Health Law PA News

Newsletters of the Pennsylvania Health Law Project
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Assisted Living Regulations Approved by the IRRC

On June 3rd, the Independent Regulatory Review Commission (IRRC) approved the regulations that will guide the licensure of assisted living residences in Pennsylvania. The Department of Public Welfare released the regulations (in "final-form") in early May and interested stakeholders submitted comments to the IRRC, the Standing Committees in the Pennsylvania House (Aging and Older Adult Services) and Senate (Public Health and Welfare), and individual legislators prior to IRRC's public vote.

Now that IRRC has approved the regulations, they will be sent to the Attorney General who will review them for form and legality. Assuming that office's approval, which is widely expected, the regulations will be published in the *Pennsylvania Bulletin* and expected to take effect in early 2011.

The regulations establish licensure standards for assisted living residences (ALRs), which provide food, shelter, personal care assistance and some health coverage to older adults and people with disabilities who are not so sick as to require ongoing skilled nursing care. About 50,000 Pennsylvanians live in facilities that may call themselves assisted living but that are actually licensed by the Commonwealth of Pennsylvania as personal care homes.

For the past two years, the Pennsylvania Assisted Living Consumer Alliance (PALCA), a collaboration of consumers, family members, and local and state wide organizations (including PHLP), has advocated for safety, freedom of choice and high legal standards for residents in assisted living facilities in the state. PALCA was pleased to see that the regulations included many changes they recommended such as:

- a requirement that ALRs provide a written decision when an admission is denied due to a supposed inability to meet a person's needs;
- the inclusion of an appendix listing all residents' rights in one place;
- defining core packages that will help consumers compare ALRs;
- a requirement that assessments and support plans be completed prior to admission, in most cases. The support plan outlines the care needs of the new resident and how ALRs will address them; and

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- a requirement that the final support plan be incorporated into the resident-ALR contract.

Despite these improvements, PALCA believes several provisions will harm consumers. Areas of specific concern are:

- ***Inadequate Requirements for Administrators and Direct Care Staff***: The regulations remove requirements for any educational qualifications (including a high school diploma) for administrators of assisted living facilities. PALCA is concerned that minimal training requirements for administrators and direct care staff will compromise residents' health and safety. Unlike personal care homes, ALRs will be permitted to serve individuals who need the level of care traditionally provided by a nursing home. As a result, assisted living residents will be sicker and will have higher care needs than people currently served in personal care homes; however, administrators are only required to have 100 hours of training (the same amount required for personal care home administrators) and direct care staff are only required to have 18 hours of training under the final-form regulations.

- ***Inadequate Room Size Requirements:*** PALCA disapproves of the reduction of square footage requirements for new and existing living units for single and double occupancy; permitting room sizes even smaller than those set forth in previous drafts of the regulations. Under the regulations, new construction units may have single occupancy units that are only 225 square feet. For existing structures, a single occupancy unit can be as small as 160 square feet. These small room sizes limit a person's ability to move a wheelchair and can decrease their independence. PALCA maintains rooms should be sized in accord with "marketplace" standards of at least 250 square feet for a single occupancy unit, and up to 500 square feet, for a single bedroom living unit.

  Also troubling is a new provision permitting an exception to the room size requirements at the Department's discretion. This is problematic because the regulations do not include standards for ALRs seeking an exception or for the Department to grant an exception. Unlike the process for seeking waivers for any other provision of the regulations, the exception process does not provide for public posting of the exception request or a period of public comment prior to final review and decision. Since an "exception" is in fact a "waiver," the same requirements should be in place.

- ***The regulations also do not ensure appropriate use of bed rails:*** Although the regulations added language limiting the use of bed rails, these requirements do not meet or exceed the rules for bed rail use in personal care homes as required by Act 56 (the statute creating the licensure status for assisted living residences and requiring DPW to issue the assisted living regulations).

- ***Inadequate fire safety requirements:*** PALCA is alarmed residents will not have sufficient protection from potential fire hazards such as kitchen areas where electric appliances will be used.

To review PALCA's full comments on the assisted living final-form regulations, visit PHLP's Web site (www.phlp.org) and click on "Assisted Living." PHLP's website and future newsletters will have more information about the impact of the new regulations.

PA Establishes High Risk Health Insurance Program; Consumers Must Be Ready to Apply August 1st!

Individuals with pre-existing conditions in Pennsylvania who have been unable to get insurance may soon be able to get health coverage through a High Risk Pool set up by Pennsylvania's Department of Insurance (DOI). However, interested individuals will need to act fast to apply as openings are limited because of limited funds. The DOI recently submitted a proposal to the federal government (available at www.insurance.pa.gov) for covering Pennsylvania. Although some details could change, the DOI will start accepting applications from interested Pennsylvanians on August 1st, decide which Pennsylvanians qualify on August 15th, and start health coverage September 1st.

There's a small window of time for interested Pennsylvanians to submit applications so that someone has the best chance to qualify and get enrolled when coverage begins. It appears that the Pool will use a lottery system when the program opens for applications on August 1st.

The Patient Protection and Affordable Care Act requires states or the federal government to develop High Risk Pools that will provide coverage to people with pre-existing health conditions who are not otherwise able to get health insurance. These Pools will exist through December 2013. On January 1, 2014, it will be illegal for private health insurance carriers to deny coverage, impose a waiting period, or charge higher premiums for someone with a pre-existing condition.

Funding for the High Risk Pool is limited. Pennsylvania will receive $160 million dollars in federal funds for 2010-2013 for its program, which will provide health insurance coverage for approximately 5,000 eligible individuals.

To qualify for Pennsylvania's High Risk Pool, an individual must meet citizenship requirements, be uninsured for six months, and have a qualifying pre-existing condition or be someone that experienced problems getting private coverage due to a pre-existing condition. Qualifying individuals (who submit a timely application and are selected through the lottery) will receive a broad package of benefits including prescription drugs, durable medical equipment, maternity care, mental health care for serious mental illness, and other inpatient and outpatient services.

Qualified individuals who are enrolled for coverage will pay $168/month if their income is under 200% FPL ($21,600/year for a single person and $44,100/year for a family of four). Individuals with higher incomes will pay $468/month for coverage.

Details about how people can apply are not yet available. Pennsylvanians are expected to have the choice of submitting an application by paper (via US Mail) or online. PHLP will post additional information as it becomes available on our website at www.phlp.org. For more information, individuals can contact our Helpline at 1-800-274-3258 or the Department of Insurance at 1-877-881-6388.

Please support PHLP by making a donation through the United Way of Southeastern PA. Go to www.uwsepa.org and select donor Choice number 10277.

More ACCESS Plus Recipients Can Get Disease Management Services Starting July 1st!

The ACCESS Plus Disease Management Program is expanding to cover more health conditions starting July 1st. ACCESS Plus is the Medicaid (known as Medical Assistance in PA) health care delivery system in the 42 counties of the state that do not have mandatory managed care. Currently, only ACCESS Plus recipients with Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease and Congestive Heart Failure are eligible to receive Disease Management services.

Participation in Disease Management is voluntary for people with qualifying conditions. Individuals who participate in Disease Management get services to help them better manage their health such as treatment support (reminders to make and keep appointments and get prescriptions refilled), help coordinating care, and educational materials to help them better understand and manage their disease.

Starting July 1st, ACCESS Plus recipients with the following conditions will also be eligible to receive disease management services if they are interested:

- Stroke
- Peripheral Vascular Disease
- Hypertension
- Inflammatory Bowel Disease
- Peptic Ulcers
- Rheumatoid Arthritis
- Low Back Pain
- Multiple Sclerosis (MS)
- Transient Ischemic Attack (TIA)
- Hyperlipidemia
- Cystic Fibrosis
- Gastroesophageal Reflux Disease (GERD)
- Hepatitis
- Systemic Lupus Erythematosus
- Seizure Disorders
- Migraine Headaches

ACCESS Plus recipients were recently mailed information about the expansion of the Disease Management Program. Individuals with any of the listed conditions should be contacted by their ACCESS Plus Care Manager about getting Disease Management Services. Interested individuals can also call the ACCESS Plus hotline at 1-800-543-7633.

State Budget Update

The Governor and General Assembly are still working on getting a final state budget passed for FY10-11 that starts July 1, 2010. Earlier this year, the Governor released his proposed budget which relies heavily on the assumption that Pennsylvania will receive enhanced payments for the Medicaid program from the federal government (known as FMAP) beyond December 31, 2010. The Governor penciled $850 million in federal Medicaid assistance into the revenue side of the state's ledger, reducing its projected shortfall to $1.2 billion. However, Congress has still not approved the extension of these funds for Pennsylvania or for any other state. Officials from the Department of Public Welfare (DPW) have expressed serious concern about the negative impact on Medicaid and other programs administered by DPW should the enhanced FMAP payments not be extended. The Governor has stated that the only way to compensate for the loss would be to lay off at least 20,000 government workers, including teachers and police officers. A final state budget is not expected to be passed before July 1st. Individuals who want to express their opinion on extending enhanced FMAP payments to states should contact their federal representatives.

Health Care Reform Changes Now Underway

Although major pieces of the health care reform legislation have a 2014 start date (such as Medicaid expansion, coverage mandates, and subsidy programs), health care in Pennsylvania and across the nation will undergo significant changes sooner. In addition to the creation of a High Risk Pool that will offer health insurance to people who are unable to obtain it currently due to a preexisting condition (described previously), there are several other early changes included in the Patient Protection and Affordable Care Act (the Act):

- ***Small Business Tax Credits***: To encourage small businesses to offer health insurance coverage, the Act included tax credits, effective in 2010, for small business owners who provide insurance for their employees. The credits are potentially worth 35% of their insurance premium costs.
- ***Maintenance of Effort Requirements:*** When the Act was signed into law, states were immediately required to keep their existing Medicaid eligibility and benefit standards until at least 2014. This requirement prevents states from cutting benefits now in anticipation of future costs.
- ***Closing the Doughnut hole in Medicare D:*** Medicare Part D recipients who reach the "doughnut-hole" in 2010 will automatically receive a $250 rebate check from Medicare. The first checks will go out in June. This is the first step in eliminating the Medicare prescription drug coverage gap that many Medicare beneficiaries face once they have incurred medication costs above a certain amount. Beginning in 2011, discounts and rebates for those who reach the doughnut hole will annually increase until the coverage gap is completely phased out by 2020.

Other provisions of the Act, effective September 2010, impact commercial and non-profit health insurers:

- Health insurance plans will no longer be allowed to drop consumers from coverage when they get sick (known in the industry as "rescissions");
- Insurers will be prohibited from discriminating against children with pre-existing conditions by denying them coverage;
- Lifetime limits on coverage will be banned;
- Health insurance plans will be required to provide preventive services, such as checkups, without requiring consumers to pay a deductible or copayments; and
- Plans will be required to spend a percentage of their income from premium payments on medical services: 80% for individual and small group plans, and 85% for large group plans.

September 2010 also marks the beginning of the requirement that employer sponsored plans offer coverage to children up to age 26. Some plans have already started this. Parents with recent college graduates should contact their employer about eligibility before September.

Stay tuned to our website (www.phlp.org) and future newsletters for additional information on Pennsylvania's implementation of health care reform. Please see our April 2010 *Senior Health News* (available on our website) for information about how health care reform impacts older adults and persons with disabilities.

Fate of the adultBasic Program Uncertain

With its primary funding set to expire at the end of this year, the fate of Pennsylvania's adultBasic health insurance program is uncertain. AdultBasic is an affordable, bare-bones health insurance that covers over 40,000 otherwise uninsured Pennsylvanians. Another 380,000 residents of the Commonwealth are currently on the program's waiting list.

AdultBasic is primarily funded through an agreement with the Commonwealth's four nonprofit Blue Cross providers. The agreement, known as the Community Health Reinvestment Plan, directs a portion of the Blues' charitable obligation toward funding adultBasic. This obligation will expire on December 31, 2010. Because the Blue Cross plans have refused to voluntarily extend the funding, the Pennsylvania General Assembly is considering legislation that would require continued funding by the plans.

Legislation introduced by State Representative Todd A. Eachus (H.B. 2455) would require the Blue Cross plans to direct 95% of their charitable obligations toward adultBasic funding through 2014. The Eachus legislation remains in Committee in the House. Should it pass the House, its fate in the Senate does not look promising. Various Senate staffers have indicated that the Republican leadership is not likely to pass the legislation. Instead, the Senate leadership is expected to require the Blue Cross plans to extend adultBasic for additional six months, through the end of Fiscal Year 2010-2011 and into the new Governor's administration.

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Gateway Withdrawing from Most Voluntary Managed Care Counties

Gateway Health Plan (Gateway) recently announced that, as of September 30, 2010, it will no longer operate in 17 of the 19 counties where it currently offers a Voluntary Managed Care Plan. This withdrawal impacts 14,500 Medical Assistance recipients in the following counties: Cambria, Carbon, Clarion, Columbia, Franklin, Jefferson, Lackawanna, Luzerne, Mercer, Monroe, Montour, Northumberland, Pike, Schuylkill, Somerset, Susquehanna, and Wyoming. Gateway cited cost concerns as the reason for the withdrawal. Gateway will continue to offer a Voluntary Managed Care Plan in Blair and Erie Counties. They will also continue to operate a mandatory managed care plan in the HealthChoices SW and Lehigh-Capital regions.

Gateway plans to send notices to affected members in July that will explain their options for ongoing coverage. These members will have the choice of using ACCESS Plus to get their Medical Assistance or, in all counties except Northumberland, joining another Voluntary Managed Care Plan. Consumer advocates and other stakeholders have been notified of this decision by the Department of Public Welfare (DPW) or Gateway.

DPW is working to make sure that affected consumers continue to receive necessary health care services during this transition. Efforts will be made to keep individuals with their current primary care physician; in cases where this is not possible, ACCESS Plus or the individual's new Voluntary Managed Care Plan will work with the member to make sure that any special needs or requests that they have are met.

Consumers with questions about Gateway's withdrawal can contact Gateway Member Services at 1-800-392-1147 (press 2 for Member Services). Individuals can also contact PHLP's Helpline at 1-800-274-3258 with questions and concerns.

Major Hospital Systems in the Southeast Sign New Contracts with Medicaid Plan

Crozer Health System and Keystone Mercy Health Plan
Medicaid (also known as Medical Assistance in PA) consumers using the Crozer Health System (Crozer) will be able to stay with (or return to) their Crozer providers now that Crozer and Keystone Mercy Health Plan (KMHP) have signed a new one-year agreement. The parties reached agreement on the new contract on April 30th, the day the previous contract was set to expire. As was reported in the March issue of the *Health Law News*, a contract termination would have affected approximately 17,000 KMHP members. Because no other Medicaid managed care plan contracts with Crozer, affected members would not have been able to continue seeing their Crozer providers. As required by federal law, affected KMHP members were sent letters informing them of the termination thirty days before the May 1st termination. Members who used a primary care physician (PCP) owned or solely-affiliated with Crozer had to choose a new PCP, and those that did not were auto-assigned a new physician. Though it caused significant confusion and disruption to care, the eleventh-hour agreement between KMHP and Crozer does allow KMHP members to remain with their Crozer providers. Those who had been auto-assigned to a new PCP by KMHP should have been automatically reassigned back to their Crozer provider. KMHP members who chose a new PCP but who now want to return to their Crozer provider need to call KMHP and ask to be switched back.

Children's Hospital of Philadelphia and Keystone Mercy Health Plan
Similarly, KMHP recently avoided a contract termination that would have affected over 67,000 children by signing a new three-year contract with the Children's Hospital of Philadelphia. The parties reached agreement on May 26th, the day before the thirty-day advance notice letters were to be mailed to affected health plan members.

Albert Einstein Healthcare Network and Keystone Mercy Health Plan
In order to continue negotiating a new contract, Albert Einstein Healthcare Network (Einstein) and KMHP have extended their current contract until July 30th (it was initially scheduled to end on May 31). The Einstein network includes Albert Einstein Medical Center, Einstein Center One, Einstein at Elkins Park, Germantown Community Health Services, MossRehab, and Willowcrest.

Should Einstein and KMHP not agree on a new contract, affected KMHP members can remain with their Einstein providers by switching to another Medicaid managed care plan. All of the remaining plans in the Southeast HealthChoices zone – Aetna Better Health, Coventry Cares, Health Partners, and AmeriChoice – contract with Einstein. Alternatively, affected KMHP members can stay with KMHP and choose a new provider within KMHP's network.

As a reminder, affected consumers must receive thirty days advance notice of a potential contract termination. Additionally, if a contract terminates, continuity of care rules require that plans permit members who are pregnant or in an ongoing course of treatment to stay with their existing physicians for at least sixty days.

2010 Federal Poverty Guidelines Update

The 2009 Federal Poverty Guidelines continue to remain in effect for income-based programs (such as Medical Assistance and the Medicare Part D Low-Income Subsidy Program). Congress is currently debating a bill (American Jobs and Closing Tax Loopholes Act, HR 4213) that includes keeping the 2009 federal poverty levels (FPLs) through the end of 2010. This particular provision of the act is not controversial and is expected to be included in the bill when finally passed. If approved, this extension of the 2009 federal poverty levels will ensure that people do not lose their access to the important benefits provided by programs that rely on this standard for eligibility.

Consumer Subcommittee Provides Input to DPW on HealthChoices Contract

The Consumer Subcommittee of the Medical Assistance Advisory Committee recently made recommendations to DPW for changes to the HealthChoices Physical Health contract. HealthChoices is the Medicaid health care delivery system in the Southwest, Southeast, and Lehigh-Capital regions of PA where most Medicaid recipients are required to get their physical health services through managed care organizations (PH-MCOs). DPW contracts with PH-MCOs and expects them to follow certain rules and requirements laid out in the contract and other documents. The contracts between DPW and PH-MCOs are renegotiated every year. The Subcommittee's suggestions include:

(1) Improve Language Access for Consumers with Limited English Proficiency: PH-MCOs should be required to provide immediate interpreter services to all limited English proficiency (LEP) consumers by phone or in-person when they are at medical appointments.

(2) Medical Necessity Determinations: The burden should be on the PH-MCO, not the Medicaid consumer, to show that the consumer's health has changed before the plan can determine that the service is no longer medically necessary.

(3) Transfer of Medical Records: The process for transferring medical records should be as easy as possible for consumers who are changing Primary Care Physicians (PCPs). Standard releases should be automatically generated and sent to consumers changing PCPs.

(4) Specificity and Clarity in Pharmacy Benefits Explanation: Consumers, before they sign up for a plan, should be able to easily compare plans to determine whether a particular medication is covered and what their co-pay (if any) will be. It is very frustrating for consumers to hand a prescription to a pharmacist and be told that they cannot have a medication because it is not covered by their health plan.

(5) Ongoing Course of Treatment for Consumers Affected by Contract Terminations: Consumers should be able to continue seeing their providers when they are in the midst of receiving an ongoing course of treatment at the time of a contract termination between their MCO and their health care provider. In the wake of several contract terminations within the past year, PHLP has become acutely aware of the problems consumers face when their access to care is disrupted, especially when they are in the middle of treatment.

Prescriptions for Pennsylvania: Lessons Learned From Recent (Near) Contract Terminations Between Health Care Providers and Medicaid MCOs

An Opinion Piece by Laval Miller-Wilson, J.D., PHLP Executive Director

Recently, Medicaid consumers in the Commonwealth have had their provider choice threatened because some of Pennsylvania's major health care providers (hospitals) are dropping out of Medicaid managed care insurance plans. As reported in this and earlier PHLP newsletters, several contracts between hospitals and plans were either ended or extended hours before their expiration. In two instances—contracts between Keystone Mercy Health Plan (KMHP) and Crozer Health System (Crozer) and between AmeriHealth Mercy Health Plan and Penn State Hershey Medical Center—thousands of Medicaid consumers received confusing and conflicting information that they had to suddenly change their primary care provider.

Contract disputes between health insurance plans and hospitals are common and typically center on disagreements about payment levels, financial risk sharing arrangements, and accuracy or timeliness of payments; and, it is understood that hospitals and plans may terminate their arrangements. However these parties, and the Commonwealth's Department of Public Welfare, need to do more to prevent consumer confusion and to ensure consumers have provider choice.

Health insurance plans that choose to bid on Medicaid contracts need to be good stewards of those funds, knowing that health care for low-income populations is complex and costly. For their part, hospital systems need to be accessible to Medicaid beneficiaries. "If you work there, serve there" should be the motto. Moreover, hospital systems must contract with more than one Medicaid managed care plan because limited arrangements with only one plan (as in the Crozer-KMHP situation) erode consumer choice.

Both plans and hospitals need to negotiate their contracts with the consumer notice deadline in mind. Federal law requires that when contracts are terminated, affected consumers receive 30 days advance notice. PHLP was bitterly disappointed by the negotiating process in Crozer-KMHP. Consumers should never receive letters and outreach calls announcing a termination and encouraging consumers to change providers, then another communication weeks later saying "sorry, never mind."

Finally, the Commonwealth of Pennsylvania is also culpable. Despite assigning Medicaid coverage to private managed care insurance companies, state officials are ultimately responsible for monitoring and regulating the Medicaid network. The promise of Pennsylvania's Medicaid managed care was to improve the quality of health care services by ensuring continuity of care with a primary care provider. These contract disputes between hospitals and health plans are leading to the abandonment of this promise, forcing patients into new practices, and placing a heavy burden on practitioners whose offices must suddenly care for hundreds of new patients all at once. The state should consider contract amendments that, among other things, allow consumers to continue with their providers when they are in a course of treatment, penalize parties for early termination and reward parties for continuing contract arrangements. Several other contract suggestions are described in this newsletter.

An Update on the KMHP Enrollment Suspension

In our January Newsletter we reported on DPW's decision to suspend new enrollments into Keystone Mercy Health Plan (KMHP) for at least six months beginning on April 1, 2010. As a reminder, the enrollment suspension does not affect existing KMHP members. Additionally, the enrollment suspension **will not** apply to new births or individuals added to the household of an existing KMHP member. If an existing KMHP member chooses to change to another plan, he will not be able to change back to KMHP until the enrollment suspension is lifted.

DPW has now decided to allow an additional exception to the enrollment suspension for newly eligible pregnant women who live in Delaware County. These individuals can enroll into KMHP upon request. Please note that this exception only applies to pregnant women who are newly eligible for Medical Assistance. Women who are already on MA and in a managed care plan who are pregnant or who become pregnant cannot switch out of their plan and into Keystone Mercy.

Consumers who have any questions about their health plan choices can contact PA Enrollment Services at 1-800-440-3989 or PHLP's Helpline at 1-800-274-3258.

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