MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS ACT
(DRAFT, DECEMBER 2, 2011)

SUMMARY

This Act implements a coordinated and capitated long-term care program for Medicaid beneficiaries who are chronically ill or who have disabilities and need health and long-term care services and supports, such as home care or adult day care. The program will allow these people to stay in their homes and communities as long as possible, and delay the transition to institutional care. The plan arranges and pays for a large selection of health and social services, and provides choice and flexibility in obtaining needed services from one place, at a lower cost than under a Medicaid fee-for-service program.

MODEL LEGISLATION

Section 1. Short Title. This Act shall be known as the "Medicaid Managed Long-Term Services and Supports Act."

Section 2. Definitions.

A. Eligible Medicaid beneficiaries means the following:

1. Frail elders (ages 60+) who are receiving 1915(c) Medicaid waiver services;

2. Adults with physical disabilities (ages 18-64) who are receiving Medicaid home and community based waiver services;

3. Children (ages 3-17) with physical disabilities who are receiving Medicaid home and community based waiver services;

4. Individuals who are dually eligible under the Medicaid program and the Medicare program established under Title XVIII of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended; and

5. Medicaid consumers with a nursing facility level of care, or at risk for needing a nursing facility level of care.

B. Eligible services include acute care, including medical, pharmacy, dental, and behavioral health services, and the following long-term care services and supports:

1. Nursing facility care;

2. Services provided in assisted living facilities;

3. Hospice;

4. Adult day care;

5. Medical equipment and supplies;

6. Personal care;

COMMON CAUSE Holding Power Accountable

7. Home accessibility adaptation;

8. Behavior management;

9. Case management;

10. Therapies, to include:

    a. Occupational therapy;

    b. Speech therapy;

    c. Respiratory therapy; and

    d. Physical therapy;

11. Intermittent and skilled nursing;

12. Medication administration;

13. Medication management;

14. Nutritional assessment and risk reduction;

15. Caregiver training;

16. Respite care;

17. Transportation; and

18. Personal emergency response system.

Section 3. The **{insert state department of health and human services}** shall establish a capitated Medicaid long-term services and supports coordinated care program. The department shall make payments for long-term care, including home and community-based services, using a managed care model.

The **{insert state department of health and human services}** shall submit, if necessary, applications to the United States Department of Health and Human Services for waivers of federal Medicaid requirements that would otherwise be violated in the implementation of the system, and shall consolidate current home and community based waivers where appropriate. The **{insert state department of health and human services}** shall ensure that all participants are enrolled in health insuring corporations under contract with the **{insert state department of health and human services}** pursuant to the appropriate section of the state code. The program shall be statewide, fully integrated, and risk based; shall integrate Medicaid-reimbursed primary, acute, and long-term care services; and shall align incentives to ensure the right care is delivered in the most appropriate place and time.

COMMON CAUSE
Holding Power Accountable

In designing the program, the **{insert state department of health and human services}** shall ensure that the program:

A. Reduces fragmentation and offers a seamless approach to meeting people's needs;

B. Delivers needed supports and services in the most integrated, appropriate, and cost-effective way possible;

C. Offers a continuum of acute and long-term care services, which includes an array of home and community-based options including community-based residential alternatives;

D. Includes a comprehensive quality approach across the entire continuum of long term care services; and

E. Consults stakeholders in the program development process.

Section 4. {Severability Clause}
Section 5. {Repealer Clause}
Section 6. {Effective Date}

COMMON CAUSE
Holding Power Accountable

RESOLUTION URGING STATES AND INTERESTED PARTIES TO PARTNER AND IDENTIFY OPPORTUNITIES TO ADDRESS AND REDUCE PRESCRIPTION DRUG ABUSE AND MISUSE (DRAFT, DECEMBER 2, 2011)

SUMMARY

This resolution calls on state officials, prescribers, pharmacists, school-based organizations, and manufacturers of branded and generic prescription medications to partner and evaluate existing efforts aimed at deterring prescription drug abuse; to determine the effectiveness of current efforts; and to make recommendations to the state on best practices for combating abuse while ensuring that access is not restricted for those individuals who are in need of prescription medications.

MODEL RESOLUTION

WHEREAS, Prescription drug abuse and misuse is an increasing public health concern in the United States; and

WHEREAS, A balanced approach to preventing prescription drug abuse must ensure sufficient access to medications for patients with a legitimate medical need; and

WHEREAS, Prescription drugs account for the second most commonly abused category of drugs, behind marijuana and ahead of cocaine, heroin, methamphetamine, and other drugs; and

WHEREAS, The misuse and abuse of prescription drugs has become increasingly prevalent among teens and young adults. For example, among 12-17 year olds, prescription drug abuse took either first or second place in abuse prevalence; and

WHEREAS, While opioids, stimulants, and central nervous system depressants are properly used by millions of people, the misuse and abuse of these products are imposing increasing costs on individuals, families, and society; and

WHEREAS, The personal and financial toll of prescription drug abuse and misuse are negatively impacting the states through law enforcement constraints, drug treatment costs, and incarceration costs; and

WHEREAS, Efforts to reduce prescription drug abuse should not negatively impact a patient's access to necessary and prescribed drug treatments.

NOW THEREFORE BE IT RESOLVED THAT, Officials in **{insert state}** are encouraged to partner with prescribers, pharmacists, school-based organizations, and manufacturers of branded and generic prescription medications to evaluate existing efforts at deterring prescription drug abuse; determine the effectiveness of current efforts; and make recommendations to the state on best practices for combating abuse while ensuring that access is not restricted for those individuals who are in need of prescription medications.

COMMON CAUSE
Holding Power Accountable

HEALTH CARE EQUITABLE PAYMENT ACT
(DRAFT, DECEMBER 2, 2011)

SUMMARY

This Act allows puts certains guidelines in place to prevent third-party payers from engaging in discriminatory payment practices with independent healthcare providers and self-paying patients.

BACKGROUND

Medical Savings Accounts (MSAs) were introduced largely due to the efforts of the late J. Patrick Rooney, whose Golden Rule Insurance Co. had experimented with high-deductible health insurance policies offering greater control and freedom of choice for patients.

There were to be no restrictions concerning which physician, which hospital, or which form of treatment was elected. This is consistent with economic principles where the buyer and seller freely compete for goods and services without third party intervention, thus providing for the best and most economical method of purchase of medical services.

Another important aspect of MSAs was the projected growth of cash balances over the years, as judicious use would likely allow excess funds to accumulate.

A restricted form of the idea, Health Savings Accounts (HSAs), enacted into federal law, permits a federal tax advantage.

The concept should have been a great success in reducing spending and prices, while expanding freedom of choice. However, success has been greatly limited, largely because of discrimination against self-paying patients, or patients using an out-of-network provider. Hospitals have a practice of charging 400% to 1,000% of their baseline rates to these non-preferred consumers.

Thus, even if a patient using an HSA plus a high-deductible health plan (HDHP) should receive a 25% discount after being subjected to a 400% increase, he would still be paying 300%, or three times the amount the hospital willingly accepts from contracted insurers. If a 1,000% charge rate were to be used, a 25% reduction would result in the individual paying 750%, or 7.5 times as much as multi-billion-dollar insurance cartels pay for the same service.

As other large insurers developed HSAs and HDHPs, they tied them to in-network "providers," negating their most important purpose, to provide complete freedom to choose one's physician and hospital by using one's own money.

Third-party payers are now punishing their subscribers for seeking out-of-network physicians, even in the event of a medical emergency. If a patient has met his in-network deductible for the year, but is subsequently treated by an out-of-network physician, a whole new deductible applies—often a larger one. Additionally, the percentage copay is always higher for the out-of-network physician, even if he was the only one available in an emergency.

Worse, it is not based upon the billed charges, but rather upon the "usual and customary rates" (UCR). These rates have absolutely nothing to do with actual rates charged by physicians, but rather, are numbers that vary widely from one company to another, and can be

COMMON CAUSE
Holding Power Accountable

essentially whatever the company decides they should be. There is no way for the subscriber/patient to know in advance what the UCR is, because his insurer refuses to divulge this information.

Another major problem with third-party payment is that it is much lower for surgery performed in a physician-owned outpatient surgery center, or for imaging studies or other procedures done in independent facilities, than for exactly the same procedures performed in hospital-owned facilities. This payment scheme discriminates against truly independent practitioners and stifles competition. It promotes the formation of cartels, contrary to the purpose of the Sherman Antitrust legislation.

Discriminatory payment is threatening the viability of independent physicians and facilities. The *Patient Protection and Affordable Care Act* apparently realizes this, and prohibits hospitals that claim tax benefits under Section 501(c)(3) from charging certain uninsured patients "more than the amounts generally billed to individuals who have insurance covering such care." 26 U.S.C. Section 501(r)(5).

MODEL LEGISLATION

Section 1. Short Title. This Act shall be known as "Health Care Equitable Payment Act."

Section 2. Antitrust.

A. Any express or implied agreement with an insurance company concerning prices charged to the self-paying patient or out-of-network patient shall constitute unlawful restraint of trade and be actionable.

B. For state accreditation, hospitals must modify their nondiscrimination policy to include self-insured patients. For example: "The hospital must not discriminate on the basis of age, gender, race, ethnicity, national origin, sexual orientation, disability, *or payment method*."

Section 3. Prohibition of State Discrimination Against Independent Providers.

A. No state-funded benefits programs, including but not limited to worker's compensation, Medicaid, or state employee benefits, shall pay more to favored providers such as hospitals or hospital-owned facilities than to independent physicians or facilities for equivalent services.

Section 4. Protection of the Right of Private Contract of Individuals.

A. Any agreement, understanding, or practice, written or oral, implied or expressed, between any hospital and insurance company that shifts higher costs to the self-paying patient is hereby declared to be unlawful, null and void, and of no legal effect.
(Drafting Note: This prevents insurers from interfering with the free bargaining between an individual and a hospital, and is analogous to "right-to-work" legislation.)

B. Hospitals that claim tax benefits under Section 501(c)(3) must offer self-insured or self-paying patients, including those with HSA/HDHPs, billing rates that are comparable to those that the hospital generally accepts from insurance companies.

C. No hospital or medical facility may refuse to accept payment from a patient based directly or indirectly on a contract with an insurance company.
(Drafting Note: This prevents insurers from interfering in the right of hospitals to offer and be paid by patients for services that are "covered" but denied.)

COMMON CAUSE Holding Power Accountable

Section 5. {Severability Clause}
Section 6. {Repealer Clause}
Section 7. {Effective Date}

COMMON CAUSE
Holding Power Accountable

RESOLUTION ENSURING PATIENT PROTECTIONS REMAIN IN PLACE IN MEDICAID PHARMACY BENEFITS (DRAFT, DECEMBER 2, 2011)

SUMMARY

This resolution urges state officials to implement certain safeguards and patient protections if the state's Medicaid pharmacy benefits are transitioned from a fee-for-service setting to managed care.

MODEL RESOLUTION

WHEREAS, Medicaid provides health care and prescription drug coverage to the state's most vulnerable patients; and

WHEREAS, Budgetary pressures and changes brought about by the *Patient Protection and Affordable Care Act* are causing some states to consider changing the way their state's Medicaid pharmacy benefit is delivered; and

WHEREAS, An increasing number of states are shifting their Medicaid pharmacy benefit from a fee-for-service (FFS) model to a Medicaid managed care model (MCO); and

WHEREAS, It is critical that the preferred drug list (PDL) requirements and protections currently afforded patients in FFS remain in place as states make changes to their Medicaid pharmacy benefit; and

WHEREAS, Such PDL requirements and patient protections will help ensure continued access to and quality of care for Medicaid patients whose pharmacy benefit is shifted to Medicaid managed care; and

WHEREAS, Important patient protections currently exist in states that employ a FFS Medicaid pharmacy benefit model as required by Section 1927 of the Social Security Act; and

WHEREAS, Section 1927 of the Social Security Act generally requires, at a minimum, that there be open Pharmacy and Therapeutics (P&T) Committee meetings; that any prior authorization (PA) requests be responded to within 24 hours; and also requires coverage of branded products where a Medicaid rebate is offered and sets forth minimum PDL requirements; and

WHEREAS, Section 1927(d)(5)(B) of the Social Security Act allows for PAs only if the approval system in place can provide a response to the request, by phone or other telecommunications device, within 24 hours. In addition, pursuant to section 1927, states are required to provide for the dispensing of at least a 72-hour supply of a drug in emergency situations. These protections are no less important, or meaningful, in managed Medicaid; and

WHEREAS, Prescription drug coverage plays a critical role in a patient's overall treatment, and ensuring that sufficient therapeutic options are available is important to the quality of patient care; and

WHEREAS, Physicians are best able to make treatment decisions for their patients based on the patient's medical history, drug history, and physical and/or mental condition; and

COMMON CAUSE Holding Power Accountable

WHEREAS, Physicians should ultimately determine the prescription drug therapy, or other treatment, that is best for their patient; and

WHEREAS, Medicaid patients shifted to Medicaid managed care should receive at least the same coverage of and access to prescription drugs as they received under FFS; and

WHEREAS, An independent and transparent P&T Committee that meets certain minimum requirements is essential to helping ensure robust formulary coverage and sufficient access to meet patient needs; and

WHEREAS, While formulary management tools can provide an effective means to help ensure appropriate drug utilization and manage costs, it is important that such tools not create barriers to access. P&T Committees can play an important role in monitoring and appropriately implementing formulary management tools; and

WHEREAS, In order to help prevent formulary management tools—like prior authorization, step therapy, or generic "fail first"—from limiting physician choice and decision-making, it is important that certain guidelines for their implementation be established.

NOW THEREFORE IT BE RESOLVED THAT, {Insert state} should be free to choose how the Medicaid pharmacy benefit is delivered as long as the state has strong and specific patient protections in place that, among other things, respect the prescriber's treatment recommendation(s) and ensure coverage of and access to a broad range of generic and branded prescription drug therapies; and

BE IT FURTHER RESOLVED THAT, **{Insert state legislative body}** urges adoption of the following criteria, if **{insert state}**'s Medicaid pharmacy benefit is shifted to the MCO setting:

1. The PDL for the Medicaid MCO is no more restrictive than the state's FFS PDL;

2. The MCO PDL is developed and reviewed by an independent P&T Committee;

3. A P&T Committee reviews the MCO's medication therapy management tools for appropriateness;

4. MCOs adopt a fair, transparent and uniform process for handling PAs and appeals; and

5. Physicians are empowered to make the final decision regarding the best course of therapy for their patients; and

BE IT FURTHER RESOLVED THAT, {Insert state}'s Medicaid officials examine the Texas and Florida models, which have been successful in working to implement important patient protections and safeguards.

COMMON CAUSE
Holding Power Accountable

STANDARDS FOR HEALTH CARE COMMUNICATION ACT
(DRAFT, DECEMBER 2, 2011)

SUMMARY

This Act ensures that academic detailers are bound to the same standards and rules as those in the private sector. "Academic detailing" is comprised of prescriber outreach programs typically funded by the government or by universities.

Section 1. This Act may be cited as the "Standards for Health Care Communication Act."

Section 2. Legislation.

A. Academic detailers shall observe standards of conduct in their educational materials and written and oral presentations as established by rules adopted by the appropriate state department or agency that are consistent with the following federal regulations regarding labeling and false and misleading advertising:

1. The Food and Drug Administration labeling requirements of 21 Code of Federal Regulations;

2. Part 201 (2007) and prescription drug advertising provisions of 21 Code of Federal Regulations; and

3. Part 202 (2007) and the Office of the Inspector General's Compliance Program Guidance for Pharmaceutical Manufacturers issued in April 2003, as amended.

Section 3. {Severability Clause}
Section 4. {Repealer Clause}
Section 5. {Effective Date}

COMMON CAUSE
Holding Power Accountable