elderly, the disabled and poor children and their parents would be unable to receive needed health care services.

Medicare is a program under the jurisdiction of the federal government. It is funded with employer and employee contributions to the Medicare Trust Fund. Title XVIII of the Social Security Act is the federal law laying out the requirements of the Program, and there are federal regulations that implement the Act. In most areas, Medicare is operated by private profit and non-profit health care insurance companies, either as an administrative services organization (ASO) or through insurance purchased by the federal government.

Medicaid is a health care program (not an insurance program.) It is funded with federal and state tax dollars. The program provisions are in Title XIX of the Social Security Act and in accompanying regulations at the federal level. Oversight is through the federal Department of Health and Human Services (HHS), and within that Department, by the Centers for Medicare and Medicaid Services (CMS). In Pennsylvania, the Public Welfare Code establishes the state requirements of the program and there are state regulations that implement the law.

Medicaid was originally designed to provide coverage to those individuals receiving Welfare payments. But over the years, Medicaid expanded to cover many groups not receiving these payments. Also, welfare reform, enacted in the 1990s, greatly decreased those receiving cash assistance from the states. In fact, in Pennsylvania, fewer than 250,000 people received cash grants in 2009-2010, while over 2 million were eligible for Medicaid.

The program has become a major provider of several types of care and a critical funder for many providers. Without Medicaid, it is likely that nursing home care, home and community based services (H&CBS), community health centers, such as Federally Qualified Health Centers and Rural Health Clinics, safety net and many rural hospitals, and the public mental health system would not be accessible to low-income residents. Since Medicaid is such a large payer in the health care system, it is a substantial contributor to the economy, supporting many thousand jobs in the health care sector.

One factor that makes it difficult to coordinate care for this segment of the population is the “churning” of people on and off the Medicaid roles. As individuals go through cycles of employment and unemployment, and as they have episodes that require intensive care they cannot afford and as they spend their own money on health care, they gain and lose eligibility for the program. While there are some elderly and disabled people who will, by necessity, be eligible for the program for their lifetimes, many others may gain and lose eligibility several times each year. Twenty percent of the people eligible for Medicaid will cycle on and off the program in a year.

A major distinction of the program is the diverse nature of the services it covers and the severely ill patients that are eligible for benefits. Many individuals with HIV/AIDs, premature newborns, ventilator-dependent children and adults, autistic children, persons with severe mental illness, drug and alcohol disorders, traumatic brain injuries, and the physically disabled are often eligible for Medicaid. Services that can be covered include rehabilitation, nursing home care, long-term care services (such as home health care and personal care) provided in residences, speech, physical and occupational therapy, respiratory care, care coordination, and targeted case management. These

types of services are often not available under private health insurance policies or are severely limited.

### Size and types of enrollees

In July 2010, according to the Pennsylvania Department of Public Welfare, 2,236,299 individuals were eligible for Medicaid. The number of enrollees has increased every year for the past decade. In July 2000, only 1,424,858 residents were in Medicaid. Five years ago, the number was 1,791,598. The growth of the program has been dramatic. The percentage increase over the decade equals 56 percent, while over the past five years, the program has grown by almost 26 percent.

These increases are likely the result of many factors. In the past few years, the recession led to many people losing their jobs and enrolling in Medicaid. Additionally, fewer employers continue to provide health insurance to their employees, forcing those employees to seek other options for health care coverage. Also, by some measures, Pennsylvania is the third oldest state in the country. As the commonwealth continues to age and as seniors are unable to afford their health care, they turn to Medicaid to cover the services that Medicare does not provide. States across the country have experienced similar growth in their programs.

Relatively few persons in the program are adults without children and many of them have one or more chronic illnesses.

The following chart shows the breakdown of the individuals in Medicaid in Pennsylvania:

Percent of eligibles	
<b>Adults w/o children</b>	6
<b>Elderly</b>	14
<b>Disabled</b>	21
<b>Parents and their children</b>	59

## Guidelines and Benefits

Medicaid has a number of broad guidelines, including:

1. Medicaid is an entitlement program. That is, if an individual meets the income and asset limits and is in an eligible category, that person is entitled to benefits under the program. There is no waiting list. Inadequate funding is not a reason to deny eligibility or services.
2. Medicaid programs must provide certain mandatory services to enrollees, including physicians' services, hospital care, and lab and x-ray services at Federally Qualified Health Centers, nursing facility services for those 21 years of age and older, transportation services, and many more.
3. Optional services, including prescription drugs, clinic services, care by other practitioners, such as dentists, optometrists, podiatrists, chiropractors, hospice services, and several others may also be provided. A list of these services is attached to this report as an exhibit.
4. The program must be operated in the same manner throughout the state, although this provision may be waived in some instances.
5. Minimal copayments may be imposed on enrollees.
6. There is considerable flexibility afforded states to set payment rates for providers.

One of the misconceptions about the Medicare program is that it covers long-term care services, including nursing home care and home and community based services. In fact, Medicare provides these services in only a very limited way. It does cover short-term stays in nursing homes, up to 100 days, when a Medicare recipient is discharged from the hospital. These stays have become more common, with the disappearance of the "step-down" or rehabilitation units of acute care general hospitals. But after the 100 days, if a person continues to require nursing home care, using his or her own funds, using benefits of a long-term care insurance policy (which very few people have), or using Medicaid are usually the only options.

Medicaid is by far the largest funder of long-term care services. It is estimated that two-thirds of the elderly

will require long-term care services in their lifetimes.

Medicaid is the payer of last resort for this type of care and currently pays for 40 percent of the country's long-term care. About 60 percent of the residents of nursing homes are enrolled in Medicaid.

Many admissions to private nursing homes are individuals with middle class incomes. These people are charged the private pay rate until they have exhausted most of their assets. The facility then assists the patient in applying for Medicaid and in many cases the person is determined eligible. Thus, the private nursing home industry treats the Medicaid program as the "insurance" policy for middle class patients. Rules have been implemented that restrict residents of nursing homes from divesting themselves of their assets (giving their funds to their children) in order to become eligible for Medicaid, but whole cottage industries exist to figure out how to get around the rules.

It can be difficult for a Medicaid enrollee to gain admission to these private nursing homes. Therefore, public nursing homes become the safety net for Medicaid. They accept all patients and are even higher in their percentage of Medicaid patients. However, because these facilities rely more on Medicaid funding than private homes, they have a hard time maintaining the buildings and providing extra services for residents. They are often referred to as "Medicaid" facilities.

## Eligibility criteria

While the federal government has certain requirements a state must follow when determining eligibility, there is some discretion left to the states. Pennsylvania, as all other states, has developed criteria regarding eligibility for Medicaid, when permitted. The entire process for determining eligibility is quite complicated.

In determining eligibility, states use Federal Poverty Guidelines (FPGs). The FPGs have been described as the level of income below which families lack the resources to meet the basic needs for healthy living, including food, shelter, and clothing needed to preserve health. Federal law requires HHS to calculate FPGs each year for families of various sizes. In 2009, the FPG for a family of two is an income of \$14,570 per year; for a family of four, it is \$22,050 per year.

Given the FPGs, it is clear that Medicaid provides health coverage to many of the poorest, most vulnerable

and most intensive users of health care services in the commonwealth. The following section is a slightly modified version of a DPW website that describes eligibility requirements:

An individual must meet income, resource (in most cases), and other eligibility requirements in order to be eligible for Medicaid. Persons must fall into one of several categories:

- Individuals who are aged (age 65 and older), blind, and disabled. (Identified for Medicaid purposes as SSI-related).
- Families with children under age 21. (Identified for Medicaid purposes as TANF-related).
- Single and married individuals with a temporary disability, age 59 through 64, limited income, or special circumstances. (Identified for Medical Assistance purposes as GA-related):
  - Under-going drug and alcohol treatment
  - Victim of domestic violence
  - Caring for a child or disabled person
- Special Medicaid conditions.

## Income

Medical Assistance eligibility is determined using income and household size in comparison to income limits. Age and disability are also factors in determining which income limits apply. (Income limits for the various eligibility groups are listed below.)

Examples of income counted in determining eligibility include:

- Wages (certain deductions are allowed)
- Interest
- Dividends
- Social Security
- Veterans' Benefits

- Pensions
- Spouse's income if living with him/her

Examples of income not counted when determining eligibility include:

- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI)
- Food Stamps
- Low Income Home Energy Assistance Program (LIHEAP) benefits
- Foster Care payments
- Certain housing or utility subsidies
- Weatherization Payments

## Resources

Medical Assistance eligibility is also determined using resource and household size in comparison to resource limits. (Resource limits for the various eligibility groups are listed below or in the section for that category.)<sup>5</sup>

Examples of resources counted in determining eligibility include:

- Cash
- Checking accounts
- Savings accounts and certificates
- Christmas or vacation clubs
- Stocks and bonds
- Some trust funds
- Life insurance
- Vehicles
- Revocable burial funds
- Non-resident property

<sup>5</sup> Resource limits do not apply for families with children in the household, under their care and control, and under the age of 21.

Examples of resources not counted in determining eligibility include:

- A recipient's home
- Revocable and irrevocable burial reserves subject to specified limits
- Burial space and marker
- One motor vehicle

### Resource Limits

Each Medical Assistance eligibility group has resource limits. The charts below provide specific details:

Non-Money Payment (NMP) Medical Assistance	
<b>GA-Related</b>	<b>SSI-Related</b>
One Person = \$250	One Person = \$2,000
Two People = \$1,000	Two People = \$3,000
TANF-related = Does not apply: Resources for families with children in the household and under care and control are excluded.	

Medically-Needy Only Medical Assistance	
<b>GA or SSI-Related</b>	<b>Cost Sharing, Specified Low-Income Medical Assistance Beneficiary, Qualifying Individual Categories</b>
One Person = \$2,400	One Person = \$4,000
Two People = \$3,200	Two People = \$6,000
Each Additional = \$300 Person	
TANF-related = Does not apply: Resources for families with children in the household and under care and control are excluded.	

### Other Eligibility Requirements

- **Identity** - Identity can be verified by a driver's license, state identification card, or another piece of identification.
- **Social Security Number (SSN)** - A SSN must be provided for each person applying for Medical Assistance. County Assistance Office staff will help

you apply for a SSN for anyone who does not have one.

- **Residency** - Medical Assistance is available to individuals who are residents of Pennsylvania if all other eligibility requirements are met. There is no requirement regarding the length of time that a person must live in Pennsylvania.
- **Citizenship** - Medical Assistance is available to U.S. citizens, refugees, and certain lawfully admitted aliens. Other aliens may be eligible for limited Medical Assistance benefits if an emergency medical condition exists. U.S. citizens, refugees, and legal aliens must submit documentation proving U.S. citizenship or legal alien status.

### Funding and expenditures

Medicaid is funded by the state and federal governments. The state and federal shares of funding for services provided in Medicaid is determined using a complicated formula that takes into account the per capita income of the state, with the federal government contributing between 50 percent, at a minimum, and 76 percent in the poorest state. Administrative costs are also funded with state and federal funds, and vary depending upon the nature of the expenditure.

One of the difficulties faced by state administrators is that the Medicaid program becomes much more important and more costly during difficult economic times. As people lose their jobs and employers cut back on providing health insurance, more residents become eligible for Medicaid. However, this is the same time that state revenues are declining. Businesses and their employees have reduced incomes, contributing less in state corporate and personal income taxes, and individuals and families purchase fewer goods and services, resulting in lower sales tax revenue. Over the years, states have taken a variety of steps to deal with this situation, including:

1. Raising revenues through income and sales tax increases.
2. Implementing programmatic cost containment strategies, such as reducing provider fees, placing

limits on services, eliminating optional benefits, and developing alternatives to expensive nursing home care.

3. Implementing administrative cost containment proposals, such as increasing fraud and abuse activities, improving claims processing systems to identify and deny payments for inappropriate services, and outsourcing certain functions.
4. Employing creative financing techniques, such as intergovernmental transfers and provider specific taxes.

It is the conventional wisdom among Medicaid officials throughout the country that all of the “low hanging fruit” has already been picked. There are no magic bullets to save large amounts of Medicaid dollars. Future efforts will need to be more thoughtful and creative. Most believe that the single most important effort should be to focus on managing, integrating and coordinating care for the 5 percent of Medicaid recipients for whom 50 percent of the funds are expended. Suggestions relating to possible strategies to accomplish this objective will be discussed later in this report.

Recognizing the extremely difficult times we now face, Congress passed the American Recovery and Reinvestment Act (ARRA), which, in part, provided states with additional funds to administer Medicaid. Prior to ARRA, Pennsylvania’s Federal Medical Assistance Percentage (FMAP) was about 55 percent. ARRA increased Pennsylvania’s FMAP to almost 66 percent.

That additional funding was due to stop in December 2010, but Congress recently agreed to continue that funding, at a reduced level, through June 2011. At that time, Pennsylvania faces a decline in federal money for its Medicaid program of almost \$2 billion.

Medicaid is administered by several organizational units in Pennsylvania, including the Offices of Medical Assistance Programs, Mental Health and Substance Abuse Services, and Developmental Disabilities in DPW, as well as the Department of Aging. The governor’s budget for 2010-2011 estimates that a grand total of over \$20 billion will be appropriated for Medicaid, as follows in the chart:

<b>STATE FUNDS</b>	<b>In thousands</b>
<b>General Funds</b>	\$5,572,207
<b>Assessments (for certain providers)</b>	1,047,016
<b>Tobacco Settlement Funds</b>	231,578
<b>Lottery Funds</b>	178,438
<b>Other State Funds</b>	73,940
<b>Total</b>	<b>\$7,103,179</b>
<b>Federal Funds</b>	
<b>Federal Medicaid Funds</b>	11,161,799
<b>ARRA Funds</b>	1,858,024
<b>Other Federal Funds</b>	10,000
<b>Total</b>	<b>\$13,029,823</b>
<b>GRAND TOTAL</b>	<b>\$20,133,002</b>

When viewing this level of spending, it must be remembered that 16 percent of Pennsylvania’s lowest income, frail elderly, severely disabled, ventilator-dependent, chronically ill, and seriously mentally ill residents are among the residents receiving care.

When analyzing Medicaid spending, comparisons to private insurance are often examined. Medicaid is the more expensive program on a per enrollee basis because many of its members are elderly and disabled and need services that are expensive and outside the scope of most private insurance coverage. But, studies have shown that when adjusted for the severity of illness of the population, Medicaid actually spends less than private insurance. Nationally, average annual growth in spending for Medicaid and private insurance between 2000 and 2008 were both five percent.

Pennsylvania’s Medicaid program also makes supplemental payments to hospitals. It is required by federal law to make certain disproportionate share payments. (Other such payments are permitted but not required.) The payments recognize that the same hospitals that see the most Medicaid patients are also treating the most uninsured patients. These payments will be decreased as PPACA is implemented. There are eligibility criteria and formulas to determine which hospitals qualify for these payments and how much they receive.

There are additional disproportionate share payments, the most notable being the Community Access Fund. This payment was created when most of the General Assistance category was eliminated in the 1990s, thus increasing the number of uninsured. There are a few additional, but much smaller disproportionate share payments, many that target just one or two hospitals.

Finally, there are payments made to hospitals for medical education. These payments, modeled on similar payments made through the Medicare program, are suppose to recognize the additional costs incurred by hospitals with physician resident and nurse teaching programs.

The budget for 2010-2011 called for reducing these payments, but an agreement with the hospital industry to impose an assessment on all hospitals will result in no reductions and will, in fact, mean additional payments to hospitals.

The largest disproportionate share payments and medical education payments outlined in the 2010-2011 governor's budget are as follows. The numbers are in thousands.

	Total	Federal	State
<b>Required disproportionate share</b>	\$88,977	\$43,779	\$45,198
<b>Community access fund</b>	\$81,846	\$43,782	\$38,064
<b>Medical education</b>	\$84,074	\$55,670	\$28,404

### adultBasic

As stated above, federal participation in the Medicaid program is limited to people who fall into one of several categories, including children, the aged, blind, and disabled. An excluded group is low income adults without children.

States may choose to cover this group using all state funds. Pennsylvania opted to do this when the program began and, under its Medicaid program, arranges for health care services for these very low income adults.

In Pennsylvania, this group is referred to as General Assistance. Only about three percent of the people eligible for the Pennsylvania Medicaid program fall into this category. Because of the very low income limits for General Assistance, many working adults do not qualify as General Assistance recipients.

The General Assembly recognized this situation. In 2001, they established the adultBasic Program as part of Act 77. This Act laid out how the commonwealth was going to use funds provided as a result of the Tobacco Settlement Master Agreement. The adultBasic Program was one of several provisions for utilizing these funds.

The adultBasic program began in July 2002. For an individual to be eligible for the program, his or her income cannot exceed 200 percent of the federal poverty level. The program is operated by private insurance companies, provides only basic health care services, and enrollees are required to pay modest premiums each month. Additionally, to be eligible, a person must have been without health insurance for six months, with some exceptions. Finally, a person cannot be denied coverage due to preexisting conditions.

As funds from the Tobacco Settlement Master Agreement decreased over the years, funding for adultBasic was in jeopardy. State administrators approached Pennsylvania's Blue Cross and Blue Shield Plans for assistance. In 2005, the Community Health Reinvestment Agreement (CHRA) was signed with these non-profit plans. Most of the funding for adultBasic after 2005 was provided by the Blues under the CHRA.

There were approximately 46,000 adults enrolled in the program, and there was a large waiting list of other individuals potentially eligible for the program. However, the size of the waiting list, almost 400,000, was likely overstated since the circumstances of many of those on the list probably had changed, making them ineligible for adultBasic.<sup>6</sup>

<sup>6</sup> As of February 28, 2011, the adultBasic insurance program will have exhausted 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 options (with higher premiums and fewer benefits) known as the "Special Care" program offered by Blue Cross/Blue Shield insurers.

## Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is Pennsylvania's program designed to provide health insurance for Pennsylvania children. It was authorized when House Bill 20 was signed into law in 1992. It was expanded in 2007, through the Cover All Kids initiative. Under CHIP, as expanded by Cover All Kids, all children in Pennsylvania, unless covered by the Medicaid program or private insurance, are eligible for CHIP. Premiums for coverage are required for certain families and are based on a family's income.

CHIP coverage is provided, not by government, but through contracts with several private for-profit and non-profit insurance companies. Enrollees may choose among those companies providing care in their counties.

In 1997, Congress passed the federal program, called State Children's Health Insurance Program (SCHIP). Its characteristics are similar to Medicaid and its structure is similar to Pennsylvania's CHIP, on which many claim SCHIP is based. It is funded by both state and federal funds, with oversight by CMS. However, there is one important difference: SCHIP is a block grant program. Therefore, if a state uses its allocation of federal SCHIP funds, any additional funds used for the program would have to be all state funds. There is also a requirement that state funds be used to match federal SCHIP money.

## The Uninsured

A report issued by the U.S. Census in September 2010 stated that the number of people without health insurance increased from 15.4 percent in 2008 to 16.7 percent (or 50.7 million) in 2009. The percentage with private insurance was the lowest since the government began keeping data in 1987. These numbers reflect the effects of the economic downturn from which we are now slowly recovering. Economic estimates have generally agreed that this recovery will take time and it is possible that the number of people without health insurance will continue to grow, at least, in the near future.

Pennsylvania has over 1,000,000 uninsured individuals, which comprises 8.2 percent of the population. While only 4.6 percent of children under the age of 19 are uninsured (and are likely eligible for CHIP), 24.3 percent of those between the ages of 19 and 25 have no health insurance. There are a large number of individuals who have been uninsured for a long time. 17.5 percent of uninsured residents have been without coverage for five years and 27 percent have been uncovered for over two years.

Many people who are uninsured forgo receiving health care services, particularly preventive care. They simply cannot afford to pay for any health care services that they view as discretionary. But, of course, preventive services are a necessary part of a comprehensive health care plan. These services have been emphasized more in the last several years as one way to reduce costly emergency and hospital care when more serious complications arise due to lack of preventive care.

Others receive health care services from Community Health Centers (CHCs), which include several types of federally funded entities, such as Federally Qualified Health Centers and Rural Health Clinics. CHCs are required to treat the uninsured. 38 percent of CHC patients are uninsured. These facilities are the primary safety net for this population.

Some of the uninsured are eligible for government programs, but have not enrolled. This may be due to lack of knowledge about the programs, inability to pay for any premiums, copayments and deductibles, or not having any pressing medical problems. As discussed elsewhere in this report, the number of uninsured will decrease dramatically as certain provisions of the PPACA are implemented.

The next section of this report will provide a general overview of the current status of the issue of physician supply in Pennsylvania, before addressing the anticipated impact of national health care reform on Pennsylvania's health care delivery system.

## Section 2

### **Physician Supply and the Decline of Primary Care Physicians**

Unfortunately, for many already “insured,” health care coverage does not equate to access and access does not guarantee quality. One needs to look no further than the Medicare and Medicaid programs where, since their inception, in virtually every state in the nation there have been access issues for certain provider specialties and services and within certain population groups and geographic areas. This has also been true of other government run or financed health programs such as Women, Infants and Children (WIC), CHIP, Veterans Administration as well as coverage offered through for-profit and non-profit insurers and care offered through private practices (large and small, urban and rural) as well as care at or through hospitals, health centers and health systems of every kind. Unless major coordinated and aggressive actions are taken, the disparity between coverage and access to quality health care will become even more acute as new coverage mandates are implemented as a result of PPACA.

The purpose of this section is to provide general background information relating to the current state of physician supply in Pennsylvania, as well as information relating to the decline of primary care physicians. This report will then discuss current health professional shortage areas in Pennsylvania, provide a survey of current physician data, discuss graduate medical education issues, and assess the shortage of nurse practitioners and physician assistants. Information regarding Medicare and Medicaid participation issues is also provided. Finally, this section provides a basic overview of programs currently in place that are designed to encourage the training, recruitment, and retention of primary care physicians, nurse practitioners, and physician assistants.

#### **Physician Supply Issues Nationally and in Pennsylvania**

Even before an additional 32 million individuals become eligible for insurance in 2014, the overall supply and specialty and geographic distribution of physicians is

insufficient nationally and in Pennsylvania. The shortage of active primary care physicians is a particular problem by any measure and differs sharply depending where one lives. In his January 2010 report to the Pennsylvania Medical Society, Peter Cunningham, Ph.D., noted that although the general physician supply in Pennsylvania is similar to the average for the U.S., simulated estimates of access for Pennsylvania counties indicate considerable variation (largely reflecting differences in uninsured rates and other population characteristics) and differences in physician supply also contribute to differences in access. This report includes similar findings on access and notes the troubling statistic that more than one-third of physicians had difficulty obtaining a specialty referral in the past year.

The expansion of coverage mandated by PPACA relies heavily on the primary care workforce, in particular physicians, advanced practice nurses, and physician assistants. It is also heavily dependent upon the expansion and staffing of Federally Qualified Health Centers (FQHCs) and other health centers and clinics in areas already known to have shortages. (See Section 3 Table, “PPACA Funding for Health Care Workforce and Primary Care).”

#### **Current Health Professional Shortage Areas**

The federal Health Services and Resources Administration (part of HHS), with state input, assesses primary care need and designates health professional shortage areas (HPSAs) for primary medical health professionals (there are also designations for mental health and dental shortages). These designations are granted as the result of assessments and applications prepared by the states and can be made based on a geographic service area, population group, or facility. They are a key qualifier for federal funding assistance for health center expansion/development, more favorable reimbursement, recruitment and retention benefits, etc. As the data indicate below, both the nation and Pennsylvania are already in a precarious situation. The nation faces a shortage of primary care physicians, and Pennsylvania is in need of an additional 325 primary care physicians.

### Primary Medical HPSA Data for Pennsylvania and United States as of September 1, 2010

Data	PA	US
<b>Number of Primary Medical HPSAs</b>	174	6,247
<b>Population in Primary Medical HPSAs</b>	1,411,959	66,052,207
<b>Estimated Underserved Population Using 2000:1 Ratio</b>	736,744	37,434,053
<b>Primary Care Physicians Needed to Remove Designation</b>	149	7,399
<b>Primary Care Physicians Needed to Achieve 2000:1 Ratio</b>	325	17,078

Keep in mind that these designations understate the problem, as it is difficult or impossible to obtain designations in areas where medical schools create a high density of physicians, even though the presence of medical schools does not always translate into primary care patient access.

### Current Pennsylvania Physician Data

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

- 68 percent of Pennsylvania's licensed physicians are engaged in patient care (about 32,000).
- About 8,800 physicians with Pennsylvania licenses practice outside the state.
- About 13.2 percent of physicians practice part-time.
- 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 two of every five physicians are employed by hospitals or multi-specialty group practices.
- 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.
- 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 share of primary care physicians than the U.S. in general.
- 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.
- 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 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.)

Pennsylvania has a fair share of the many allopathic and osteopathic medical schools in the U.S. with seven allopathic medical schools and two colleges of osteopathic medicine. It also has numerous primary care residency programs. 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.

## Graduate Medical Education Issues

Looking forward, the Association of American Medical Colleges (AAMC) estimates that at current graduation and training rates, the nation could see a shortage of 125,000 doctors nationally in the next 15 years. Of about 954,000 doctors nationally, 352,900 are primary care physicians but the AAMC estimates a need for 45,000 more primary care doctors by 2020. Worse yet, within the next five years, AAMC estimates a national shortage of about 63,000 physicians across all specialties.

The challenge is even more daunting considering that the U.S. only trains about 27,000 doctors a year, according to a January 2010 editorial by the current president and CEO of the Association of American Medical Colleges and former Dean of Pennsylvania State University (PSU) School of Medicine, Darrell Kirch, M.D. A careful review of these statistics reveals an even more alarming trend relating to shortages in primary care. Although the Council on Graduate Medical Education (COGME) recommends that at least 40 percent of the physician workforce be in primary care, it noted in a May 2009 letter to Secretary of Health and Human Services Kathleen Sebelius and Congressional leaders that the primary care physician workforce (now 35 percent of all practicing physicians) is declining rapidly. Further, studies indicate that fewer than 20 percent of all U.S. medical students are choosing primary care specialties.

Literature addressing this issue has identified numerous factors that serve to discourage primary care as a career choice. These factors include poor income relative to other specialties, few primary care role models during their exposure to clinical medicine, high and underfunded administrative burdens required to care for complex patients, lack of respect, professional isolation, limited time off, and difficulty in finding jobs for spouses (in rural settings). These issues must be addressed in order to successfully address these shortages.

## Nurse Practitioners and Physician Assistants

In assessing the current status of the ability of the health system to provide adequate primary care, the

supply of nurse practitioners (NPs) and physician assistants (PAs) must also be evaluated. The Trust for America's Health (TFAH) estimates that Pennsylvania has an overall nursing shortage of 21,200, ranking it fifth in the country. Taking a closer look at advanced practice nurses and physician assistants reveals many of the same supply and demand issues already discussed related to physicians. Richard A. Cooper, MD, a professor of medicine and senior fellow, Leonard Davis Institute of Health Care Economics, notes that as with physicians, our health care system has failed to adequately train or provide a sufficient supply of NPs or PAs to meet the needs of a technologically advanced and accessible health care system and future demand.

### National Nurse Practitioner and Physician Assistant Outlook

<b>Nurse Practitioners:</b>	<ul style="list-style-type: none"> <li>• Output is approximately 8,000 yearly and has not changed for several years.</li> <li>• Even if all new NPs practiced primary care (whether independently or not), the services that they delivered would be equivalent to approximately 25,000 primary care physicians; yet, the deficit of primary care physicians in 2015 could be twice that number, and, of course, not all NPs will practice primary care.</li> </ul>
<b>Physician Assistants:</b>	<ul style="list-style-type: none"> <li>• The number of PAs in practice could double to 110,000 by 2015 but this is less than one PA for every five medical and surgical specialists.</li> <li>• Many older physicians are accustomed to practicing without PAs, but residents and fellows in technically demanding specialties learn in teams that include PAs, and they expect PAs to be part of their teams in the future. Yet, there simply will not be enough.</li> </ul>

On October 5, 2010, the Institute of Medicine released the report, *The Future of Nursing: Leading Change*,

*Advancing Health*, which contains four key messages: 1) nurses should practice to the full extent of their education and training; 2) nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; 3) nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the U.S; and 4) effective workforce planning and policy making require better data collection and information infrastructure.

According to Kaiser Health News (October 6, 2010), the AMA response quoted in *The Hill* (October 5, 2010) supported “a physician-led approach to care—with each member of the team playing the role they are trained to play ...” and the *Wall Street Journal’s* Health Blog (October 5, 2010) predicts the most controversial recommendations are likely those that deal with “scope of practice.” While there are still some seriously contested payment issues regarding compensation for services by advanced practice nurses in Pennsylvania (as in many other states), Pennsylvania advanced practice nurses already have prescriptive authority and there are a number of nurse managed practices in the commonwealth, the largest and most notable in Philadelphia.

Professor Cooper and others see no way that health care reform can succeed without adequate numbers of physicians, nurse practitioners, and physician assistants, and without taking steps to ensure that major portions of the work that are currently performed by physicians become the responsibility of other skilled professionals, principally PAs and NPs. It would appear that Donna Torrisi, one of Pennsylvania’s foremost advocates of nurse practitioners and nurse-managed clinics, would agree at least in part with Cooper. She is quoted in a recent *USA Today* feature as commenting that “you need everybody” to meet the need for primary care. “You need the doctors. You need the physician assistants, you need the nurse practitioners.”

The commonwealth needs to take full advantage of its variety of practice types, settings, and scope of practice policies to more effectively meet existing and future demand in all areas of the state and particularly in “primary medical health professional shortage areas.” As mentioned in other areas of this document, there is also increasing interest and encouragement at the federal level in accountable care organizations and primary care medical homes—noteworthy models of each are developing in Pennsylvania and these models could make best use of the training, skills, and competencies of all members of the health care team.

## Medicare and Medicaid Physician Participation Issues

Troubling trends regarding physician participation are emerging to one degree or another in many places across the country including Pennsylvania. Although the Cunningham report to the Pennsylvania Medical Society cites simulated estimates for Pennsylvania indicating that physicians in the state are less likely to have closed practices with respect to Medicare and Medicaid patients than the U.S., they likely experience greater problems with specialty referrals than U.S. physicians generally.

As more “baby boomers” reach Medicare age and PPACA adds an enormous number of previously uninsured or under-insured Pennsylvanians to Medicaid, the problem can only get worse if not addressed. The access problem is even more acute for those predominantly low income, rural and minority Medicare recipients that were the beneficiaries of the additional benefits offered by Medicare Advantage plans. These plans are under severe financial pressure, as much of the funding for PPACA will be funded through reduced Medicare expenditures.

In June, prompted by Congressional failure to stop an automatic cut in Medicare payments (already only 78 percent of private insurer rates), *USA Today* took a look at Medicare participation rates across the country. The

indicators even before the proposed cut are probably just a preview of what lies ahead, cut or no cut. For example, the article found as follows:

Examples: Medicare Participation Studies	
• The American Academy of Family Physicians: 13 percent of respondents did not participate in Medicare last year, up from 8 percent in 2008 and 6 percent in 2004.	
• The American Osteopathic Association (AOA): 15 percent of its members do not participate in Medicare and 19 percent do not accept new Medicare patients. If the cut is not reversed, AOA says, the numbers will double.	
• The American Medical Association: 17 percent of more than 9,000 doctors surveyed restrict the number of Medicare patients in their practice. Among primary care physicians, the rate is 31 percent.	
• Illinois: 18 percent restrict the number of patients and in New York, about 1,100 doctors have left Medicare. Even the medical society president is not taking new Medicare patients.	
• Texas: Texas doctors have been fleeing Medicare for several years. Opt-outs in Texas went from three or less per year between 1998-2002, rising to 70 in 2007, 151 in 2008, 135 in 2009 and on pace for 200 in 2010. Worse yet, a Texas Medical Association poll found that more than four in 10 doctors are considering opting out.	

The system is in jeopardy of entering a vicious cycle, where a larger and larger share of patient load is funded by low paying and “high hassle” Medicare and Medicaid programs, and the economic and administrative burden on practices will lead more to refuse new Medicare and Medicaid patients or opt out altogether. The more that this occurs, the greater

the burden on those practitioners who still serve and accept Medicare and Medicaid patients.

## Policies in Place to Train, Recruit, and Retain Primary Care Physicians, Nurse Practitioners, and Physician Assistants

While Pennsylvania, and the country generally, are currently experiencing difficulties in ensuring an adequate supply of physicians and other health professionals, it is important to note that several programs are in existence with the primary goal of addressing this issue.

The primary health system infrastructure designed to provide access to primary care are Federally Qualified Health Centers (FQHCs), FQHC Look-alikes, Rural Health Clinics, and other mission-like providers. In Pennsylvania, these providers, which are represented by the Pennsylvania Association of Community Health Centers (PACHC), serve more than 600,000 people at more than 200 sites in underserved areas throughout Pennsylvania. FQHCs receive federal grants to support access of uncompensated care, enhanced Medicaid and Medicare revenue, access to medical malpractice coverage, and other benefits. The Pennsylvania Department of Health (PA DOH) also funds the association to expand access to health care within Pennsylvania by providing technical assistance to communities and organizations interested in expanding access to care by establishing FQHCs and FQHC Look-alikes.<sup>7</sup>

In addition to this safety net program, other important programs exist (which are outlined in the chart on page 29) to improve access. Understanding the scope and extent of these programs is important before additional action can be proposed.

<sup>7</sup> An FQHC Look-alike is an organization that meets all of the eligibility requirements of an organization that receives federal grants, but does not receive grant funding. FQHC Look-alikes receive many of the benefits of FQHCs, most notably enhanced Medicare and Medicaid reimbursement.

## Current Programs Relating to the Training, Recruitment, and Retention of Primary Care Physicians, Nurse Practitioners, and Physician Assistants

<b>Pennsylvania Department of Health Shortage Area Designation Activities:</b>	The Pennsylvania Department of Health (PA DOH) assesses, provides technical assistance, and applies for federal medically underserved designations in Pennsylvania for Health Professional Shortage Areas (HPSAs) for Primary Care, Dental, and Mental Health, and for Medically Underserved Areas (MUA) and Medically Underserved Populations (MUP). The PA DOH also funds PACHC to expand access to health care within PA by providing technical assistance to communities and organizations interested in expanding access to care by establishing FQHCs and FQHC Look-alikes.
<b>State Loan Repayment Program (SLRP):</b>	This is a federal and state funded program for primary health care practitioners providing direct patient services in HPSAs. Each participant contracts for a minimum of three years and a maximum of four. Physicians and dentists are eligible for up to \$64,000 of loan repayment; nurse practitioners, nurse midwives and physician assistants are eligible for up to \$40,000.
<b>Conrad State 30 J-1 Waiver Program:</b>	This federal program permits the PA DOH to recommend up to 30 international medical graduates completing their training in the U.S. to have the requirement of their J-1 Visa to return to their home country at the completion of their training waived. This waiver requires that these physicians provide care for three years in a HPSA, MUA or MUP.
<b>Community Primary Challenge Grant Program:</b>	This is a state funded annual competitive grant program that funds grantees in HPSAs and MUAs to increase access to primary medical and dental care through the expansion of primary care services, and the increase of primary care providers. Grantees are generally funded for 24 months.
<b>National Health Service Corps:</b>	This is a federal program that provides loan repayment and scholarship opportunities for practitioners who provide health care in HPSAs. The PA DOH works cooperatively with HRSA on the coordination of elements of this program.
<b>Pennsylvania Office of Rural Health (ORH) – Penn State University:</b>	This office, funded by the U.S. Department of Health and Human Services (USDHHS) and PA DOH, is dedicated to rural health education, outreach and advocacy.
<b>Pennsylvania Area Health Education Centers (AHEC):</b>	The USDHHS and the PA DOH fund AHECs (through the PSU College of Medicine) to: increase the recruitment of primary care providers into underserved communities through community-based training; improve retention of primary care providers in underserved communities by offering statewide and regional continuing education programs; increase the number of individuals from minority and underserved communities who enter primary care and allied health professions by providing health career promotional programs; and assist primary care providers in preparing to respond to community medical needs in the event of a public health emergency and facilitate participation by primary care providers in local emergency preparedness planning.
<b>Bridging the Gaps Community Health Internship Program:</b>	The DOH provides funding for this seven week summer program linking the training of health professions students with internships at practice sites in underserved communities (Philadelphia, Pittsburgh, and Erie.)

As demonstrated by the above summary, Pennsylvania has instituted a large number of programs designed to help ensure adequate physician supply, and to encourage the provision of primary care in professional health shortage areas. The data set forth in this section, however, demonstrate that these efforts—even

before the advent of health care reform (described in the next section)—have not been commensurate with the scope of the problem.

In the next section, we will assess the impact of national health care reform nationally and in Pennsylvania.

## Section 3

### Impact of National Health Care Reform

National health care reform provides a major opportunity for Pennsylvania to provide additional care for its neediest citizens and most underserved communities. The increased demand that will be experienced by the health care delivery system as a result of national health care reform coverage expansions could, however, overwhelm the existing system and jeopardize access to care for all of Pennsylvania's citizens.

Below, some of the major components of health care reform will be outlined and discussed, with a specific focus on how the legislation will affect the commonwealth's Medicaid program. In addition, the likely affect of coverage expansions—based on evidence from the recent experience in Massachusetts—will be described. As will be demonstrated below, the anticipated affect of health care reform on Pennsylvania will be enormous.

#### National Health Care Reform

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (PPACA), into law. In summary, the legislation will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- 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 some people to make coverage more affordable.
- 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.
- 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.
- Health insurance risk pools for individuals with pre-existing conditions who do not have health insurance coverage will be established.<sup>8</sup>

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 PPACA also includes several provisions to address the shortage of primary care, which are outlined in Table 1 on page 31.

#### Medicaid Eligibility Expansion

Medicaid plays a primary role in covering more of the uninsured under the new health reform law. 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. This will include adults under age 65 without dependent children who are currently not eligible for the program. Subsidies for coverage will be made available through state-based Health Insurance Exchanges for individuals with incomes above Medicaid levels between 133 percent and 400 percent of poverty. Individuals eligible for Medicaid will not be eligible for subsidies in the exchange.

In addition to these major eligibility changes, the law also includes other reforms that will affect the operation of the Medicaid program. For example, in an effort to boost provider participation and access, the health

<sup>8</sup> Pennsylvania's high-cost risk pool program, known as "Fair Care," became operational in August 2010. See the following website for additional information regarding this program: [http://www.portal.state.pa.us/portal/server.pt/community/health\\_insurance/9189/pa\\_fair\\_care/666211](http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/pa_fair_care/666211)

**Table 1: PPACA Funding for Health Care Workforce and Primary Care**

<b>National Health Service Corps (NHSC):</b>	Beginning October 1, 2010, PPACA will provide funding for the NHSC (\$1.5 billion over five years) for scholarships and loan repayments for doctors, nurses, and other health care providers who work in areas with a shortage of health professionals.
<b>Federally Funded Community Health Centers</b>	Beginning October 1, 2010, PPACA is to make \$11 billion available over five years to expand federally funded community health centers which currently serve about 19 million patients a year to which they have added about 2.1 million additional patients as a result of a \$2 billion investment in Community Health Centers in the American Recovery and Reinvestment Act. According to the White House, this \$11 billion investment will <i>nearly double the number of patients over the five year period</i> . In Pennsylvania, they note that this funding can go towards helping the <i>229 existing Community Health Centers in Pennsylvania</i> and can also support the construction of new centers.
<b>Health Workforce Training</b>	On June 16, 2010, HHS announced \$250 million of investments in primary care workforce development (through HRSA) from the \$500 million available in fiscal year 2010 from the new Prevention and Public Health Fund created by PPACA. The \$250 million, will be used to train and develop <i>16,000 new primary care providers</i> by creating additional primary care residency slots (\$168 million), supporting physician assistant training in primary care (\$32 million), encouraging students to pursue full-time nursing careers (\$30 million), establishing new nurse practitioner-led clinics (\$15 million), and encouraging states to plan for and address health professional workforce (\$5 million).

reform law increases Medicaid payments for primary care physicians and services to 100 percent of the Medicare payment rates for 2013 and 2014 with full federal financing for the increased costs. The new law provides full federal financing (100 percent federal) for those newly eligible for Medicaid from 2014 to 2016 and then phases down the federal contribution to 90 percent by 2020. States will receive their current (not enhanced) match rates for individuals currently eligible for Medicaid. A wide array of other reforms affecting the program is also included in the new law.<sup>9</sup>

## Estimated Pennsylvania Medicaid Expansion

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 in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership, and priorities, there is a range of implementation scenarios that will impact the number of people who participate or sign up for coverage. In light of this variation, the study authors identified two models (the “standard participation scenario” and the “enhanced outreach scenario”). The standard scenario represents the most likely estimate, while the enhanced outreach scenario assumes extraordinary success in identifying possible Medicaid eligibles. 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 enormous.

<sup>9</sup> For example, beginning in October 2013, the legislation reduces federal Medicaid disproportionate share hospital (DSH) payments from \$18.1 billion to \$14.1 billion through a methodology developed by HHS. In addition, in January 2014, states will be required to cover children under age 26 who are in foster care as of the date they turn 18 years of age and were enrolled in Medicaid while in foster care. Other notable provisions include the availability of demonstration projects, quality reporting requirements, and program integrity reforms.

## Estimated Enrollment in Pennsylvania Health Insurance Exchange

The Rendell Administration's Governor's Health Care Reform Advisory Committee 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 Insurance Exchange. One notable difference between these models is that Lewin made projections for 2014, while RAND has projected exchange utilization for 2016, after the market has stabilized. In any event, the participation of individuals within this exchange will represent an enormous increase in the number of insured individuals within Pennsylvania.

## Anticipated Medical Needs of Newly Eligible

Commentators have also observed that not only will the health system experience a large increase in the number of insured, but that these individuals will likely have high-medical needs due to their previously limited interaction with the health care system.

A recent report by the Kaiser Commission titled "Uninsured and Untreated: A Look at Uninsured Adults Who Received No Medical Care for Two Years" evaluated this issue to help provide insight on the anticipated medical needs of individuals who will become eligible for Medicaid in 2014. This study confirmed that uninsured adults with incomes at or below 133 percent of the poverty level are likely to have significant unmet needs. For example, the study demonstrated that among adults at or below 133 percent of the federal poverty level who were uninsured for at least two years, 38 percent received no medical care during the two years when they lacked coverage.

In addition, a recent study (which was conducted to help provide insight into the anticipated national expansion of Medicaid included in PPACA) of Oregon's expansion of Medicaid coverage to low-income adults published in a recent issue of *Health Affairs* revealed that individuals who enrolled in the Oregon Medicaid program were likely to have worse health than those that did not. This recent study serves to further support the expanded need for services that will be experienced by the health care system following the 2014 Medicaid expansion.

Simply put, not only will the number of individuals eligible for insurance expand tremendously, the medical needs of the newly insured will be substantial. The "pent-up demand" of these newly insured will serve to add additional stress to the health care delivery system.

## The Massachusetts Experience

In 2006, Massachusetts implemented comprehensive health insurance reform. Because the Massachusetts reform effort contains many of the same elements of its federal counterpart (e.g. mandated coverage, health insurance exchanges, etc.), the experience of this state since its reform effort can be instructive to Pennsylvania and the rest of the nation as they prepare for the 2014 coverage expansion.

While the success of Massachusetts in expanding coverage to approximately 96 percent of its residents (up from approximately 86 percent in 2006) is undeniable, this success has put enormous pressure on primary care. Demand is overwhelming supply, and the physician workforce is coming under more stress and strain. A recent article in the publication *American Medical News* of the American Medical Association summarized the Massachusetts experience and provided the following statistics demonstrating the affect the law has had on the health care delivery system. For example:

- Forty percent of Massachusetts family physicians no longer accept new patients, up from 30 percent in 2007, according to a June 2009 study by the state medical society.
- Nearly 60 percent of internists have stopped taking new patients, up from 49 percent in 2007.
- The average wait for an appointment with a primary care doctor in the state is 44 days.
- The number of primary care physicians practicing in Massachusetts is at a "critical" low.
- According to a Massachusetts Medical Society Physician Workforce Study, physician labor shortages in the primary care specialties of internal medicine and family medicine were found to be "critical," and the specialties of dermatology, emergency medicine, general surgery, neurology, neurosurgery, oncology, orthopedics, psychiatry,

urology, and vascular surgery are facing “severe” shortages.

Despite the challenges being faced by Massachusetts, it is important to note that the state was better situated (due to a relatively larger percentage of primary care providers) to handle the increase in newly insured patients than other states will be when health insurance expansions take effect in 2014. As a result, the experience in Massachusetts should serve as a “wake-up call” to Pennsylvania policy makers responsible for ensuring that the Pennsylvania health care delivery system is able to make the promise of expanded coverage a reality.

In summary, the impact of national health care reform will be enormous. A significant number of uninsured Pennsylvanians will receive new 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.

As noted previously, Pennsylvania is currently facing a shortage of physicians. 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.

## Section 4

### 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 provides 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, as well as the rationale for these goals.

#### 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 care shortage areas. Failure to address these issues will result in increased waiting times for appointments, ongoing utilization of inappropriate emergency room services, lack of preventative care, and adverse health outcomes.

#### Policy Response #2:

##### **Aggressively implement approaches to ensure the financial viability of the Medicaid Program.**

As discussed in previous sections of this report, Medicaid is Pennsylvania's primary vehicle for providing primary health care coverage to low-income and high-need populations, and the program serves as the foundation for expanded coverage under national health care reform. 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 continue to contain costs, the program will continue to crowd out other important spending priorities.

In light of the importance of this program to Pennsylvania citizens and the state budget, as well as the program's critical role in covering uninsured individuals under national health care reform, ongoing and relentless efforts to ensure the financial viability of this program must be a key priority for state policy makers.

#### Policy Response #3:

##### **Adopt strategies to increase Medical Assistance 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.**

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. 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.

Studies have demonstrated that physician 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 care for newly-eligible Medicaid consumers a reality. These initiatives will also be aided by the Administration's efforts to address professional liability reforms.

In the next section, we will identify specific projects or initiatives available to policy makers to implement each of the goals identified in this section.

## Section 5

### **Options and Recommendations: Strategies to Increase Physician Supply in Particular Primary Care Supply**

The governor should send very strong signals that he will take aggressive actions in the present environment (and in 2014 and beyond) to enforce requirements to ensure that both public and private health insurers meet all statutory, regulatory, and contract requirements for providing access to adequate supply of quality providers and services. This message should be accompanied with strong and timely leadership on the development and implementation of strategies which put insurers, health professionals and the broader health system in the commonwealth in a position to be effective stewards of the public's trust and their professional responsibilities to effectively leverage existing resources within Pennsylvania. In addition, leadership must creatively seek and use resources made available by the federal government, foundations, and other sources of funds. It will be critical for the governor to invite, facilitate, lead, and (where necessary) hold appropriate entities responsible, while ensuring that the commonwealth obtains maximum benefit of outside resources and competes effectively for the common "health."

It is also necessary to recognize that the health care workforce is fungible. So although we may have many resources in Pennsylvania to solve access and quality issues, we must assume that our neighboring states are competing for the same resources and adopting innovative strategies. We need strategies to develop our own talent, train them here, and recruit and retain them in the professions and specialties that are most needed, and place and retain them in the places with the greatest need. Given the length of the pipeline and the competition from other states, we also need to continue (and better) recruit health care workforce from other states and countries and to geographic and practice site locations that have the best chance for retention over the long-term. We need to think big,

look for partners and partnerships, be innovative, and do both the big and the small things.

Below, this section of the report will discuss the need for an overarching strategy and governing body to direct this critically important effort. Following this discussion, the report will provide a series of policy options available to aggressively address this issue, and provide some general recommendations that could be provided to the Administration.

### **Need for Overarching Strategy and Governance**

The challenge to ensure that we have an adequate health workforce where and when they are needed must be met and addressed by many players in government, academia, teaching hospitals and other training sites, insurers, regulators, and businesses, among others. A possible vehicle to address these challenges is the Primary Health Care Practitioners Program established by the Children's Health Care Act (Act 113 of 1992, 62 P.S. §§ 5001.101 – 5001.3105), which has a broad mandate as it applies to primary care. A summary of this program is outlined in the chart on page 37.

In order for this program to be as effective as possible, the mandated Advisory Committee (which is now defunct) should be reconstituted and revitalized under the direction of the Secretary of the Department of Health. In addition to the revitalization of the advisory committee, there are significant recommendations relating to the Primary Health Care Practitioner's Program outlined later in this section which can improve its effectiveness in utilizing its resources, leveraging other resources and providing much needed leadership.

While the revitalization of the Primary Health Care Practitioner's Program Advisory Committee is a good first step, there is a pressing need to establish a broader entity to establish an overarching strategy and governance in order to leverage and create synergy of the many assets Pennsylvania has to address the more comprehensive health care workforce needs. These needs go beyond the Health Care Reform Implementation Executive Order (issued by the Rendell Administration) and structures, although such an effort is essential and needs to be continued by the governor

**The Pennsylvania Department of Health Primary Health Care Practitioners Program. This program was established by the Children's Health Care Act (Act 113 of 1992, 62 P.S. §§ 5001.101 – 5001.3105), which authorized or required:**

- The establishment of a Primary Care Practitioner Program in DOH
- Promoting the training of primary health care practitioners and service in rural and inner city designated medically underserved areas
- Promoting the capacity of local communities to support primary health care practitioners
- Promoting the recruitment and retention of primary health care practitioners in rural and inner city designated medically underserved areas
- Providing to the General Assembly an annual report on the activities of the DOH
- To the extent possible, maximizing federal, local, and private funding to achieve the purposes of the Act
- Creating an Advisory Committee to assist in carrying out the provisions of the Act

as a first order of business. The health care workforce supply, demand and distribution issues, if anything, are a more fundamental need to the health care system (not just the health financing system). As stated before, Pennsylvania is experiencing access problems now even without PPACA implementation. To each individual Pennsylvanian, coverage must equal access to quality care.

### **Creation of Health Care Workforce Interagency Workgroup and Public/Private Partnership for Strategic Health Care Workforce Development**

There are several models that can be reviewed by the governor and his staff which may provide some insight for a path forward to create a structure(s) or process(es) for developing the strategic guidance for health care workforce issues and to guide the planning and implementation of many of the recommended

actions below in this and 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.

In Pennsylvania, the governor should establish and charge both a *health care workforce interagency workgroup* lead by the Secretary of Health and composed of other relevant cabinet officers and commonwealth programs and a *public/private partnership for Strategic Health Care Workforce Development* composed of relevant stakeholders in the education, training, financing, recruitment, and retention of the health care workforce (initially, the physician, physician assistant and advanced practice nurse workforce). These entities would develop and commit to overarching collaborative strategies to meet Pennsylvania's needs in the short, intermediate, and long-term. These efforts and entities should be integrated with other relevant existing PA DOH structures and the Secretary of Health should be given the authority and necessary mandates to lead these efforts.<sup>10</sup>

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. These activities could include, as appropriate, various recommendations in this report (which are outlined below), other health care reform activities, health workforce and infrastructure development, and other demonstration and/or evaluation initiatives in accordance with strategic priorities.

<sup>10</sup> The PPACA has funded State Health Workforce Planning Grants made available to states as a way of addressing some of these issues. Pennsylvania's application was made via the State Department of Labor and Industry Workforce Investment Board, in collaboration with the Governor's Office of Health Care Reform, the Department of Health, and the Department of Education. This group and planning effort should be integrated with the interagency workgroup and public/private partnership.

## Options and Recommendations

### 1) 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 Department of Insurance to regulate health insurers. This authority can serve as a catalyst to ensure that health insurers take appropriate steps to ensure access to care for Pennsylvania consumers. 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 equals access to quality care*. He should also announce his direction to 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. He should also instruct for-profit, not-for-profit, and government health insurers to outline steps that they are taking, individually and, to the extent legal and practicable, to ensure plan specific and collective action to invest in primary care workforce issues and to generally meet access requirements.
- **Convene All Health Insurers to Discuss the Successor to (and the Broadening of Participation in) the 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 (and insurer controlled funds as well) as an alternative to the expiring “voluntary” community health reinvestment fund that can be used to strategically target health care workforce issues. Its first priority should be to address primary care workforce issues including but not limited to graduate medical education (GME), recruitment and retention, and practice

support (including use of tele-medicine) in health professional shortage areas. Such a voluntary agreement would obviate the need to legislate a “tax” similar to New York’s Professional Education/ GME Reform incentive pool requiring all payors to contribute to GME.

- **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. Such a fund could also seek matching funds and solicit participation of other existing community, regional, or national foundations. These activities are not without precedent. Wisconsin, for example, mandated an endowment as part of a BCBS conversion.

### 2) Explore Opportunities to Reform Graduate Medical Education

Another critical component to increase physician supply and encourage the provision of primary care in health care shortage areas is to explore opportunities to reform 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 a May 5, 2009, letter to the Department of Health and Human Services, 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.

### COGME Recommendations to Realign Training Priorities:

- Provide incentives and remove statutory barriers to the establishment and expansion of training venues in non-hospital primary care settings, including rural and underserved settings.
  - Mandate accountability for GME funding in order to reshape the incentives for teaching hospitals and academic medical centers to improve the health of the nation.
  - Permanently correct the income disparity between primary care and subspecialty physicians.
  - Make Graduate Medical Education sites laboratories for innovations in primary care delivery and responsible for producing the next generation of physicians who will work in them.
  - Provide financial support for primary care physicians to establish the infrastructure to coordinate patient care and reduce their administrative burden.
- **Identify and Exploit Federal Funding Opportunities.** In addition to other payment reforms noted elsewhere in this document, the governor should direct the Medicaid program to aggressively identify federal match opportunities for primary care training and recruitment and retention strategies in urban and rural underserved areas/populations/facilities and primary care practice settings demonstrating, evaluating, or implementing accountable care organizations, primary care medical homes, and or the Chronic Care Commission.
  - **Improved Use of Medicaid Revenues.** Finally, the Administration should review the feasibility of using or improving the use of Medicaid revenues to pay for a portion of GME. 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.

### 3) Implement Department of Health Policy Reforms

As described above, the Primary Care Practitioner's Program currently exists within the PA DOH. One of the recommendations of this report is to re-institute and revitalize the defunct Advisory Committee mandated in the legislation, and to utilize this Advisory Committee to serve as a focal point to develop and manage current and future recruitment/retention needs, opportunities, and strategies. In addition to re-instituting this Committee, the PA DOH could implement the following additional program enhancements:

- Develop a comprehensive, coordinated and integrated recruitment and retention strategy with PA DOH Primary Care Office, the PA Office of Rural Health, the PA Area Health Education Center, and the Pennsylvania Medical Society. Include liaison with the commonwealth's medical, physician assistant, and nurse practitioner schools to encourage development and support for teaching and mentoring opportunities in primary care in both private and non-profit settings, and promote positive clinical experience in ambulatory settings, particularly in HPSAs, medically underserved areas (MUAs) and medically underserved populations (MUPs).
- Seek resources and accelerate the complete assessment of the commonwealth to identify new and renewed designations for HPSAs, MUAs, and MUPs, including primary medical, mental health, and dental.
- 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. This may require a new governance and decision making mechanism.
- Fill federally funded vacancies in the State Primary Care Office.
- Improve alignment of designation activities with workforce incentives. These improvements could include greater assessment efforts focused on safety net facilities located in areas not eligible for a geographic or population designation, use of the clinician survey process to inform providers of

Primary Care Office Services and Resources, and proactive identification of clinical sites which might benefit from recruitment and retention programs after a geographic or population designation is created or updated.

- 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 by improving 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.

#### 4) 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. A look at loan repayment amounts of neighboring states versus Pennsylvania shows that, from that standpoint alone, Pennsylvania competes poorly for physicians and other primary care practitioners interested in loan forgiveness or repayment in return for serving in designated shortage areas.

#### Comparison – State Loan Repayment and Forgiveness Programs

State	Repayment Terms
<b>Maryland</b>	\$120,000 over four years
<b>Delaware</b>	\$105,000 over three years
<b>Ohio</b>	\$80,000 over four years
<b>New Jersey</b>	\$120,000 over four years
<b>Virginia</b>	\$120,000 over four years
<b>West Virginia</b>	\$10,000 per year in loan forgiveness
<b>New York</b>	\$150,000 over five years plus \$100,000 for practice support over the next two years; or \$40,000 over 2 years for loan forgiveness
<b>Pennsylvania</b>	Physicians and dentists up to \$64,000 over three or four years; Nurse practitioners, nurse midwives and physician assistants up to \$40,000

Possible changes to the legislation authorizing loan repayments could include increasing the amount of loan forgiveness to compete against other states; amending the eligibility application process to consider whether the individual will practice in a medically underserved area; and providing additional weight to Pennsylvania applicants who completed training in Pennsylvania and Pennsylvania natives who completed training out of state.

#### 5) 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 that have already been made to encourage this service.

Nationally and in Pennsylvania there is a surprisingly large reservoir of volunteer talent available to address unmet health needs and underserved populations consisting of volunteer physicians and other health professionals. Volunteers in Medicine (VIM), the only national non-profit dedicated to assisting with the

development of free clinics, notes that there are, nationally over 250,000 retired physicians, 350,000 nurses, and 40,000 dentists. Many find volunteering both meaningful and therapeutic and are joined by many other practicing clinicians.

Many of the VIM clinics are community integrated, owned, and supported. Nine clinics in Pennsylvania are members of the VIM Alliance (in Butler, Erie, Lebanon, Mifflinville, Pittsburgh, Southampton, State College, West Chester, and Wilkes-Barre). Even with the recent passage of health care reform, additional VIM safety net clinics will be necessary for many years to come.

In order to encourage the development of these clinics, the commonwealth can take the following steps:

- Promote existing provisions that facilitate the use and protect the interests of retired and active physician and other volunteer protections.
- Develop initiatives to assist and promote the efforts of VIM and like organizations as appropriate.

- Evaluate the need for and development of improved locum tenens resources for practices and facilities with particular attention to underserved and primary care health professional shortage areas using retired and other practicing clinicians.
- Review the use of or integration of the federal and state Medical Reserve Corps assets for locum tenens and other efforts to address under service.
- Review the use of PA National Guard and Reserve Component medical service personnel to meet civilian needs when it fits the training requirement and objectives of those armed services.

In conclusion, the commonwealth and the administration will face enormous challenges to increase physician supply and encourage the provision of primary care in health 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.

## Section 6

### Options and Recommendations: Strategies to Ensure the Financial Viability of the Medicaid Program

Before providing options and recommendations relating to specific initiatives to ensure the financial viability of the Medicaid Program, it is important to provide some background information on past efforts to reform the program, as well as the current capability of the program to implement these initiatives in light of recent furloughs, funding cuts, and hiring freezes.

#### Assessment of Recent Cost Savings and Containment Initiatives

Over the past decade, the Pennsylvania 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. These activities have been successful in containing the growth of expenditures, while maintaining certain “core principles” adopted by the previous administration of ensuring that no one currently receiving services will lose eligibility, and that children will not experience any reduction in services. The list of initiatives is extensive, and includes the following:

- The establishment of a pharmacy division within the fee-for-service (FFS) system, and a wide range of associated pharmacy cost savings initiatives (e.g. preferred drug list, quantity limits, clinical prior authorizations, dynamic pricing, and payment rate changes).
- Improved contract negotiation efforts, enhanced third-party liability, and improved fraud and abuse detection efforts.
- Implementation of managed care concepts within the fee-for-service delivery system through the establishment of “ACCESS Plus,” an enhanced primary care case management program. These

reforms have included the establishment of a medical home, disease management for individuals with chronic conditions, provider credentialing, and the creation of a case management unit for individuals dealing with multiple and complex chronic conditions.

- Use of a competitive bidding process to select contractors to maintain and operate the specialty pharmacy drug program for individuals receiving services under the FFS system.
- Creation of pay-for-performance programs within the HealthChoices mandatory managed care and ACCESS Plus programs to improve health outcomes and contain costs moving forward.
- Implementation of managed care “efficiency adjustments” designed to identify unnecessary costs within capitated rates paid to HealthChoices managed care organizations, and to subsequently remove these costs from the rates.
- Provider “tax” initiatives (including taxes on hospitals, nursing facilities, ICFs/MR and managed care organizations) designed to maximize federal participation in the Medicaid program.

Although the above-referenced summary is not exhaustive, it provides evidence of the scope and extent of activities implemented by DPW to contain costs. It may be reasonable to conclude, as mentioned previously, that the “low-hanging fruit” has been identified and exploited, and that 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.

#### Existing Organizational Challenges

Although the Pennsylvania Medicaid program will be under enormous pressure to continue to implement complex and labor intensive initiatives over the next several years to contain the growth of the program, the commonwealth and DPW may not be adequately equipped to meet this enormous challenge. There are several reasons for this concern, many of which were outlined in a recent report by the Kaiser Commission on Medicaid for the Uninsured, which was based on

conversations with leading state Medicaid directors, including Pennsylvania's former Medicaid director, Michael Nardone.

This report essentially described a “perfect storm,” where state Medicaid agencies were facing enormous pressures to cut costs (in light of the expansion of Medicaid rolls during a period of weak state revenue growth or outright declines), but are expected to prepare for a key role in implementing health care reform. This pressure to do more with less also comes at a time when many state workforces have been subject to salary and hiring freezes (since January 2008 in Pennsylvania), as well as periodic furloughs. As noted by one Medicaid director in the report, there is a prevailing state of “cognitive fiscal dissonance” where states are trying to meet Medicaid budget reduction targets while at the same time dealing with the need to implement health care reform. All of these issues are present in Pennsylvania. While perhaps not debilitating, they will certainly make it more difficult for the commonwealth to implement many of the initiatives outlined below.

## Options

### 1) 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. The number of elderly will rise steadily over the next several decades as baby boomers continue to age. Despite this reality, few people have long-term care insurance or have the assets to pay for LTCS. Therefore, Medicaid will bear the burden of paying for LTCS.

LTCS include those provided in nursing homes (including intermediate care facilities for the mentally retarded), as well as home and community based services (H&CBS) that enable individuals to live independently in their communities. Services covered under the traditional Medicaid program include home health care, rehabilitation services, medical equipment, case management, and other medical services.

Additionally, state Medicaid programs have been able to apply for and receive waivers from the federal government in order to reimburse for non-medical services as a part of their efforts to have elderly and disabled enrollees stay in the community even though they are medically eligible for nursing home care. These non-medical services include personal care, such as assistance with bathing, dressing, toileting; support services, such as housekeeping, shopping, laundry; transportation; home modifications, including ramps and redesigned rooms; respite for caregivers; and home maintenance.

During the past several years, federal and state programs have been expanding the provision of these non-medical H&CBS. The federal government has made it less onerous to receive approval to provide these non-medical services, while states have continued to expand their commitment to H&CBS. They recognize that the aging of baby boomers will present a monumental challenge to the capacity of nursing homes to care for these patients and a financial challenge to state government to afford to continue care. And if more individuals can stay in their homes or other community settings, there is a better chance the program will be able to pay for care for this fragile population.

Therefore, funding for H&CBS nationally has increased steadily across all Medicaid programs. In 2007, H&CBS accounted for 43 percent of all Medicaid LTCS expenditures. However, 72 percent of this funding went towards care for the developmentally disabled and only 28 percent was for the elderly and adult disabled. About 75 percent of all payments for the elderly and adult disabled continue to be spent on nursing home care.

Pennsylvania was an early proponent of H&CBS. Medicaid has several programs designed to increase the number of persons needing long-term care to stay in the community. The aging waiver is a home and community based waiver that provides LTCS to qualified older Pennsylvanians living in their homes and communities. The Attendant Care Program assists the physically disabled to perform activities of daily living. The COMM CARE waiver was developed for persons with a traumatic brain injury and helps these individuals live as independently as possible. The independence waiver helps individuals with severe physical disabilities to live in the community. A program called LIFE

(Living Independence for the Elderly) provides a comprehensive package of services for the frail elderly who need a nursing home level of care but want to remain in the community. MFP (Money Follows the Person) is an initiative to help people who want to leave nursing homes and reside in the community. There are limitations on the number of Medicaid recipients who can be accepted into these and similar programs.

These efforts have resulted in some progress in “rebalancing” the long-term care system from one where institutional care is dominant to one that provides services intended to keep people in their homes and communities. From 1999 to 2006, the number of people receiving H&CBS in Pennsylvania increased by 16 percent. In all states, the increase was only 6 percent.

However, the percentage of individuals receiving care in nursing homes, rather than in the community, remains quite high. Data collected in two separate surveys in two separate years show this disparity. In 2006, Pennsylvania had 2.2 percent of the nation’s recipients of H&CBS (63,637 out of 2,862,727) and in 2008 had 5.7 percent of the country’s nursing home residents (78,982 of 1,388,383). So, while the entire country had twice as many individuals receiving H&CBS as were residents in nursing homes, Pennsylvania had more people in nursing facilities than in the community—a huge disparity.

In 2009, Pennsylvania spent a higher percentage of its LTCS expenditures on institutional care (65.4 percent) than all but seven states out of 40 that reported sufficient data to be ranked and the national average is 55.2 percent. If the developmentally disabled are removed from the ranking, the data shows that Pennsylvania spent 82.1 percent of the LTCS dollars on institutional care for the elderly and disabled. The national average is 66.2 percent.

So clearly, more needs to be done. One option is long-term care managed care. Long-term care managed care (LTCMC) is designed to help people with chronic illnesses or disabilities and who need long-term care services to remain in their residences and communities as long as possible. Like traditional physical health managed care organizations, LTCMC plans are paid on a capitated basis. These plans arrange and pay for health and social services for those individuals

who meet the clinical criteria for nursing home care, and provide choice and flexibility in obtaining needed services.

LTCMC is a contractual agreement between a Medicaid agency and a contractor under the terms of which the contractor accepts financial risk through a capitated payment for providing long-term care benefits to Medicaid beneficiaries. Elements include

- **Care coordination.** The contractor coordinates care and provides long-term care services, usually through subcontracts with traditional providers.
- **Financial risk.** The degree of financial risk varies by program. In some programs, the contractor assumes financial risk for the entire range of long-term care services including home care, adult day care, residential care, and nursing home care. In other programs, contractors are only partially at risk; the contractor’s financial liability is limited in some way, usually by capping the amount of nursing home care for which it is responsible at a certain number of days.

Early adopters of LTCMC include Minnesota and Wisconsin, but to date only nine states have implemented some form of LTCMC programs. LTCMC has several potential cost and care benefits. By providing a full at-risk capitated model, the contractor has the incentive to provide services to patients in the least costly—and the least restrictive—setting. By managing care for the elderly and disabled early, institutional care can be delayed, patients will be more satisfied by continuing to live in their homes, and the Medicaid program will save money.

In 2007, nationwide, people who were dual eligible for both Medicaid and Medicare accounted for only 18 percent of all Medicaid recipients, while 46 percent of all Medicaid spending was for this group. And over one-half of Medicaid spending was for long-term care.

Therefore, some state models of LTCMC target dual eligible beneficiaries and therefore integrate both Medicare and Medicaid services into their contracts. Integrating the full array of Medicare and Medicaid benefits, both fee-for-service as well as long-term care benefits, has the potential for a more seamless and well-coordinated service delivery system for these beneficiaries, thereby potentially reducing

fragmentation and inefficiencies and enhancing quality. Certain waivers and approval of CMS is required for state Medicaid programs to implement programs for dual eligibles.

## 2) Enhanced 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 coordinate behavioral health care and physical health care among Medicaid patients. Also, people with both serious mental illnesses and drug and alcohol disorders along with chronic conditions present additional challenges.

The physical health needs of Pennsylvania Medicaid patients are managed and paid by private physical health MCOs (PH-MCOs) or directly by the state through the traditional fee-for-service (FFS) system. Medicaid behavioral health services are the responsibility of county government for 42 counties and the direct responsibility of the state for the remaining 25 counties. There are contracts with private behavioral health MCOs (BH-MCOs) in all counties, with the exception of Philadelphia County, which operates its own BH-MCO. At the state level, two different offices oversee these services: the PH-

MCOs by the Office of Medical Assistance Programs (OMAP) and the counties and the BH-MCOs by the Office of Mental Health and Substance Abuse Services (OMHSAS).

The physical health needs of Medicaid patients are the responsibility of the traditional health care system. Physicians, hospitals, pharmacies, and other providers treat Medicaid patients alongside those with private insurance, Medicare, and other coverage.

The seriously mentally ill receive care through a completely separate health care system, the public mental health system. Services are provided by public mental health clinics and typically include care by psychiatrists, usually for the purpose of prescribing mental health drugs, but also include counseling, social services, housing, and other support services. Most of the non-medical services are paid separately through county government and funded by both state and county tax dollars. (In the opinion of some behavioral health policy makers, a similar drug and alcohol health care system does not exist.) The traditional health care system and the public mental health system rarely meet or overlap. Two separate state government agencies, two separate payers, and, most significantly, two separate systems of care make coordinating care for dual diagnosis Medicaid patients a huge challenge.

Data recently obtained from the department's OMAP confirms the national findings relating to the costs of individuals suffering from behavioral health, substance abuse, and chronic diseases, and serve to highlight the need to integrate care to control costs. For example, individuals with combinations of these conditions incur, on a yearly basis, the average costs in the chart below.

### Costs for Patients with Combinations of Behavioral Health & Chronic Diseases

Behavioral Health	Chronic Diseases	Drug and Alcohol Abuse	Unique Recipients	Total Cost	Average per Recipient
Y	Y	Y	6,578	\$177,242,204	\$26,944.69
Y	Y	N	52,141	\$1,119,590,951	\$21,471.37
Y	N	Y	22,452	\$376,010,889	\$16,747.32
N	Y	Y	6,960	\$111,093,538	\$15,961.72

The information in the chart relates to program data for FY 2009, and includes information relating to both the FFS and managed care programs. The average cost per recipient is for the full calendar year. This information is striking evidence of the need to improve coordination of care for these individuals.

There are no statewide comprehensive programs anywhere, to our knowledge, which effectively and efficiently integrate care for behavioral and physical health. Pennsylvania, though, has implemented two pilot integrated care programs—one in the southeastern and one in the southwestern parts of the state.

These pilots attempt to bring together government agencies, county government, managed care organizations, providers, and consumers in an effort to integrate and improve health care services for persons with serious mental illness, as well as with chronic physical health problems.

The pilots stratify the Medicaid participants based on their behavioral and physical health conditions, develop integrated health plans, develop real time notification of hospital admissions and emergency room visits, and identify medication issues. The goal, over time, will be to reduce unnecessary hospital admissions and emergency room visits. A shared pool of funds will be developed by the MCOs so that the plans can share any savings realized. There will be a study of the pilot outcomes over the next year or so. There are many other elements of the demonstration projects, such as outreach to consumers, education, case and care managers, post-hospital discharge planning, data management and information exchange, and potentially the colocation of services.

Pennsylvania may be the most advanced state in terms of care of persons with severe mental illness and substance abuse disorders. All Medicaid recipients are in BH-MCOs, managed by county government or the state and largely provided through private plans. And the commonwealth is engaged in the pilots mentioned above. Can more be done? Other elements of coordinating care that could be considered include:

1. “Carve-in” behavioral health managed care into the PH-MCOs. This would go back to the manner in which care was provided more than a decade ago. The “carve-out” occurred because OMHSAS, advocates, and consumers believed the needs

of the seriously mentally ill were not being met by the PH-MCOs. However, the carve-out, arguably, has created some inappropriate incentives. For example, while the PH-MCOs are responsible for mental health drugs (many are quite expensive), the BH-MCOs benefit when patients improve drug adherence, reducing emergency room visits and hospital admissions. If this option were chosen, contract provisions would need to be developed and enforced to prevent any possibility that PH-MCOs neglected care for behavioral health patients.

2. Develop incentives for behavioral health and physical health providers to coordinate care. Efforts are being made by providers in the two systems to work together. A few BH providers are hiring primary care physicians. Mental health workers are being hired by FQHCs or are placed in FQHCs by local mental health providers. One behavioral health provider actually started a dental practice next to its facility. Encouraging and incentivizing these types of efforts, perhaps through the development of shared pay-for-performance measures, is absolutely necessary. Even if a carve-in were implemented, if providers are not working together, the effort will likely fail.
3. Expand the pilot statewide. If the study of the pilot shows that patient outcomes were improved and money was saved, look at whether the process is transferable to other regions, and if so, phase in throughout the commonwealth.

### **3) Continued Development of “Medical Home” Models**

In January 2007, then Gov. Rendell released the “Prescription for Pennsylvania,” his plan for “improving the health care of all Pennsylvanians, making the health care system more efficient and containing its cost.” One element of his plan was a Chronic Care Initiative. In May 2007, he appointed members to the Chronic Care Management, Reimbursement and Cost Reduction Commission. Its charge was to develop and implement a strategic plan for dealing with the increasing prevalence of chronic diseases among the commonwealth’s residents by improving care for those that have chronic conditions through improved approaches to practice and early intervention.

The commission's strategic plan, completed in February 2008, noted that chronic diseases account for about 80 percent of health care costs, 76 percent of visits to physicians, and 90 percent of prescriptions. Only 56 percent of chronic disease patients receive the recommend plan of care for their conditions. The plan goes on to state that the factors that contribute to these results include the manner in which patients deal with their chronic conditions; the way in which medicine is practiced; and the fact that providers are poorly compensated for treating chronic care patients. Consequently, chronic disease patients who have not learned to manage their own diseases wait until a crisis develops and need to be rushed to, or referred to, the hospital emergency room. It is a system that is frustrating for providers, increases suffering for patients and one that is ripe for change in the form of the Chronic Care Model, which was developed by Edward H. Wagner, MD, MPH.

The six key components of the Chronic Care Model are:

- **Self-Management Support:** Patient assistance in managing chronic disease and setting health improvement goals
- **Delivery System Design:** Transformation from a reactive physician model to a proactive model using multidisciplinary care teams
- **Decision Support:** Care based on evidence-based care guidelines
- **Clinical Information Systems:** Better tracking and monitoring of chronic disease patients across disciplines and timeframes
- **Community:** Partnerships with community resources that encourage healthy living
- **Health Systems:** Incentives for quality improvement among care givers

The commission's strategic plan went on to define strategic goals with several core elements. One goal was the development of learning collaboratives, intensive programs where primary care practice teams receive education and support in order to redesign and transform their practices. The learning collaboratives teach primary care practice teams—physicians, nurse

practitioners, physician assistants, nurses, and any other members of a practice team—how to redesign their practices in order to be more effective in caring for their chronically ill patients. A few of the core concepts include practicing as a true team; using evidence-based care guidelines and data to inform care planning and management; and providing patient self-management education directly or through external professional and lay community resources that are culturally and linguistically appropriate.

With the first focus being on diabetes, early outcomes are promising. At a meeting of the Southeastern Pennsylvania Learning Collaborative, presenters described positive results for key measures (for example, lower hemoglobin A1C levels) for patients in practices that were trained through the learning collaboratives.

On a national level, a patient-centered medical home (PCMH) is an approach to providing comprehensive care to patients. It is built on the concept of creating a partnership between the patient and the patient's medical providers. It emphasizes comprehensive care, a team approach to delivering care, and continuous care throughout a patient's life. The hope is that by developing such a partnership access to care will improve, patients will be healthier, and, over the long run, money will be saved.

In 2007, several national medical associations developed principles for PCMH, as follows:

- **Personal physician** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous, and comprehensive care.
- **Physician-directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; and end of life care.

- **Care is coordinated and integrated** across all elements of the complex health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

Pennsylvania's Medicaid program has begun to consider options for the design of the medical home concept. They are looking at innovative and creative elements to be implemented as part of this initiative and as part of the health care reform efforts.

One example being considered is to develop "virtual" medical homes for persons with behavioral health and physical health diagnoses. It is often difficult for behavioral health patients to make and keep appointments with physicians. A "virtual" medical home could visit public mental health clinics and provide necessary examinations in a setting more familiar to serious mental illness patients.

#### 4) Reform of County-Based BH HealthChoices Program

DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) oversees the behavioral health component of the HealthChoices program, which provides behavioral and substance abuse services to Pennsylvania's Medicaid population statewide. Unlike the PH-MCO 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 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).

DPW holds contracts with the counties (or county joinders) or directly with the BH-MCO in the 23 county region, and makes payments on a per-member, per-month (PMPM) basis. Rates vary with the recipients' eligibility category and geographic location. When a county subcontracts with a BH-MCO, the contract will specify how much of the financial risk is passed on to the BH-MCO. In most cases, the contract specifies that the BH-MCO will assume full financial risk.

It is generally understood that the Rendell Administration had been focused on improving county behavioral health infrastructure—not cost savings—by implementing the "county right of first opportunity." Pursuant to this model, counties that earn "profits" through the administration of the program are entitled to "re-invest" these funds to support county infrastructure. This funding is undoubtedly important to the relevant counties, and these funds are utilized to provide critical services to individuals who are not eligible for Medicaid. That said, 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 the department has less leverage to negotiate payment rates with county governments than it would if it were to directly negotiate with BH-MCOs.

The Corbett 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 the department to contract directly—perhaps by geographic zone—with BH-MCOs. This approach would streamline the administrative structure, allow more rigorous rate negotiations, and lead to reductions in the capitated rates paid to BH-MCOs. Note that the anticipated expansion of Medicaid in 2014—to individuals at or below 133 percent of the poverty level—may ameliorate the impact of a reduction in county “re-investment funds.” Nonetheless, the impact of this reform on the counties must be carefully considered. It also goes without saying that this initiative could be vigorously opposed by the County Commissioner’s Association and numerous other interest groups.

## 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 for Medicaid. 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.

Since 2005, DPW has provided part of the PH-MCOs’ rates through a P4P program that incentivizes the plans to improve their quality performance. The goal of DPW was to shift from “paying for care” to “paying for *quality care*.” Payouts of up to 2.5 percent of an MCO’s capitated rates are based on quality improvements in several standardized performance measures, as well as other criteria, including a plan’s accreditation status.

The performance measures were chosen based on historical program-wide need for improvement, the breadth of impact across the HealthChoices population, and consideration of high-profile indicators

for chronic diseases with a large potential for impact on quality and savings. Goals are set for each plan based on previous year’s performance, and payouts are based, in part, on whether the goal was met and on the performance of the MCOs relative to standardized performance measures.<sup>11</sup>

Beginning in 2008, DPW had implemented a separate P4P initiative for contracted MCO providers. Pursuant to this program, MCOs were provided with an additional \$1 PMPM in their capitation payment rates to implement provider P4P programs within their networks. As a result of this initiative, MCOs designed and implemented programs that aligned with the measures included in the MCO P4P program to improve quality outcomes for consumers. These programs largely target primary care providers and OB/GYNs, and serve to strengthen the “medical home” model. A similar program has been implemented in DPW’s ACCESS Plus Program, where the DPW rewards both the primary care case management contractor and providers for improvements in clinical quality.

As a result of the program design features described above, as well as the implementation of innovative P4P programs, the HealthChoices MCOs and the ACCESS Plus program have demonstrated improved outcome results. For example, DPW recently issued a progress review evaluating the performance of the MCO P4P program from July 2005 through December 2008. In developing this report, DPW conducted weighted average comparisons across all P4P measures. This report revealed improvement in 10 of the 12 P4P measures, and provides significant evidence of the success of this important investment in health and well-being of Medicaid consumers.

Despite the success of these programs, the commonwealth has jeopardized the MCO P4P program by removing funding for this program within the FY 09-10 Budget. Although this funding was subsequently restored, it is important to ensure that this program is maintained in the face of the current fiscal crises. 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

<sup>11</sup> The P4P program utilizes HEDIS (Healthcare Effectiveness Data and Information Set), which is a set of performance measures designed to allow purchasers and consumers to compare the performance of MCOs. HEDIS is the most widely used set of performance measures in the managed care industry. The program also uses Pennsylvania Performance Measures, which are measure areas of key interest that are not captured by HEDIS.

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

The most significant effort related to payment reform in the Medicaid program took place over the past two decades. About two-thirds of Pennsylvania's Medicaid enrollees are in capitated programs. They receive their services through capitated MCOs. MCOs are paid a per member per month (PMPM) amount from Medicaid. The PMPM varies by category of enrollee and is negotiated with each MCO. The MCOs then perform most of the functions of the Medicaid agency, including network development, provider enrollment, claims processing and payment, and utilization review. The State oversees the activities of the MCOs and determines the eligibility of enrollees. The MCOs have more flexibility than the State does as it operates the fee-for-service (FFS) program. For example, MCOs can negotiate rates with providers, while Medicaid must maintain a uniform payment method through the state.

Other types of payment reform are being discussed in the context of health care reform. Two of these are accountable care organizations (ACOs) and bundled payments. A bundled payment is a single payment for an episode of treatment, as opposed to a payment for each service. It has been described as a middle ground between a purely FFS 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. They all need to work together to provide services in the most efficient manner. In theory, the elimination of duplication of services and unnecessary care should lead to savings to be shared among all care providers.

CMS has stated that "Physicians and hospitals could then decide how best to provide these services in a more efficient manner on a patient-by-patient basis, and could allocate the payment among themselves in a way that allowed each to share in the savings." This payment system has the potential for more effective

and efficient care, better outcomes for patients, higher reimbursement for providers and savings to payers.

There are several options for the structure of a bundled payment. For example, a bundled payment could include—or exclude—several elements of an episode of care. Any or all of the following could be included: the inpatient hospital stay; attending physician and specialist services; rehabilitation hospital services; home care services; prescription drugs and others. The entity most often discussed as receiving the payment is the hospital. The hospital would then negotiate payment rates, limitations, and conditions for payment with the other providers. The hospital would receive the bundled payment and then pay other providers for the care they deliver. Also, the bundled payment to the hospital could vary, depending on the patient's specific or general diagnosis, similar to the way hospitals are paid now under one of the various diagnosis-related group systems.

A provision in the recently passed health care law allows the Medicare program to share cost savings with organizations that agree to be responsible for quality, outcomes and the cost of care for a population of patients. These entities are called accountable care organizations (ACOs.) They can take several different forms, as specified in the law:

1. Physicians and other professionals in group practices
2. Physicians and other professionals in networks of practices
3. Partnerships or joint venture arrangements between hospitals and physicians/professionals
4. Hospitals employing physicians/professionals
5. Other forms that the Secretary of Health and Human Services may determine appropriate

The ACOs must meet the following requirements:

1. Have a formal legal structure to receive and distribute shared savings.
2. Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum).

3. Agree to participate in the program for not less than a three year period.
4. Have sufficient information regarding participating ACO health care professionals as the secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
5. Have a leadership and management structure that includes clinical and administrative systems.
6. Have defined processes to: (a) promote evidenced-based medicine; (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR)); and (c) coordinate care.
7. Demonstrate it meets patient-centeredness criteria, as determined by the secretary.

The first ACOs under the Medicare program are scheduled to begin in January 2012. There are still many unknowns regarding this initiative. Some questions should be answered later this year when CMS publishes additional information about ACOs.

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.

In addition, Pennsylvania can seek to utilize existing funding available through the Commonwealth Universal Research Enhancement (CURE) Program of the Tobacco Settlement Act to conduct research and provide recommendations relating to these alternative payment programs.

By way of background, 19 percent of tobacco settlement funds go to the CURE program each year. Of this percentage, 70 percent is used to fund grants to research institutions that already receive grant funding. The remaining 30 percent (called non-formula grants) are awarded competitively by the Health Research Advisory Committee. Each year,

only one or two priority research topics or areas are selected by the committee in conjunction with the Department of Health, and a competitive Request for Application (RFA) is then written to solicit research proposals solely in those one or two research areas. It is anticipated that non-formula funds for next year will be approximately \$16-18 million, so each topic could receive funding of about \$8-9 million.

The administration should consider using this existing, discretionary funding to evaluate payment reform initiatives. In light of the current fiscal crises, all available funding should focus on critical, state wide priorities relating to the need to prepare and fund national health system reform.

## **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 (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 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. For example, studies indicate that good gum health can lower an individual's risk of developing diabetes. Researchers have also found that certain heart conditions, such as coronary artery blockage, are present twice as often in patients with periodontal (gum) disease. Some studies suggest a link between gum disease and premature, underweight births.

In order to address this issue, Pennsylvania could consider implementing an Administrative Services

Organization (ASO) model for dental services. 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 contractor would perform prior authorization and utilization review and the state would retain all financial risks 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. Additionally, ASOs can reduce administrative duties for state staff. This approach could be implemented within the department's FFS system, or the responsibility for dental care could be "carved-out" of the PH-HealthChoices Program, and the program could be implemented state-wide.

### **8) Improved Coordination Among State Government Programs (e.g. Medicaid, CHIP, PACE, PEBTF)**

In Pennsylvania, governmental health care programs are operated by the Department of Health (several programs, including drug and alcohol, chronic renal disease, 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 (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 with different offices within their own department.

Additionally, state government has a huge role in the implementation of health care reform, from the implementation of electronic health records and the health information exchange per ARRA to developing health insurance exchanges and expanding Medicaid as outlined in PPACA. Multiple agencies will be responsible for these efforts.

Attempts to improve coordination have been made. On his second day in office in January 2003, then

Gov. Rendell formed the Office of Healthcare Reform (GOHCR) by executive order. That document outlines GOHCR's responsibilities: to "(1) facilitate the analysis of administrative, fiscal, and regulatory policies and practice; (2) oversee the redesign and operations and infrastructure; and (3) direct the creation and maintenance of a system to assure accountability of designated agencies for their assigned powers, duties, and responsibilities." While GOHCR has accomplished a great deal over the past eight years, coordination among programs remains a challenge.

One option to improve the way in which the commonwealth's health care programs operate is to appoint a "health care czar." While similar to the current GOHCR, a health care czar could be given more day-to-day responsibilities, which was specifically excluded by the executive order that created GOHCR. This would result in dual reporting by various program managers—to their cabinet secretary and to the health care czar. This organizational technique has precedent. For example, each department's chief counsel reports not only to his or her department's secretary, but also to the governor's general counsel.

Another option would be to combine certain programs together. While recent attempts to house all long-term care programs in the Department of Aging (DOA) have failed to be approved by the General Assembly, the administration may try again. The rationale is to better coordinate care for the elderly and disabled who need long-term care services. Responsibility for these people is currently split between DPW and DOA. Or all of the government's pharmaceutical programs could be placed under one manager. The two largest programs are PACE and Medicaid, operated out of two departments, DPW and DOA. Another example would be to combine CHIP and Medicaid. The two programs complement each other, are both overseen by CMS, and have many similar policies and procedures. Over half of the country's State Medicaid Directors are also responsible for their states' CHIP programs.

By combining programs, there may be some administrative cost savings. Policies and procedures might be more uniform across programs and it could be easier for various providers to participate in government programs. Additionally, the commonwealth may be able to purchase certain products or services at a better price when the volume of purchases

increases. Currently, PACE and Medicaid both purchase drugs and are able to procure supplemental rebates from pharmaceutical manufacturers. By combining the programs, it may be possible for the state to obtain larger supplemental rebates.

However, when combining programs together, a layer of complication may also result. For example, payment systems will need be designed (or redesigned) to take into account one or more sets of policies. Provider relations staffs, which presumably would be combined and reduced, would need to learn multiple programs. And there could be complications related to the commonwealth's budgeting process. Additionally, the approval of the General Assembly is needed for such organizational changes and legislators have generally (with some exceptions) been reluctant to move bills to implement major organizational redesign.

Despite these challenges, the opportunities for improved coordination are enormous, and it is critical for the administration to take steps to improve the collective management of these critical programs.

## 9) Reform of Medical Assistance Transportation Delivery System

In 2007, the Pennsylvania General Assembly directed the Pennsylvania Department of Transportation (in association with DPW, the Department of Aging, and the Governor's Office of the Budget) to perform a study of the Pennsylvania Human Services Transportation System.<sup>12</sup> The goals of the study were, among other things, to develop recommendations to improve service delivery, control the rate of cost growth, and improve customer service across all programs. The study was developed during a 15-month process, which included research into other states, an in-depth analysis computer modeling effort using actual program data, and a comprehensive public input process. The final report was released on July 17, 2009, to Gov. Rendell and all members of the General Assembly.<sup>13</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; 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. The report specifically notes that the regional consolidation approach—which could involve having one entity (such as a for-profit broker) responsible for managing all aspects of human services transportation except trip delivery—“offers the most potential for improving service while reducing expenses and controlling costs.”

The results of detailed trip simulations and financial analysis of a six-county study region were also included in the report. This analysis showed cost reductions of 11 percent, as well as increases in customer service outcomes (e.g. increased service availability, shorter trip times, and more timely delivery). This analysis provides, for the first time, objective information on the possible efficiencies of a consolidated approach. As a next step, the report recommends that the commonwealth take steps to consolidate human service transportation management, pilot a regional approach, and conduct listening sessions to ensure that consumer needs are known and understood.

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.

<sup>12</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% of the fare for persons 65 years or older and for persons with disabilities.

<sup>13</sup> A copy of the report may be found at the following link, by clicking “bureau publications”: [www.dot.state.pa.us/Internet/Bureaus/pdBPT.nsf/TransHomepage?openFrameset](http://www.dot.state.pa.us/Internet/Bureaus/pdBPT.nsf/TransHomepage?openFrameset)

A risk-based capitated payment structure will allow Pennsylvania to better predict transportation expenditures, and will create incentives for the contractor to manage service provisions so that costs do not exceed revenue. Brokers may potentially create efficiencies and lower costs through competitive bidding and by assuring the scheduling of the least costly, most appropriate method of transportation for a client. A broker model may also allow states to tap into advanced technologies of transportation coordination.

### **10) Selective Contracting for Durable Medical Equipment and Home Health**

Presently, Pennsylvania pays for DME and home health services on a fee-for-service (FFS) 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, DPW could establish specified geographic regions, and perhaps choose two vendors for each region for both DME and home health services. DPW could also require PH-HealthChoices MCOs, via its contracts, to implement similar selective contracting approaches, to the extent that they have not already done so.

Cost savings could be substantial. In the Medicare DME arena, for example, California rolled out its bidding program in fiscal year 2004-2005 with an estimated savings on DME expenses of 8 - 9 percent. Similar savings have resulted in Florida, New York, and Texas from their competitive bid process. Demonstration projects conducted by CMS in Florida and Texas showed savings of 17-22 percent on DME with no significant loss of service or quality.

It is important to note, however, that these initiatives 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.

### **11) Evaluate Utilization of “Telephony” Systems for In-home Care Services**

As discussed in previous sections of this report, home health care is an increasingly important sector of the health care industry due to its cost advantages over institutions and patients’ preference for care in their homes. However, home health care costs are rising significantly, and federal reports have documented inefficiency and fraud in the home health care industry. One of the strategies adopted by policy makers is to take advantage of existing technology, such as using telephony systems, to capture information about the provision of home and community based services. Telephony systems serve to ensure compliance with the plan of care, reduce fraud and abuse, and streamline administrative processes (e.g. time and attendance, billing, etc.). Among other functions, these systems require home care workers to call when they arrive and leave the care site, and enter a code to verify their presence on site at the consumer’s home or other service location. This requirement obviously improves quality, and reduces the incidence of over-billing.

In 2005, Pennsylvania began efforts to implement what was known as the “Service Assurance Initiative.” The concept originated within the Governor’s Office of Management and Productivity, an organization created by Gov. Rendell to identify and implement novel cost-saving ideas within state government. The Service Assurance Pilot was designed to utilize telephone-based technology to assist in the in-home services quality assurance/quality improvement effort. The initial goal was to include approximately 15,000 clients receiving in-home services from various program offices in the pilot population. Although the system would be implemented on a pilot basis within selected counties, the ultimate aim was to expand the project statewide. After a significant outreach effort to various consumer and provider groups to inform them of this effort and gain their support, the commonwealth issued a Request for Proposal (RFP). Proposals

were submitted by several vendors, and DPW began negotiations with the selected vendor. However, for reasons that have not been disclosed, the negotiations appear to have broken down and a system was not ultimately implemented.

In light of the benefits of these systems (and despite the challenges to implementation), several states and jurisdictions have mandated or plan to mandate electronic visit verification. These include Washington, New Mexico, Tennessee, Oklahoma, Louisiana, and Miami-Dade County. In light of the opportunity for cost savings, the administration should re-visit this issue, and determine whether it is appropriate to move forward with efforts to encourage the use of these systems.

## Section 7

### **Options and Recommendations: Strategies to Increase Medicaid Physician Participation Rates**

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 are also typically much 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. Additionally, there is at least the perception that Medicaid patients are difficult to treat, do not keep appointments, and require much administrative time and effort on the part of physicians' offices.

Research indicates that raising reimbursement for Medicaid providers results in their increasing the number of Medicaid patients they treat. For example, one study published in the *Journal Medical Care Research and Review* found that a 20 percent increase in Medicaid fees (relative to Medicare rates) added to the number of Medicaid patients seen by 10.6 percent. This study also concluded that in addition to increasing reimbursement rates, a number of other factors influence a provider's decision to accept Medicaid consumers. The benefit of increasing rates on provider participation in state Medicaid programs appears to moderate as rates approach the Medicare level.

As states struggle with Medicaid spending, some have sought to reduce or limit the growth of reimbursements as a cost-containment strategy. This approach is counterproductive, because reducing or limiting

reimbursement rates inevitably contributes to access problems. Although many physicians continue to see Medicaid patients, an increasing number are less willing to take on new patients and prefer patients covered by other types of insurance that reimburse at higher levels. Reimbursement levels and access are linked. Without sufficient reimbursement, provider participation and access to care will decline, and Medicaid consumers will seek treatment in expensive emergency room settings for primary care services.

The issue of access and adequate reimbursement has become even more critical in light of the expansion of the Medicaid population anticipated as a result of national health care reform. Recently, a national health insurance company (United Health) commissioned Opinion Research Corporation to undertake a national survey of primary care physicians to explore what they saw as barriers to, and solutions for, ensuring Medicaid beneficiaries get access to appropriate health care.

This analysis concluded that, absent broader changes to the health care system, only 6 percent of primary care physicians reported that they expected to actively increase their Medicaid patient roster beyond current levels, and 35 percent said they expected their number to decrease. This was particularly marked for those practices only treating a small proportion of Medicaid patients, suggesting many of them were effectively looking to withdraw from the program. Those primary care physicians who were more willing to increase their Medicaid population tended to be already serving a greater share of Medicaid patients, a member of an ethnic minority, younger, and practicing at a federally-qualified health center. Of the perceived barriers to accepting more Medicaid patients, the top two factors, according to primary care physicians, were Medicaid reimbursement and Medicaid-specific paperwork and administrative burdens.

Turning to the expected increases in the Medicaid-eligible population as a result of the new national health reform legislation, primary care physicians were skeptical that—absent other changes—most of the new Medicaid patients in their area would be able to find a suitable primary care physician to serve them. Sixty-seven percent thought that patients would not be able to find a suitable primary care physician, and 10 percent thought they would, with 23 percent unsure. Larger physician

groups and those already serving more Medicaid patients were likely to be more optimistic.

In light of this evidence, and the imminent expansion of Medicaid eligibility, it is critical for the commonwealth to implement a comprehensive strategy to increase Medicaid participation rates. Options and recommendations to address this issue are outlined below.

## Options and Recommendations

### 1) Increase Physician Reimbursement Rates

There are several methods that could be used to increase reimbursement to physicians. The challenge will be to convince state government that now is the time for this investment, given the severe budgetary problems confronting the governor and the General Assembly.

One option is to expand the Pay for Performance Program in both the HealthChoices and the ACCESS Plus programs. It may be easier for Medicaid to support this type of expenditure since the payment is being made for positive outcomes for Medicaid patients. These programs are already in place and Medicaid officials are pleased with the results. Additionally, these types of programs are being developed in private health insurance programs and in other State Medicaid programs.

A second possibility is to raise fees for providers who treat Medicaid patients in rural and urban areas where there is a shortage of generalist 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" 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, hopefully, incent physicians to

treat additional Medicaid patients. Some officials have stated that that is unlikely and that the payment would simply reward those physicians already treating many Medicaid patients, but that it would not improve access to care.

Across the board fee increases for all physician services may be prohibitively expensive, but targeted fee increases may be appropriate. In the past, fees have been raised for primary care and obstetrical services. A study of the Medicaid fee schedule may reveal some areas that need to be addressed.

Finally, beginning the process of developing internal consistency among fees should be studied. 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. Then, the Medicaid program might 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.

### 2) Ensure 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 two million Medicaid consumers. Under HealthChoices, DPW contracts with MCOs to provide a complete package of benefits to Medicaid consumers who enroll in their plan. The MCOs are paid a set of 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 (known as the "bottom of the

actuarially sound rate range”). 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 health system reform, 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) Continue to 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 continue 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.)**

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.

Specific taxes on a service or product can be imposed in an attempt to change behavior. The most vivid example is 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, New York, Maryland, and New Jersey have higher taxes, West Virginia and Ohio lower, and Delaware the same.

In 2010, 20 states and cities have considered levying taxes on soft drinks in order to combat the ever-growing problem of obesity among both children and adults. Only Washington state succeeded in passing a soda tax, but the tax was successfully appealed later in 2010. There has been so little success in passing a soft drink tax due to complications in how to implement the tax (on ounces or teaspoons of sugar), lobbying efforts of the industry, and doubt about whether the tax would be effective.

Many states, including Pennsylvania, have developed dedicated taxes to fund Medicaid. All are provider taxes that raise funds for the program and may provide fee increases for the provider-type being taxed. In Pennsylvania, there are such taxes for nursing homes, intermediate care facilities for the mentally retarded, managed care organizations, and hospitals.

States had been using provider taxes to raise state money, pay back the taxed providers in full with both state and federal funds, and using the remaining proceeds from the tax to be used to match additional federal funds. Several years ago, HHS and Congress developed rules that prohibit holding the taxed providers harmless, making it much more difficult for states to use this technique. Unless all providers in the taxed group are 100 percent Medicaid providers, the result is that some providers will gain more in resulting fee increases than the tax they pay, but others will be losers. Some states see this as a reward for those providers who agree to treat a large number of Medicaid patients.

Other assessments, with the proceeds dedicated to the Medicaid program, or to a specific purpose within Medicaid, such as maintaining or increasing physician fees (and other provider 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 have provider reimbursement at a reasonable level. This will be absolutely necessary for there to be access to necessary medical services. Perhaps an alternative, but related, approach of providing tax breaks to physicians that serve Medicaid consumers can also be evaluated.

### **5) Reducing Administrative Burdens Relating to Medicaid Participation**

Providers across the country have typically contended that the “hassle factor” relating to the participation in Medicaid have 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 care 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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**Exhibit – Optional Services Covered by Pennsylvania Medicaid Program<sup>i</sup>**

<b>Optional Service</b>	<b>Number of States That Cover Optional Services</b>	<b>PA</b>
<b>Licensed practitioners' services (e.g., podiatrists, psychologists, nurse anesthetists)</b>	50	Yes
<b>Private duty nursing</b>	22	Yes
<b>Nurse practitioner</b>	49	Yes
<b>Clinic services</b>	48	Yes
<b>Dental services</b>	45	Yes
<b>Physical therapy</b>	34	Yes
<b>Occupational therapy</b>	31	Yes
<b>Speech, hearing and language therapy</b>	35	Yes
<b>Prescribed drugs</b>	50	Yes
<b>Prosthetic devices</b>	49	Yes
<b>Eyeglasses</b>	43	Yes
<b>Diagnostic / Screening / Preventative services</b>	40	Yes
<b>Rehabilitative services</b>	50	Yes
<b>Transportation</b>	50	Yes
<b>Abortion<sup>ii</sup></b>	17	No
<b>Sterilizations</b>	49	Yes
<b>Optometric services</b>	50	Yes
<b>End stage renal</b>	50	Yes
<b>Intermediate Care Facility for the Mentally Retarded services</b>	49	Yes
<b>Inpatient hospital services to individuals age 65 or older in an Institution for Mental Diseases</b>	44	Yes
<b>Nursing facility services to individuals age 65 or older in an Institution for Mental Diseases</b>	44	Yes
<b>Inpatient psychiatric services for individuals under age 21</b>	50	Yes
<b>Nursing facility services for individuals under age 21</b>	50	Yes
<b>Case management services</b>	49	Yes
<b>Respiratory care services (ventilator-dependent)</b>	50	Yes
<b>Hospice care services</b>	47	Yes
<b>Personal care services</b>	31	Yes
<b>Home and Community-Based Services (HCBS)</b>	50	Yes

<sup>i</sup> Document source: Pennsylvania Medical Assistance: A Comparison with Other State Medicaid programs. Pennsylvania Medicaid Policy Center, University of Pittsburgh [http://www.pamedicaid.pitt.edu/documents/PA%20comparison\\_rp\\_10.pdf](http://www.pamedicaid.pitt.edu/documents/PA%20comparison_rp_10.pdf)

<sup>ii</sup> 32 states, including Pennsylvania, plus DC cover abortion in the case of rape, incest and/or danger to the life of the mother. Another 17 states cover "medically necessary" abortion.

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