# Health Law PA News

NEWSLETTER OF THE PENNSYLVANIA HEALTH LAW PROJECT
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VOLUME 5, NUMBER 1 JANUARY 2001

## -In this edition-



## Health Department to Send Act 68 Managed Care Regulations to Regulatory Review Commission

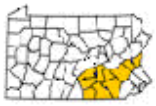
The Pennsylvania Department of Health (DOH) is expected to send its revised managed care (Act 68 of 1998) regulations back to the Independent Regulatory Review Commission (IRRC) for approval or disapproval very soon. DOH circulated a draft of the revised regulations recently, and invited stakeholders to give their response to them on January 3.

*"...consumer groups stressed the need to get regulations in place to limit managed care abuses."*

These regulations will govern managed care plans' (HMOs) operations for the foreseeable future.

The draft incorporated a number of recommendations that consumer groups and the IRRC made to the draft Act 68 regs that DOH proposed over a year ago. Significant changes were made in the areas

*(See **Act 68 Regs** on page 2)*



## HealthChoices Expansion Update

As reported in the last edition of the *Health Law PA* News, HealthChoices mandatory managed care is phasing in to the Lehigh-Capital region starting October 2001 for recipients who are already voluntarily in a Medicaid HMO. Fee-For-Services recipients will be required to join an HMO by April 2002. Individuals who do not select an HMO by that time will be automatically assigned to one.

The ten Lehigh-Capital counties are Adams, Berks, Cumberland, Dauphin, Lancaster, Lebanon, Lehigh, Northampton, Perry, and York.

DPW has completed its proposal process and chosen the following four contractors to provide HealthChoices coverage in these counties:

- AmeriHealth Mercy Health Plan
- Gateway Health Plan
- HealthMATE
- MedPLUS+

Each plan has operated for some time alongside the Fee-For-Service program in various voluntary managed care counties. Gateway and MedPLUS+ also operate in the HealthChoices Southwest mandatory managed care program.

Also of note, on January 2, 2001, the marketing activities of voluntary HMOs operating in the Lehigh-Capital region were limited to County Assistance Offices. Home visits are allowed *only* at the request of an MA recipient.

Starting August 20, 2001, all enrollment in HMOs will be carried out by an Independent Enrollment Assistance Program (IEAP) contracted by DPW. HMOs will no longer be allowed to market or enroll people in their plans.

*(**Act 68 Regs** from page 1)*
of utilization review and complaints and grievances. Examples of changes include:

- Plans must make utilization review criteria available to providers on request.
- Plans cannot base denials on utilization criteria alone, but must provide a clinical rationale as well.
- Plans must provide the member preparing for a grievance hearing with all information relating to the matter being grieved.
- The member has the right to cross examine the plan's staff at the second level grievance.

At the January 3 DOH gathering, consumer groups stressed the need to get regulations in place to limit managed care abuses. They testified that while the regulations are not perfect, they represent a major improvement over the previous version. Managed care representatives, on the other hand, generally opposed the regulations because of the increased consumer protections.

Interested persons can check the DOH website at *www.doh.state.pa.us* or the Pennsylvania Bulletin to i) learn when the final draft is released, ii) to review the proposed regulations, and iii) learn how to comment. The IRRC cannot change the regulations that DOH brings to it at this time, but must approve or disapprove the package. ■

## Medical Necessity Redraft Retains Cost Benefit Analysis

DPW's Office of Medical Assistance Programs (OMAP) has circulated a redraft of its proposed changes to the regulatory definition of "medically necessary." Pennsylvania's Medicaid program has had one of the best medical necessity definitions for consumers in the country. The definitions is important because it is the legal criterion used to determine if prescribed health care should be approved by the HMOs or DPW.

For the first time in Pennsylvania, the new definition would separately require that the prescribed care is both "reasonable" and "necessary." Under the draft regulation, a service or benefit is not reasonable if it: i) is more costly than an equally effective medically appropriate alternative, or ii) serves the same purpose as a service or benefit the recipient is currently receiving.

This draft definition, like DPW's previous effort to change the existing medical necessity definition, would introduce a cost benefit analysis to the determination whether the state will pay for a benefit or service that a licensed practitioner has prescribed. Consumer advocates have criticized this approach as extremely dangerous, especially in the hands of HMOs and other entities that prior authorize services, and have a financial incentive to deny care. Advocates see this provision as inviting payers to substitute their judgment for the judgment of treating professionals.

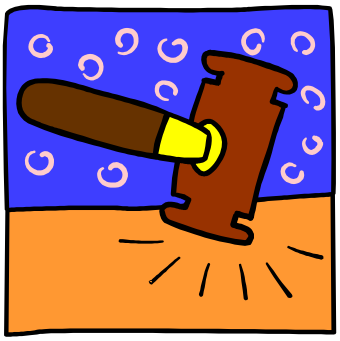
***"Advocates see [the cost-benefit analysis] provision as inviting payers to substitute their judgment for the judgment of treating professionals."***

The language that would permit denial of payment if the recipient is receiving another service that serves the same purpose, has been criticized by consumer advocates as too vague to apply.

Under the draft, a service or benefit establishes necessity (but not necessarily reasonableness) if it meets any prong of a four-pronged test that includes: i) reasonable expectation of preventing illness, condition or disability, ii) reasonable expectation of reduction or amelioration of physical, mental, behavioral or developmental effects of an illness, condition, injury or disability, iii) assisting the recipient to achieve maximum functional capacity in performing daily activities, or iv) aiding in the diagnosis and/or clinical characterization of an illness, condition, injury or disability. Consumer advocates and health care providers have supported this part of the definition, which retains the language currently governing medical necessity decisions in HealthChoices plans.

The draft is being reviewed by DPW's legal counsel, and is expected to be published as a proposed regulation in the Pennsylvania Bulletin in the upcoming weeks or months. ■

## Legislative Wrap-up



In 2000, several significant pieces of health legislation were dealt with at state and federal levels. Following is a summary of what happened to them as legislative sessions in the Pennsylvania General Assembly and the US Congress came to an end.

**Assisted Living**. Neither HB 1930 (the Adult Living Residence Act) nor HB 2700 (the Assisted Living Reform Act) passed the state House of Representatives. Assisted living legislation is expected to be introduced early in the new session.

**PACE.** Several bills that proposed to expand PACE income eligibility were proposed last session. None passed both houses of the state legislature. PACE expansion legislation is expected to be introduced early in the new session in Harrisburg.

**Tobacco Settlement**. There are many possible uses for the Tobacco Settlement money. Some possibilities discussed in 2000 included the Governor's proposal to devote 40% of the money for insuring and caring for the uninsured and 15% for home and community based services for seniors. No final decisions were made and no legislation passed last session disbursing tobacco settlement money.

**Medicare Giveback Bill**. On the federal level, this giveback bill would, in addition to giving a large amount of money to Medicare HMOs, hospitals, and other providers, increase some of the health services available to seniors under Medicare. This bill did pass the U.S. Congress in December, and it was signed into law by President Clinton.

**The "Pennsylvania Prescription Drug Fair Pricing Act"** that sought to require Pharmaceutical Companies to sell drugs to all Pennsylvanians at fair prices did not pass in the last session. A bill to address drug pricing issues is expected to be introduced in the new session.

If you have any questions about legislation, you may call your state legislators and US Senators and Representatives. To find out who those people are and their contact information, call the Pennsylvania League of Women Voters at 1-800-692-7281. ■

## Zoloft Elimination Raises Concern over Formulary Issues in Consumer Subcommittee and MAAC

The removal of the behavioral health medication Zoloft from the AmeriChoice and MedPLUS+ formularies (*PA Health Law News*, November 2000) rekindled a long-standing concern of the Consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC) over the MA formulary process in Pennsylvania.

In its October 25 meeting, the subcommittee unanimously passed a resolution calling for Zoloft to be kept on the formularies until DPW establishes an open process for determining what drugs will be covered. The motion went on to ask for a uniform formulary statewide.

***The Consumer Subcommittee remains concerned over what it views as a secretive and arbitrary process closed to MA recipients.***

At its meeting the following day, the full MAAC overwhelmingly passed a similar resolution introduced by Ken Pierce of the PA Welfare Rights Organization. The two dissenting votes were cast by representatives of UPMC Health Plan and Health Partners.

The issue was revisited at the December MAAC Meeting. DPW declined to follow the MAAC's recommentation, stating that there will be no changes to the current formulary process.

The Consumer Subcommittee remains concerned over what it views as a secretive and arbitrary process closed to MA recipients. ■

## Transportation on the Double!


The Medical Assistance Transportation Program (MATP) provides transportation to recipients even if they must see their doctor on short notice. Recipients should still call 911 in an emergency. If you encounter difficulties obtaining urgent care rides from your MATP provider, you can call PHLP for assistance at 1-800-274-3258.

## MA to Require Prior Authorization for TSS Services in FFS System

On October 26, 2000, the Office of Medical Assistance Programs (OMAP) of DPW issued for public comment a draft bulletin requiring prior authorization for Therapeutic Staff Support (TSS) services in the Fee-For-Service system. TSS services are critical "wrap-around" services that provide children one-on-one behavioral support services in school and at home. Although DPW provided minimal time for feedback on the bulletin, consumer advocacy groups and consumers, including the Consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC), submitted several responses.

According to the Consumer Subcommittee, there are many concerns with how the proposals in the draft bulletin would affect children and families in need of TSS, and there are equal concerns about the process undertaken by the Department with regard to the handling of the bulletin. The subcommittee's concerns are summarized below.

Consumers stated that they did not have adequate time to respond to the bulletin, nor did they receive the necessary background information to make informed recommendations.

Consumers and family members were also not given the opportunity to have input into the clinical criteria used for determining the medical necessity of TSS services. The criteria were subject to an "internal review process" with no input from consumers or family members.

Requiring consumers and family members to get prior authorization for TSS services is contradictory to the nature and reason for these services. Children, adolescents, and their families need TSS services to begin with due to severely unmanageable behaviors that put at risk the continuity of the family and the safety of the children. Although the proposed bulletin makes allowances for families in need of "expedited TSS services," the so-called "expedited" process is still too lengthy and involved to allow the process to occur smoothly and quickly to meet the emergency needs of the family. As a result, consumers requested that DPW waive prior authorization for 60 days to allow TSS services to begin for any child or adolescent who is determined medically eligible for these services.

DPW did respond to feedback from consumers by further revising the draft bulletin, dated December 1, 2000, which provided consumers with some of the requested background materials, reconfigured the "expedited" review process, and extended the implementation of the bulletin from February 1, 2001 to March 1, 2001. DPW accepted feedback to this "revised" draft until December 14, 2000. Consumers responded that the revised draft was too little, too late, and leaves children and families who are in need of TSS services in a more vulnerable position than they already are when they come to the attention of the system.

Call PHLP with any problems or questions at 1-800-274-3258. ■

## Pennsylvania Loses $19 Million in Tobacco Funds

The Associated Press reported on January 11, 2001 that Pennsylvania's December payment from the class-action settlement between states and tobacco companies $110 million instead of $130 million, a net loss of $19 million.

The gap is due to a provision in the settlement that requires states to enact specific legislation to protect companies participating in the settlement. The legislation forces non-participating tobacco companies either to sign on to the agreement, or pay an annual amount of money equivalent to the industry's lost market share into an escrow account.

Participating companies feared that without the provision, other companies not bound by the agreement's marketing restrictions would gain a disproportionate advantage over them.

Pennsylvania joins 15 other states who did not pass the legislation in time. The total loss to all affected states for 2000 is estimated at $197 million.

While the tobacco settlement set June 1999 as the deadline for enacting the law, states are considering suing to gain the money, since all have passed the needed legislation in the months since June 1999. "We're confident we'll prevail," said Sean Connolly, spokesman for Pennsylvania Attorney General Mike Fisher, in comments to the AP. ■

## Federal Rule Allows States to Cover More People on Medicaid

On January 11, 2001, the federal government implemented a final rule allowing states to disregard certain types or amounts of income and assets in determining eligibility for Medical Assistance.

For example, under previous federal regulations, a person with a disability or who is 65 or older and who has income at the federal poverty level, could qualify for MA in Pennsylvania. However, if the individual's income is just one dollar a month above the federal poverty level, she must incur over $100 a month in medical bills, which will not be covered by MA, before she will qualify for coverage.

The new federal regulation, however, allows states to address this inequity by disregarding additional income. It would also allow states to provide MA and MA-funded home and community-based services to persons with disabilities and persons who are 65 and older with low incomes but who have more than $2000 in assets. These individuals are currently ineligible for MA or for the various home and community-based service waivers that Pennsylvania offers. ■

## Federal Rule Averts Immediate Blow to MA Funding

Until a final rule released by the Department of Health and Human Sevices was approved by then-Secretary Donna Shalala on January 5, 2001, many states, including PA could retain billions in Medicaid funding through an accounting loophole permitted under federal regulations for several years.

The new rule eliminates this loophole, but gives states up to eight years to adjust their Medicaid budgets, based on how long they have utilized the practice. Pennsylvania will have the full eight years to wean itself from the money, starting in 2002. The Commonwealth has used the funds for a variety of purposes, including funding the SSI supplement and long-term care.

HHS made the rule in response to the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 passed by Congress. The act required that the loophole be closed because it has caused massive increases in federal Medicaid expenditures without adding coverage or making improvements to the program.

In Pennsylvania, the loophole works by allowing county nursing homes to transfer funds to the state to be used for the state Medicaid match. The state then makes a higher than usual Medicaid payment for nursing facility care, which allows facilities to recoup the money they had transferred to the state. The effect is that the state can obtain about a billion dollars of Medicaid funding without putting up its share. The new regulation limits this funding scheme by restructuring the rules governing how Medicaid upper payment limits are calculated.

Many hospitals that treat large numbers of uninsured people depend on funding available under the old rule, and many were concerned that the reform would undermine their financial viability. However, the new rule includes a provsion increasing payments to such hospitals to compensate for the new upper payment level methodology.

For affected states, the final regulation is an improvement over one proposed in October 2000, which would have phased out the loophole within a far shorter period starting in fiscal year 2001. ■

## HIPAA Protections Bolstered

According to a January 10, 2001 piece in the *Kaiser Daily Health Policy Report*, new rules issued by the Labor, Treasury, and Health and Human Services Departments on January 8 will expand and solidify consumer protections under the Health Insurance Portability and Accountability Act (HIPAA).

Under HIPAA, the new federal regulation bars health insurers "from discriminating against individual participants...based on the health characteristics of such participants..." Plans **will not** be allowed to deny coverage or raise premiums because of an individual's health status, medical history or condition, claims experience, receipt of health care, genetic information, or evidence of insurability and disability.

Plans will be allowed to exclude coverage for injuries based on their origin (e.g. recreational activities), but not for normally covered injuries due to an illness or medical condition, or domestic violence.

The new rule also stops plans from denying or reducing benefits if an enrollee is hospitalized or confined to a health care institution during the period the coverage is supposed to take effect. ■

# Announcements

### Getting MA for kids with disabilities

PHLP's revised guide to obtaining Medical Assistance for children with disabilities (Category PS95 or "the Loophole") is available. Contact PHLP at 1-800-274-3258 to obtain a copy.

### Medicare and Prescription Drugs

PHLP is gathering stories and experiences of anyone in PA who has Medicare, and cannot afford their prescriptions. We will be compiling an anthology of experiences to report to the state. If you have a story you'd like to share, or if you know someone who does, please contact Bob Murken at 1-800-274-3258.

### PHLP E-mail Alerts Available

PHLP provides e-mail free alerts to healthcare consumers and families on a variety of topics including MA, HealthChoices, managed care, CHIP, mental health services and access to prescription medicines. If you are interested in getting any of these alerts and are not already on our e-mail list, e-mail David Gates at *gates.david@verizon.net*. Include your name, your areas of interest and whether you're a consumer or the parent or caregiver of a child who needs health or mental health services. Also, if you on our list in the past but have changed your e-mail address, let us know your new address and areas of interest. We do not share our mailing lists with any commercial enterprises or other organizations.

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