AN ACT

Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," in health care outcomes, further providing for establishment, for value-based models relating to the Hospital Outcomes Program, for value-based models relating to the Managed Care Organization Outcomes Program and for managed care organization Medicaid contracts.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Sections 511-A, 524-A, 534-A and 535-A of the act of June 13, 1967 (P.L.31, No.21), known as the Human Services Code, are amended to read:

Section 511-A. Establishment.

(a) Programs.--The department shall establish the following linked Medicaid outcomes-based programs:

(1) A Hospital Outcomes Program designed to provide a hospital with information to reduce potentially avoidable events and further increase efficiency in Medicaid hospital services.

(2) A Managed Care Organization Outcomes Program

designed to provide a Medicaid managed care organization with information to reduce potentially avoidable events and further increase efficiency in Medicaid managed care programs.

(b) Targeted savings.--The department shall implement through the Medicaid outcome-based programs established under subsection (a) targeted savings to the Medicaid program. Targeted savings under this subsection shall only include:

(1) Averted costs by actions taken by hospitals or managed care organizations under the Medicaid outcome-based programs.

(2) Reduced expenditures for the Medicaid program which result from actions taken by hospitals or managed care organizations under Medicaid outcome-based programs.

(c) Amounts.--Targeted savings under subsection (b) shall be:

(1) No less than $40,000,000 for the 2020-2021 fiscal year. Savings achieved during the prior fiscal year shall not count towards the targeted savings for the 2020-2021 fiscal year.

(2) No less than $55,000,000 for the 2021-2022 fiscal year. Savings achieved during prior fiscal years shall not count towards the targeted savings amount for the 2021-2022 fiscal year.

(3) No less than $55,000,000 for the 2022-2023 fiscal year. Savings achieved during prior fiscal years shall not count towards the targeted savings amount for the 2022-2023 fiscal year.

Section 524-A. [Value-based models] Performance-based financial

incentives and penalties.

(a) Establishment.--After the implementation of the reporting system under section 522-A, the department shall [evaluate value-based models that will support hospitals in reducing rates of potentially avoidable complications and readmissions.] establish performance-based financial incentives and penalties for hospitals under the Hospital Outcomes Program.

(b) Financial incentives.--Financial incentives provided by the department under this section shall include an adjustment to the reimbursement a hospital receives under the Medicaid program based on whether the hospital successfully improved outcomes under the Hospital Outcomes Program concerning potentially avoidable readmissions and complications.

(c) Communication to hospitals.--A hospital's rate adjustment under this section shall be communicated to the hospitals under the Hospital Outcomes Program in a clear and transparent manner.

(d) Rate adjustment.--The determination of a rate adjustment under this section by the department shall include, but not be limited to, the following:

(1) Review of each hospital discharge claims data.

(2) A retrospective analysis of performance under the Hospital Outcomes Program. The department shall apply the analysis under this paragraph to each hospital on a prospective basis.

(3) Whether the hospital was able to achieve all savings mandated for expenditures under the Medicaid program.

(e) Adjustment factor.--In order to make a rate adjustment under this section, the department shall establish an adjustment

factor for hospitals concerning potentially avoidable events based on the hospital's actual versus expected risk-adjusted performance compared to the State average.

Section 534-A. [Value-based models] Performance-based financial incentives and penalties.

(a) Establishment.--After the implementation of the reporting system under section 532-A, the department shall [evaluate value-based models that will support managed care organizations in reducing rates of potentially avoidable admissions, readmissions and emergency visits.] establish performance-based financial incentives and penalties for managed care organizations based on whether the managed care organization reduced avoidable admissions, readmissions, emergency visits or complications. Financial incentives and penalties under this subsection shall include:

(1) Positive or negative changes in the annual capitated rates for managed care organization.

(2) Adjustment of the percentage of Medicaid program enrollees automatically assigned a plan by the department to a managed care organization based on the managed care organization's performance and health outcomes under the Managed Care Organization Outcomes Program.

(b) Adjustments to annual capitated rate.--The department shall adjust a managed care organization's annual capitated rate for providing service under the Medicaid program. A determination of the adjustment of a managed care organization's capitated rate shall include, but not be limited, to the following factors:

(1) A retrospective review of the managed care

organization's performance in reducing avoidable admissions, readmissions, emergency visits or complications. The review under this paragraph shall be applied to the managed care organizations in a prospective manner.

(2) Risk corridors identified by the department.

(3) The incorporation of potentially avoidable events into the capitation rates for managed care organizations providing services under the Medicaid program.

(c) Adjustment factors.--In order to make capitated rate adjustments to a managed care organization, the department shall establish specific adjustment factors for potentially avoidable events for each managed care organization plan based on the plan's actual risk adjusted performance under the program compared to the State average.

Section 535-A. Managed care organization Medicaid contracts.

(a) General rule.--The department shall amend contracts entered into or renewed on or after the effective date of this section with the department's participating managed care organizations as necessary to incorporate the Managed Care Organization Outcomes Program.

(b) Financial incentives.--Beginning on the effective date of this subsection, the department shall amend any contracts with a managed care organization as necessary to incorporate the financial incentives established under section 534-A.

Section 2. The department shall promulgate rules and regulations necessary to implement this act.

Section 3. This act shall take effect in 60 days.