# Health Law PA News

Newsletter of the Pennsylvania Health Law Project
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### Don't Forget!

HealthChoices phases into the Lehigh-Capital area starting in October 2001. If you're on MA, you'll be required to enroll in an HMO. Watch *Health Law PA News* for details.

## Changes to Loophole Will Benefit Many

Child support no longer counts as income under the Medical Assistance loophole. Many children with disabilities qualify for MA under the "disabled child" or "loophole" provision (category PS 95).

Under this provision, parental income is not counted. However, there are certain kinds of income, like Social Security survivors benefits or child support that have been counted in determining the child's eligibility for Medical Assistance. The reason for counting these kinds of income is that they are legally income of the child, not the parent. Children with more than $716 a month in child support or Social Security (or similar survivors or retirement) benefits were ineligible for Medical Assistance.

Effective September 1, 2000, DPW has changed its policy regarding child support. Child support will no longer be counted in determining Medical Assistance eligibility for children not on SSI who meet the disability standards. In other words, if a parent is receiving child support for a child with severe disabilities, that child would now qualify for Medical Assistance under the loophole, regardless of the amount of the child support (assuming the child did not have other income in his/her name that exceeded the income limit).

Families with children with disabilities who had been denied Medical Assistance due to child support should reapply. Families with children with disabilities who have been "spending down" (paying a portion of their medical or mental health bills) in order to qualify for Medical Assistance due to child support should contact their caseworker at the County Assistance Office to switch them to category PS 95 without the spend down.

Families with children who had either been denied Medical Assistance or forced to spend down to get Medical Assistance due to child support can get retroactive coverage to cover unpaid medical expenses incurred for the child anytime within the past 3 months. If the caseworker at the County Assistance Office is not aware of this new rule, refer him/her to "Operations Memorandum 000-806, rev 09-01-00, issued 8-31-2000, effective 9-1-00.

The change was brough about by all the parents who wrote to the Governor and DPW to complain about this policy.

DPW has not changed its policy regarding Social Security survivors benefits, Social Security child's benefits (based on disabled parent), Railroad Retirement benefits or interest on bank accounts and other investments in the child's name. These forms of income will continue to be counted for Medical

Assistance eligibility purposes and if they exceed $716 month (this amount will go up in January), the child will not be eligible for Medical Assistance without a spend down. ■

## New Staff and New Space for PHLP

With two new staff arrivals, and new office space, August-September 2000 was been full of transition for the Philadelphia office of PHLP. In October, the Pittsburgh office welcomed a new paralegal.

Stacey Coggins and Bob Murken joined the PHLP staff at the end of August. An attorney, Stacey came to PHLP from the firm of Ballard Spahr Andrews & Ingersoll, where she worked in litigation. Stacey is working on Medical Assistance eligibility, in addition to staffing the help line. A former volunteer coordinator with the Jesuit Volunteer Corps, Bob will be providing advocacy and assistance to help line callers, and working on other projects as a paralegal.

In October, Janice Meinert began work as a paralegal in the Pittsburgh office of PHLP. Janice previously worked in banking, and before that, as a therapist in a residential drug and alcohol program. A social worker by training, Janice will also be working on the help line, and focusing on mental health issues.

Also, earlier in August, after 7 years at 801 Arch Street in Center City, PHLP Philadelphia moved into new space a few blocks away at 924 Cherry Street. With their new headquarters located in the heart of Chinatown, the PHLP Philly staff is never at a loss for delicious Asian lunch options; Burmese has enjoyed particular notoriety in the office.

The new address is:

PA Health Law Project
924 Cherry Street, Suite 300
Philadelphia, PA 19107

(All staff phone numbers will remain the same.) ■

## Assisted Living Reform Act Introduced

After months of publicity and anticipation, the Assisted Living Reform Act was introduced on August 2, 2000. The ALRA, first announced in February and discussed in earlier editions of Senior Health News, was formally introduced with the bipartisan support of over 95 members of the Pennsylvania House of Representatives.

During the Spring, Representative Dennis O'Brien (R-Philadelphia) held hearings across the Commonwealth on the issues addressed by this bill.

Hundreds attended and support for the bill grew.

The ALRA, now officially titled House Bill 2700, embodies the recommendations of the Intragovernmental Council on Long Term Care. Representative O'Brien and others of both parties are making assisted living an issue in the current campaign. They believe voters will want their representatives to support a bill that would enable consumers of all income levels (with nursing home level needs) to receive quality assisted living services in the residential setting of their choice. They argue:

- Pennsylvania spends virtually all of its long-term care public funding on nursing homes.
- When low and middle-income individuals need care, they have little choice but a nursing home.
- Nursing home care is the most expensive.
- Remaining in one's home and receiving services there costs half as much as a nursing home.
- Pennsylvanians want to remain at home and age in place.

Here are some of the things HB 2700 will provide if it becomes law:

- **Public Funding:** State and federal money for individuals to receive services in the residential set-

ting of their choice, not just nursing homes.

- **Greater Options of Services:** A broader menu of quality services would be available to consumers in their homes than is presently are available under the state waiver program. For example, services including assistive technology and cognitive support services for individuals with cognitive impairments would be available.
- **Quality Care:** Assisted Living residences and service providers would have to meet licensing, training, and staffing requirements that insure quality care.
- **Housing Supplement:** Some consumers could be provided with money to help with their housing, including payment for an Assisted Living Residence in conjunction with their Assisted Living Services 1) if they would otherwise be forced to enter nursing facilities because they could no longer afford to maintain their residences and 2) if it were where cost effective to provide this subsidy.
- **Consumer Protections:** The Department of Health 24 hour hotline and staff, and the Department of Aging Ombudsman Program would be available to consumers of assisted living to investigate and resolve complaints.
- **Enforcement Provisions:** Assisted Living Residences and Services Providers would be required to meet all standards set in the law prior to opening and on an ongoing basis in order to remain open.

*For additional information on the Assisted Living Reform Act, call Representative O'Brien's district office at (215) 632-5150 or call your state representative.* ■

## How to Get Prescription Drug Coverage

Seniors and individuals with disabilities throughout the Commonwealth are struggling to pay for their prescription drug costs. Politicians and advocates are debating proposals to reduce drug prices and to expand Medicare to cover prescription drugs. Unlike when Medicare first began, prescription medications are now a primary form of medical care and often substitute for more costly therapies like hospitalization and surgery. Studies show, however, that having drug coverage significantly influences whether Medicare beneficiaries fill their prescriptions and, thus, take their medications. This can result in adverse health effects.

Medicare beneficiaries in our area have had to alter their health care strategies to deal with their inadequate prescription coverage. They have stopped taking certain medications, pursued samples or less expensive prescriptions from their doctors, or joined Medicare HMOs that initially offered comprehensive prescription coverage. Despite these efforts, many area seniors and people with disabilities continue to go without adequate access to prescription drugs. Many cannot take a generic or take a prescription for which there is no generic equivalent, cannot go without their prescriptions, or are part of a Medicare HMO that has entirely stopped or drastically changed its prescription coverage.

**"Unlike when Medicare first began, prescription medications are now a primary form of medical care and often substitute for more costly therapies like hospitalization and surgery."**

PHLP has spent the past several months helping hundreds of callers explore options for obtaining prescription coverage. Here are some tips to share with anyone seeking prescriptions or prescription coverage:

1. **Explore Medical Assistance (MA) eligibility:** Depending on income and resources, an individual may be eligible to have all prescription needs paid with no cost to the person. This may be accomplished through straight MA eligibility or through spend-down eligibility.

A single individuals who is disabled or over 65 may be eligible for full prescription coverage through Medical Assistance if she has an income of less than $716 per month, and resources of $2000

or less.

If her income is $716 or higher, and she has a lot of medical expenses, she might be able to use paid or incurred medical expenses to "spend-down" or reduce her countable income to the point where she would be eligible for MA.

Additionally, this individual might be eligible for some reduction in Medicare expenses which might free up more income to assist in paying for prescriptions.

**2. Explore PACE or PACENET.**
If your are over 65, PACE is available:

- to cover prescriptions (after a co-payment) for individuals with 1999 annual incomes below $14,000 for single persons and $17,200 for married couples.
- to cover prescriptions (after a co-payment) for individuals with 1999 annual incomes between $14,000 and $16,000 for single persons and between $17,200 and $19,200 for married couples who have spent $500 on their prescriptions.

A person cannot qualify for PACE if she has full prescription benefits through the state Medical Assistance program. If she has any prescription coverage through another prescription plan, PACE is the payor of last resort and will only pick up what is not covered by your primary insurance plan. You must be 65 to qualify for PACE. The PACE program can be reached at 800-225-7223 or (outside PA) at 717-652-9028.

**3. Explore Medicare HMOs for the county and what prescription coverage they offer:** All Medicare HMO's differ in their coverage, but many provide some degree of prescription coverage. The Pennsylvania Health Law Project can provide names and numbers of HMOs in each county. Before changing HMOs, make sure to ask a lot of questions. Some suggested questions include:

- ❑ *Is there a monthly premium and if so, how much?*
- ❑ *Does the HMO include my doctors in its network?*
- ❑ *What pharmacies would I have to use?*
- ❑ *Does the HMO cover my present prescription drugs on the formulary?*
- ❑ *If not, what is the cost to me for un-covered drugs?*
- ❑ *Is there an annual limit on generic drugs?*
- ❑ *Is there an annual limit on brand-name drugs?*
- ❑ *How is the limit calculated?*
- ❑ *Explain how the limit would be calculated in my case, given the drugs I take?*
- ❑ *Can you please send me information on your plan – including a summary of benefits?*

**4. Explore Medigap policies:** Many insurance companies offer policies that cover the gaps in Medicare coverage. These are called Medigap policies. The average Medigap policy covering prescription medications in Pennsylvania runs approximately $142/month, which is out of reach for many Pennsylvania seniors and doesn't provide complete coverage. Standard policies H, I, and J cover some prescriptions. PHLP can provide the names and numbers of Medigap insurers.

**5. Veterans should explore coverage offered by the Veterans Administration:** All Veterans who have served on active duty in the Armed Forces, wartime or peacetime, and received an Honorable or a General Discharge are eligible for medical care through the Department of Veterans Affairs. Currently, Veterans are placed in one of two categories, which determine the scope of health benefits. Category I Veterans are eligible for no-cost health care. Category II Veterans are eligible for relatively low-cost health care. Both Category I and Category II cover prescription medications with at most a $2.00 co-pay. For detailed information, contact local VA Regional Offices for guidance.

**6. Explore free or low-cost assistance programs from the companies that make or distribute the drugs:** These days most pharmaceutical companies have patient assistance programs through which people can get their prescriptions filled.

The first step is to find out the name of the manufacturer of the medication. Second, call the pharmaceutical manufacturer and ask if they have a patient assistance program. Ask what the requirements are for receiving free prescription drugs. Some companies require that the applicant have limited income or no insurance coverage at all in order to qualify for the program. Many companies require the applicant's physician to request participation in the program, and also to play a role in completing the application.

**7. Private Prescription Services:** People can also obtain low cost prescription drugs through a private prescription service. There are several. One is called www.needymeds.com and is an online service. The other is called Indigent Patient Services (IPS) and can be reached at (727)821-7333.

These services usually charge a one-time registration fee and a cost per prescription (and refill). For example, there might be a one-time registration fee of $25 and a $10 fee per prescription filled.

These services require people to submit a request for each specific prescription drug that they need. These services take phone requests and generate formal request forms that applicants and their doctors must sign and send to each pharmaceutical company. The pharmaceutical company will then send the medication to the doctor, who gives it to the applicant.

**8. Explore discount mail-order services:** Another way of getting lower cost medication is by contacting discount mail-order medication services. Here are just a few of the mail-order services to explore:

- Preferred Prescription Plan: (800) 881-6325
- Managed Healthcare Systems: (954) 938-7984
- RxUSA: (800) 798-7248
- U-Save: (888) 817-3784

Patients should ask questions. Be sure to understand all the benefits and responsibilities of each of the above options. The details can be complicated. For help or more information, call the Pennsylvania Health Law Project at (800)274-3258. ■

## Two HealthChoices HMOs Drop Leading Medication from their Formularies

The HealthChoices Southeast HMO HMA/AmeriChoice and the HealthChoices Southwest HMO MedPLUS+ dropped the behavioral health medication Zoloft from the list of drugs they will regularly pay for. Known as a plan's formulary, this list determines what drugs a doctor may prescribe for an enrollee under most circumstances. A plan's formulary must be approved by the Department of Public Welfare.

The removal of Zoloft, is effective July 5, 2000 for AmeriChoice and November 1, 2000 for MedPLUS+. It is the only drug of its kind that is FDA-approved for the treatment of Post-Traumatic Stress Disorder, and depression in children under age 16. According to Pfizer, which manufactures the drug, Zoloft is one of the most widely prescribed behavioral health medications among Medical Assistance recipients in the Philadelphia area.

The AmeriChoice change will only affect new prescriptions, according to DPW and the plan.

The Consumer Subcommittee of the Pennsylvania State Medical Assistance Advisory Committee has questioned DPW's approval of this change.

The consumers have long demanded a more open process whereby HealthChoices HMOs obtain approval for changes to their formularies. They have also sought to restrict HMOs from eliminating drugs like Zoloft, which are the only FDA-approved medications for particular conditions and categories of patients. ■

## Michael Dallas Waiver Program Now Available for Adults

The Department of Public Welfare has received preliminary HCFA approval of its proposed Michael Dallas Waiver (MDW) Program for adults. The program will provide home and community based waiver services, including skilled nursing and case management, to technology dependent adults.

Accessing services under the waiver has not been simple. By definition, an applicant must have a disability that would otherwise require nursing home placement, and be technology dependent. Upon

urging by the Consumer Subcommittee of the Medical Assistance Advisory Committee, DPW established the financial eligibility criteria at 300% of the SSI level.

People having problems using this or other waiver services can reach us at 800-274-3258. ■

## Governor's Health Insurance Proposal Threatened!

Pennsylvania has started receiving over $400 million per year from the tobacco companies in settlement of a national class action lawsuit. Governor Ridge has proposed spending 40% of that money to provide health insurance for up to 100,000 lower income adults without health insurance, and for up to 10,000 people with disabilities who work. However, state senators and representatives must vote on how this money is to be spent. In the meantime, they are hearing from a number of different special interest groups, all of whom would like to get more of the tobacco money for their cause. Any increase in money for other groups will most likely be taken out of the money to provide health insurance for the uninsured. That is because of all the Governor's proposals, the proposal to provide health insurance to the uninsured has the fewest vocal supporters.

**How to Access State Legislators**

If you don't know your senator or representative's name and phone number, you can get it on the Internet at *http://www.legis.state.pa.us/WU01/VC/find/counties.htm* or by calling the League of Women Voters at 1-800-692-7281. ■

## Consumer Subcommittee Reacts to Proposed Uniform Definition of Medical Necessity

In a letter to Dr. Peg Dirkers, Deputy Secretary for Medical Assistance programs, the Consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC) criticized aspects of the Department of Public Welfare's draft definition of medical necessity, which DPW hopes to apply to both HealthChoices and Fee for Service (FFS) programs.

The proposed definition mirrors the three-prong medical necessity test used by HealthChoices, and adds several provisions. According to the subcommittee, the HealthChoices definition is a good start: it works well for consumers, and has the approval of practitioners, elected officials, and the courts.

Though the committee found that much of the definition is acceptable with some minor improvements, it took grave exception to a new section that adds a cost-benefit analysis to the medical necessity criteria. The new section allows the health plan to deny any service or benefit that—in its judgment—is either more costly than another equally effective and medically appropriate one, or that serves the same purpose as one the recipient is currently receiving.

According to the subcommittee, where the provision allows the plan to deny services or benefits more costly than an equally appropriate alternate, it puts too much power in the hands of the health plan. The section would grant overly-broad discretion in medical decisions to the plan, "who has an inherent financial interest in finding that the cheapest treatment is 'medically appropriate.'" It also potentially shifts significant health care costs from the health plan to the recipient, who, along with their prescribers, do not usually have the time, information, or expertise to challenge cost assertions. Furthermore, the subcommittee claims, the subsection overrides the usual process of public comment and debate that has ensured that substitutions by the Department of one type of care for another have been acceptable to consumers.

**The section would grant overly-broad discretion in medical decisions to the plan, "who has an inherent financial interest in finding that the cheapest treatment is 'medically appropriate.'"**

A subsequent portion of the cost-benefit provision restricts payment for services that serve the same purpose as those the recipient may already be receiving. The subcommittee objected to the wording of this element on grounds that it is too broad, and could force patients to choose between equally necessary therapies, such as psychotherapy and medication. Instead, the subcommittee proposed language that would restrict payment for the same service at the same level.

DPW is expected to publish the new medical necessity definition as a proposed regulation in an upcoming Pennsylvania Bulletin. ■

## MA Transportation Update

In previous issues we discussed changes and improvements DPW is making in the Medical Assistance Transportation Program (MATP) statewide. As of July, 2000 all counties are now required to be in full compliance with DPW's New Program Requirements (33 in all) which include:

**Despite this significant progress and these major improvements in the MATP Program, there are important outstanding issues that advocates have raised but that DPW has not addressed.**

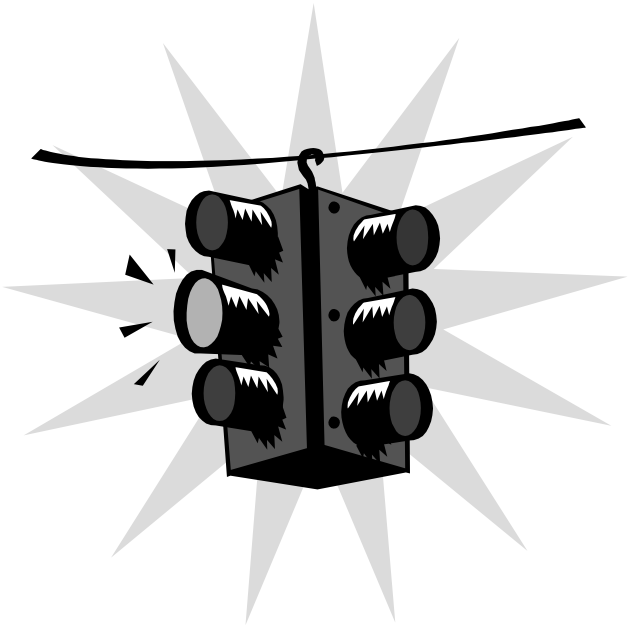
- A toll-free telephone line in place for consumers.
- Service areas that accommodate the transportation requests of consumers including transportation into neighboring counties
- Procedures to assure consumers are picked up within 15 minutes of the scheduled pick-up time and wait no longer than one hour after a medical visit for the ride home
- Prompt reimbursement of mileage (when consumers use their own or someone else's vehicle), including necessary parking and toll costs
- A complaint process for consumers to address problems and service issues

DPW also convened a workgroup that met regularly over the last six months to redraft the MATP Policy and Procedures Manual that governs how the counties run their MATP programs. The redrafted Manual was completed in July and is currently going through the approval process within DPW before the final Manual is issued. PHLP will notify our readers when the New Manual is published and if and how a copy can be obtained.

Despite this significant progress and these major improvements in the MATP Program, there are important outstanding issues that advocates have raised but that DPW has not addressed. In July, both the Consumer Subcommittee of DPW's Medical Assistance Advisory Committee (MAAC) as well as the full MAAC passed motions recommending that DPW implement the following changes:

1. Require all counties to provide door-to-door transportation for elderly persons and those with disabilities who need that service;
2. Raise the minimum mileage reimbursement rate across the state substantially beyond the 12 cents/mile currently required
3. Require "urgent care transportation" (for appointments within the next 24 hours) not just in HealthChoices areas but also in counties that have voluntary managed care;
4. Require MATPs to provide one way trips when needed-such as rides home from the emergency room, or rides home for escorts who are accompanying children or vulnerable adults one-way to a hospital or treatment facility.

If you know any MA consumers who are having difficulty accessing or using MATP services in their county, contact PHLP at 1-800-274-3258. ■



## Former Medical Director Sues Three Rivers Health Plan

Victor Cotton, the former Medical Director for Three Rivers Health Plan/MedPLUS+ filed suit in Commonwealth Court on September 12 claiming that the plan wrongfully terminated him for threatening to blow the whistle on alleged violations of patient care standards. He alleges that the non-physician CEO of TRHP behaved as if he "believed he was empowered to make any decision in the company, including medical decisions affecting patient care," and that from 1996 to 1998 the plan and its CEO "improperly disenrolled members who became organ transplant candidates" during that time.

## Three HMOs Fined for Act 68 and Other Violations

Three Pennsylvania HMOs have been fined a total of $410,000 for violations of Act 68 consumer protections and other insurance regulations according to the September 21, 2000 issue of the *Health Law Reporter*.

Keystone Health Plan West incurred fines of $200,000 for charging improper premiums, failing to document regulatory compliance, not including proper fraud warnings in some of its forms, and untimely handling of clean claims.

UPMC Health Plan must pay penalties of $135,000 for violations that include inadequate documentation of certain files, group to individual conversions, and improper claims-handling procedures. According to the Department of Insurance, UPMC did not issue certificates of creditable coverage during the period examined.

Horizon Healthcare of Pennsylvania incurred a penalty of $75,000 for inadequate file documentation, improper premiums, and faulty claims-handling. The Insurance Department also found that Horizon had violated HIPAA by including in its underwriting guidelines a provision to reject small employer groups based on prior payment history.



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