Health Law PA News

Newsletter of the Pennsylvania Health Law Project
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DPW Cancels OakTree and HealthMATE Contracts

Medical Assistance recipients who are enrolled in OakTree (in Philadelphia, Bucks, Montgomery, Delaware, and Chester) or HealthMATE (in Cumberland, Dauphin, Lackawanna, Lancaster, Luzerne, and York) are expected to have their coverage through those plans terminated as of August 31, 2001. The Department of Public welfare has announced that it will cancel its contract with the parent company of OakTree and HealthMATE, Health Risk Management, Inc. (HRM) due to the company's financial difficulties. Consumers will be able to choose new plans before then.

It appears that only a sale of HRM could prevent the ultimate cancellation of OakTree and HealthMATE contracts. In the meantime, consumers are advised to consider their alternatives, and move to change plans in time for the August 31 cancellation. Upcoming notice from DPW will inform OakTree and HealthMATE members of precise deadlines for changing plans.

How Consumers Will Be Affected

Members who are on OakTree must select another of the three remaining HealthChoices Southeast HMO's (Keystone Mercy, Health Partners or AmeriChoice), otherwise they will be auto-assigned to one. Members of HealthMATE can join one of the other available HMO's: AmeriHealth Mercy, MedPLUS+, or Gateway. Otherwise, DPW will automatically place them in the fee-for-service program, where they must use their ACCESS card.

To switch plans, consumers can call 1-800-440-3989. They should be sure to make a list of their important providers before calling, so that they can

*(See **OakTree/HealthMATE** on page 2)*

-In this edition-

DPW to Expand MA Coverage for Women with Breast and Cervical Cancer to 250% of Poverty Level

The Breast and Cervical Cancer Treatment Act of 2000 expands federal funding for Medical Assistance coverage to many low-income women who suffer from breast or cervical cancer. The Department of Public Welfare has set January, 2002 as a target date for implementing this coverage in Pennsylvania.

Women must meet the following basic criteria for eligibility:

- Screened under the Center for Disease Control Breast and Cervical Cancer Early Detection Program and found to need treatment for either breast or cervical cancer
- Household income up to 250% of federal poverty level
- Uninsured
- Under age 65
- Either a U.S. citizen, or a qualified alien.

*(**Special MA Coverage** on page 2)*

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*(**OakTree/HealthMATE** from page 1)*
choose plans that include these providers.

Provider Network Issues

Many OakTree and HealthMATE doctors and providers belong to more than one HMO. Benova will assist in identifying an HMO that has a consumer's current primary care doctor and as many other important providers in its network as possible. If a current provider is not in any of the remaining HMO's, it may not be possible to keep that provider.

Consumers who also have Medicare can continue to use Medicare providers outside the MA HMO's network for services that are covered by both Medicare and MA. As in the past, the MA HMO must pay copayments and coinsurance amounts up to the MA payment level. They may not be billed for these amounts. For non-Medicare covered services, consumers will have to use their MA plan's network.

If current providers do not accept the other HMO's, consumers can always encourage them to join their new plan's network. Consumers on HealthMATE who go into the fee-for-service system can have providers bill MA directly.

Continuity of Care

Former HealthMATE and OakTree members have the right to continue a course of treatment with a provider for 60 days after joining their new HMO, or longer if medically necessary. This means that consumers under the care of an OakTree or HealthMATE provider for an ongoing course of treatment on August 31 will be able to continue treatment with that provider for 60 days, if the provider agrees. This period may be longer if the new plan agrees to an extension. Payment will be made by the new HMO, or by the fee-for-service (FFS) system, if the consumer has gone back into FFS. Providers not in the new HMO's network can ask to join that HMO during this 60+ day period.

Women in their second or third trimester of pregnancy on July 31 will be able to receive care for themselves and their newborns from current providers through the end of the postpartum period. The new HMO must cover this care whether or not the providers are in its network.

OakTree and HealthMATE Prior-Authorizations

All new HMO's, the ACCESS plan (FFS), and Lancaster Health Plan must fully honor OakTree and HealthMATE prior-authorizations for their full term. For instance, if OakTree or HealthMATE prior-authorizes something for six months, and four months are remaining when the consumer joins the new plan, the new health plan must honor that prior authorization for the remaining four months.

Medications and Formularies

Consumers on ongoing medications should contact prospective HMO's to ask if they have that medication on their formulary. If the medication is not on-formulary, they may wish to have their doctor prescribe one that is, or request prior-authorization of their current medication from the new plan. Current prior-authorizations from OakTree or HealthMATE must be honored by the new plan.

Behavioral Health Coverage

Behavioral health coverage other than prescriptions will not be affected, but consumers may need to obtain prior authorization for behavioral health medications not on their new plan's formulary.

Help

If you have any questions or difficulties regarding this transition, please call the Pennsylvania Health Law Project at 1-800-274-3258. ■

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*(**Special MA Coverage** from page 1)*

In Pennsylvania, the CDC Breast and Cervical Cancer Early Detection Program is administered through the state Department of Health's (DOH) Healthy Women Project. In accordance with the federal limit, DOH's program will screen women with household incomes up to 250% of the federal poverty level (FPL). For 2001, this amount has been set at $1,790 per month for one person, $2,420 for two people, and an additional $629 for each additional member of the household. Since screening by the CDC/DOH program is a requirement of eligibility, the screening program's 250% FPL income ceiling effectively caps eligibility at that level.

Women eligible for the program are entitled to full MA coverage, not limited to treatment of breast or cervical cancer.

Watch *Health Law PA News* for further developments on this issue, to learn more about how DPW will be implementing coverage, and how women can access it. ■

Congress May Expand Medicaid Coverage for People with HIV

Calling it indefensible to force people to wait until their HIV develops into full-blown AIDS before they can obtain Medicaid, US Representatives Dick Gephardt and Nancy Pelosi introduced HR 2063 in early June. The bill has over 100 co-sponsors, and would give states the option under Medicaid of covering lower-income people with HIV. ■

Consumers with MA and Private Insurance Face Access Problems

Medical Assistance recipients who also have private insurance often encounter an ironic limitation in their ability to access medically necessary services and benefits.

Having both MA and private insurance creates a situation known as "third party liability" (TPL), that is, the private insurer is a third party in addition to the recipient and the MA program who may be liable for the costs of healthcare. By law, MA must always act as the secondary coverage to an individual's private insurance. This limits the MA program's liability to these expenses:

- Co-payments and co-insurance not covered by third-party insurance. MA does not necessarily pay these, but it will not pay above them.
- Services and items not covered under private insurance. This varies widely, but often includes things like wraparound services for children, extensive home health care, or prescription drugs.

A Major Obstacle to Care

Under the current system, people who have both private insurance and MA are limited to providers who participate in both networks if they want to avoid be being billed. This is true in fee-for-service as well as in managed care. This policy often limits consumers to a tiny fraction of either plan's network, drastically reducing freedom of choice.

There are two basic ways DPW's current TPL policies restrict access to care. First, if recipients use a provider who is in the private network, but who is not in the MA network, MA coverage will not apply. Therefore, any co-payments or co-insurance, or uncovered services rendered by the non-MA provider become the financial responsibility of the recipient Second, if recipients use a provider who is in the MA network, but not in the private network, neither MA nor the private insurance will apply, and the recipient is responsible for the full cost of care. This is because MA will not pay for services that *could* be covered by a recipient's private insurance. The only providers available without cost to the recipient are ones who participate in both networks. Typically, this is only a fraction of either network. While federal rules may require DPW to be more liberal, we have described the policy DPW currently applies.

Difficulties with Providers

When a recipient has managed to find a provider who is in both plans, difficulties do not always end there. Proper billing may become a major source of frustration for recipient and provider alike.

Problems often arise when a provider does not or cannot bill both MA and private insurance (e.g., a pharmacy bills only the private insurance, which carries a $15 co-pay for prescriptions, and in turn charges the consumer $15, rather than billing it to MA). If only MA is billed, the claim may be rejected outright. If only the private insurance is billed, co-payments and co-insurance may not be submitted to MA. In either case, providers have tried to collect payment from the recipient, even though this is prohibited by MA regulations.

Help with Third Party Liability Issues

PHLP has been able to assist a number of clients in resolving TPL issues. Please feel free to contact us at 1-800-274-3258. ■

HealthChoices North/Central Expansion Update

In our last Newsletter, we reported on DPW's Draft Plan to expand HealthChoices to the remaining 42 counties by dividing them into three Subzones that together make up the North/Central region. Since issuing that paper, DPW held public hearings in 3 locations throughout the Zone, hearing testimony and receiving written comments on the proposed expansion. At the May meeting of the Medical Assistance Advisory Committee (MAAC), DPW reported on the issues "most frequently raised" during the public comment period and gave its response. Though we do not have space to report all the comments and responses, we chose the two areas that generated the most comment.

Reconfiguration of the Subzones

Many counties objected to how DPW drew up the three Subzones in the North/Central region because the proposed configuration disrupted existing MH/MR and Drug & Alcohol joinders and working rela-

*(See **North/Central** on page 4)*

*(**North/Central** from page 3)*

tionships among the counties. DPW agreed with most, but not all, of the county requests to be realigned. As a result, the most recent Subzone assignments proposed for this region are as follows:

Northeast Subzone: (moving to HealthChoices in 1/2003) Carbon, Lackawanna, Luzerne, Monroe, Pike, Schuylkill, Susquehanna, Wayne and Wyoming counties

Northwest Subzone: (moving to HealthChoices in 1/2004) Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Jefferson, McKean, Mercer, Venango and Warren counties

Central Subzone: (moving to HealthChoices in 1/2005) Bradford, Centre, Clinton, Columbia, Franklin, Fulton, Huntingdon, Juniata, Lycoming, Mifflin, Montour, Northumberland, Potter, Snyder, Sullivan, Tioga, and Union counties

Also, DPW decided to remove four counties (Bedford, Blair, Cambria and Somerset) from the North/Central region. Though these counties had asked to be in the Central Subzone, DPW instead decided to make them a part of the Southwest HealthChoices Region. As a result, HealthChoices will begin in these four counties in January, 2004.

Access to Care

DPW received many comments addressing access concerns. Among these concerns expressed:

- that local existing provider services be given preference by the HMOs to ensure that local capacity be maintained;
- that out-of-county and out-of-zone providers must be included in the HMO networks to ensure adequate network capacity and consumer access;
- that Medical Assistance Transportation program infrastructure and collaboration must first be developed to meet the demands for more rides over longer distances;
- that the minimum HealthChoices service standards for dentists and home health agencies (only requiring 2 in the entire region) must be increased to ensure real access for consumers.

In response DPW stated it will encourage but not require HMOs to include out-of-zone providers in their network. Regarding other concerns, DPW noted that it "agreed" or "partially agreed" with them but offered no details or specifics on how it planned to address the issues raised. ■

Update on Single Licensure for Residential and Part-Day Facilities

State regulatory authorities have announced a change in plans for consolidating the framework of the licensing regulations for Adult Residential (AR) facilities and Adult and Adolescent Part-Day (AAPD) facilities. The state's original plan was to create a single set of regulations for all subsets of AR facilities and one set for all of the subsets of AAPD facilities. Two three-day stakeholder meetings on the proposed regulations for both types of facilities took place in April and May.

At both three-day meetings, consumers voiced their concern that the one-size-fits-all approach that the state is taking to the proposed regulations will not work. Consumers' main worry is that the proposed single licensure will lead to deregulation of these facilities, leaving consumers without adequate protections and safeguards. The state apparently heard the concerns that were voiced by various stakeholders both at these meetings and in written comments, and announced last week that it has decided to abandon the proposed single licensure regulations for the AR facilities.

While consumers are relieved that the proposed regulations for the AR facilities have been withdrawn, the proposed regulations for the AAPD facilities remain on track. Consumers have submitted numerous comments to the proposed regulations, in addition to offering oral comments at the three-day stakeholder meeting. Some major concerns are that the review and enforcement provisions are almost nonexistent; the definition of abuse and the prohibition thereof is inadequate; the waiver section allows regulators to dispense almost any section of the regulations for a provider upon request by that provider, without any provision for public input or notification; and the quality management of facilities is left almost entirely in the hands of the providers themselves, without any public oversight. These are just a few of the concerns that consumers asserted concerning the proposed Part-Day regulations.

While consumers are pleased that the state has withdrawn the AR proposal, concerns remain with the AAPD regulations, which are set to go forward as originally planned. We will keep you posted in upcoming editions of *Health Law PA News* on the status of these regulations. ■

Assisted Living Bill Passes the House, Other Bills Follow

House Bill 49 passed the Pennsylvania House of Representatives on May 22, 2001. The Adult Living Residence Act defines and licenses Assisted Living in the Commonwealth.

With several amendments, the bill goes to the Senate.

As passed, HB 49 would allow seniors to receive assisted living services in the residential setting of their choice. It would set training and qualification requirements that direct care staff must meet prior to working hands on with a senior. It defines cognitive support services for individuals with Alzheimer's or other related dementia and requires facilities to disclose to families what they offer to cognitively impaired individuals. It also would increase the state SSI supplement by about $450/month.

HB 49 is a good starting point. But, it is missing several features for which assisted living advocates have been working very hard. They seek a strong consumer rights section. HB 49 does set training, programming, or physical site requirements that a facility must meet before it can provide services to individuals with Alzheimer's or other related dementia. It does not make public funding available as it is available in nursing homes and thus, when their money runs out, people can be forced to move.

There are some additional bills in the House that relate to assisted living. HB 1300, introduced by Representative O'Brien would add the public funding piece to allow aging in place in assisted living residences. It would also simplify the application and eligibility process, which often proves burdensome for seniors and their families. Additionally, Rep. Eachus has introduced a bill on public funding, HB 1803 that would do similar things. HB 1626, HB 1627, HB 1628, HB 1629, HB 1630 and HB 1631 would all impact long term care in the Commonwealth as follows:

- HB 1626 - Calls for DOH to license Home Care Providers that provide assistance with Activities of daily living (ADLs). (This would be accomplished by HB 49 licensure of unlicensed providers, should it become law.)
- HB 1627 - Calls for creation of a statewide fatality review board with local fatality review boards permitted. These would review fatalities that occur in LTC facilities (where referred by the coroner on suspicion of abuse) and make recommendations on the closure and improvement of conditions in facilities.
- HB 1628 - Articulates admission and retention criteria for consumers in adult living residences. It appears to exclude many NH eligible individuals.
- HB 1629 - This would add key missing pieces, including cognitive support services on site, programming, and training requirements for facilities providing cognitive support services.
- HB 1630 - Creates qualified assessor training and certification for those who would be allowed to conduct assessments of level of care and needs, etc.
- HB 1631 - Consumer rights bill that would establish consumer rights for all long term care settings.

As HB 49 moves to the Senate, it is important to note that the Senate has not yet addressed the topic of Assisted Living. Senator Mowery has introduced SB 888 that would licensed and fund assisted living in the home or in an assisted living residence. SB 888 is a comprehensive piece that includes many pieces of the various House bills.

We will keep you posted as these bills proceed through the House and Senate. ■

Governor Ridge and Assembly Strike Deal on Tobacco Money

As part of their 2001-2002 state budget pact, Governor Ridge and the Pennsylvania Assembly have agreed to devote 30%, or $103 million of the state's tobacco settlement money to providing health insurance to low-income adults. This is less than the 40% chunk originally proposed by Gov. Ridge, however the amount is still large enough to have an impact. Indeed, many low-income insurance advocates see 30% as a victory: with numerous other special interests vying to expand their share of the tobacco money, a low-income insurance program had the least-well-funded and fewest vocal supporters, despite an enormous need for it.

*(See **Tobacco** on page 6)*

*(**Tobacco** from page 5)*

The program will cover low-income adults who have jobs that do not provide health benefits, and adults who are between jobs. Additionally, some of the $103 million will be used to expand Medical Assistance coverage for working adults with disabilities.

Also of note, 13% of the funds, or $45 million, will be used to expand home and community based care for the elderly. 10%, or $35 million will go to reimburse hospitals for care given to uninsured individuals. 8%, or about 28 million will be used to expand the PACENET program, providing prescription coverage to lower-income, elderly individuals. A governor's office press release projected that this increase would cover 10,000 more people.

Remaining portions are allocated to medical research, smoking cessation, and an endowment designed to stabilize yearly proceeds from the settlement, which may vary annually. ■

State Issues New Draft Regs for Wraparound Services

The Department of Public Welfare recently distributed new draft regulations for outpatient behavioral health rehabilitation services, commonly referred to as BHRS or "wraparound". BHRS is provided by staff that include some combination of a BSC (Behavioral Specialist Consultant), a MT (Mobile Therapist) and a TSS (Therapeutic Staff Support). The Medical Assistance (MA) Program provides payment for medically necessary BHRS to recipients under 21 years of age.

DPW's draft rules reflect several changes to the delivery of BHRS. Proposed changes include:

1. A specified time frame for prompt delivery of services
2. The frequency of ISPT (Interagency Service Planning Team)meetings
3. Changes in TSS (Therapeutic Staff Support) staffing qualifications, training and supervision
4. New reporting forms

A specified time frame: Consistent with the Kirk T. settlement, the rules specify BHRS must begin within 60 days of the initial request for services. The only exception to the 60 days is when services are offered as authorized but the family delays the start of the services. Additionally, the amount of services offered may be less than what was authorized if the family agrees that the lesser amount of services is appropriate.

Frequency of ISPT meeting: Rules specify that an ISPT meeting is required when BHRS are first requested but only annually thereafter unless requested by the family or other members of the team. This is a change from the current system where the ISPT meeting is required every four months with the request for re-authorization of services.

Changes with TSS: Consistent with the Kirk T. settlement, the proposed rules modify minimum staff qualifications for TSS workers as well as establish specific initial and ongoing training and supervision requirements. A TSS worker with no prior experience must receive at least 15 hours of training before providing services and no less than 24 hours additional training in the first six months of employment. Ongoing training for all TSS workers is required at 20 hours per year after the first year.

TSS supervision requirements have also changed. A TSS with less than 6 months experience must receive at least 6 hours of on-site supervision before working alone. All newly hired TSS workers must receive 3 hours of on-site supervision before working alone. A TSS working at least 20 hours a week must receive at least 1 hour a week of supervision while those working less than 20 hours must have at least ½ hour of supervision.

New reporting forms: The rules propose new reporting forms to track the time it takes before services are in place and whether or not the services were delivered at the level authorized. This tracking system will allow DPW to closely monitor the delivery of these services and hopefully intervene as necessary when families are not receiving the amount or type of services authorized.

In an effort to improve access to BHRS, DPW has identified staff "designees" in each of the OMHSAS field offices who are assigned to receive complaints associated with access to services. These "designees" can and should be contacted by consumers or their advocates when services are not being delivered as authorized.

Look for these regulations in the upcoming months in The Pennsylvania Bulletin. DPW will likely invite public comments for at least a 30-day period following publication in the Bulletin. Please call PHLP if you have any questions, including how to participate in the commenting process. ■

Psychiatric Rehabilitation to Be Covered in HealthChoices

Effective January 1, 2002, Psychiatric Rehabilitation will be an In-Plan Service for HealthChoices Southwest and HealthChoices Southeast. These services will be offered effective October 1, 2002 for the Lehigh/Capital HealthChoices Zone. This service will only be available for Medical Assistance recipients in HealthChoices and will not be covered under the fee-for-service system.

Psychiatric Rehabilitation is a service offered to mental health consumers who have one of five specific mental health diagnoses. Psych-rehab services may be provided at a program facility (site-based) or in a person's home or community setting (mobile). These are non-medical services offered to people with serious mental illness to help them achieve success in living, learning, working and social and family relationships. The emphasis in both types of services is improved overall functioning for an individual learning to cope with, understand and manage their mental illness. To qualify for this service an individual must:

- Be at least 18 years old
- Have the presence or history of serious mental illness
- Have a diagnosis of schizophrenia, major mood disorder,
- psychotic disorder not otherwise specified, schizoaffective disorder or borderline personality disorder diagnosis made by a psychiatrist
- Have a moderate to severe impairment that interferes with one or more areas of his/her life–specifically in educational, social, vocational or self-maintenance areas
- Choose to participate in the program

In order to receive psych-rehab services, an individual must first have an assessment. The behavioral health plans will each determine how that assessment process works and if prior authorization will be required. People will only be able to receive approval for mobile services if they are unable to attend a site-based service. Mobile services are provided on a one-to-one and face-to-face basis. Mobile is short-term and generally limited to six hours per week. In order to attend site-based services persons must be willing and able to participate in groups and the skills and supports needed to accomplish their goals must be available through the site-based services. Persons can only receive site-based and mobile at the same time if they are moving from one to the other and need help with that transition.

Look for more information about the development of psychiatric rehabilitation services in HealthChoices in this newsletter as the year unfolds. If you have any questions, please feel free to contact PHLP at 1-800-274-3258. ■

Department of Health Puts Act 68 Regulations into Effect

Upon their publication in the *Pennsylvania Bulletin*, Act 68 regulations went into effect on June 9.

Act 68 provides many protections to HMO enrollees, particularly in continuity of care, utilization review, notice, and the grievance, complaint, and appeals process. The implementation of regulations for the Act means that its protections are now more clearly and concretely spelled out, and can be used more easily to uphold consumer rights.

Act 68 applies to all Pennsylvania HMO's, including all HealthChoices and voluntary MA plans. DPW contracts with MA plans contain a number of protections that go beyond Act 68, and these will remain unaffected by the new regs. The new regs will solidify and consolidate many important protections for consumers in MA HMO's, however. ■

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Announcements

Urgent OakTree/HealthMATE Alert Correction

Many *Health Law PA* subscribers in counties affected by the OakTree/HealthMATE cancellations received an alert from our office that incorrectly listed the phone number for Benova. The correct number is 1-800-440-3989. Please make a note of this, and relay the proper number to anyone you may have shared the alert with.

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Lehigh/Capital Area Trainings

PHLP staff are available to conduct trainings for consumers and advocates on HealthChoices Mandatory Managed Care during and following its implementation in the Lehigh-Capital region. Please contact our office at 1-800-274-3258 for more information. Also, watch Health Law PA News over the coming months for features on issues important to consumers in all HealthChoices and voluntary managed care regions.

Add your voice to HealthChoices Lehigh/Cap

Benova, the Independent Enrollment Assistance Program for HealthChoices, is looking for more consumers to serve on its Lehigh/Capital Zone Advisory Committee. The Committee provides a forum for MA Consumers and Benova, the company charged with enrolling MA members into HealthChoices HMOs, to exchange ideas, address issues and concerns brought by the consumers, and discuss input from consumers on the implementation of HealthChoices. This forum provides an opportunity to serve as a voice for the MA community!

Anyone interested in participating as a member on this committee should contact Patricia Graves at Benova at 717-730-3108. Or, you can get some more information from us first at 800-274-3258.

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