

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

PENNSYLVANIA PHARMACISTS	:	CIVIL ACTION
ASSOCIATION, et al.,	:	
	:	NO. 99-491
Plaintiffs,	:	
	:	
	:	
v.	:	
	:	
FEATHER O. HOUSTOUN,	:	
	:	
Defendant.	:	

**MEMORANDUM**

BUCKWALTER, J.

June 7, 2000

Presently before the Court are the Plaintiffs’ and Defendant’s Motions for Summary Judgment. After oral argument on May 25, 2000, and consideration of all briefs filed, for the reasons discussed below, the Defendant’s Motion is Granted and the Plaintiffs’ Motion is Denied.

**I. BACKGROUND**

Pennsylvania Pharmacists Association (“PPA”) and sixteen individual pharmacies (“Named Pharmacy Plaintiffs”), collectively, (“Plaintiffs”) have brought this class action pursuant to 42 U.S.C. §§ 1983 and 1988 against Feather O. Houstoun, the Secretary of the Pennsylvania Department of Public Welfare (“Department”). Plaintiffs seek various forms of relief, including a declaration that the outpatient pharmacy rates implemented under a managed-

care program known as HealthChoices after February 1, 1997, were implemented in violation of federal law, the HealthChoices waiver, and pharmacies' Medical Assistance provider agreements. In addition, Plaintiffs seek to enjoin the Defendant from permitting continued reimbursement of providers under the HealthChoices program using the current outpatient pharmacy rates and directing Defendant to require reimbursement under the same rates as pharmacies being reimbursed under the Medical Assistance fee-for-service program. Finally, Plaintiffs seek attorneys' fees and costs.

PPA is a Pennsylvania non-profit corporation representing over 440 independent pharmacies and over 1,000 pharmacists employed at these facilities. The Named Pharmacy Plaintiffs are independent pharmacies operating in Southeastern Pennsylvania. Plaintiffs represent a class of all pharmacies (not only the independent pharmacies that are members of PPA) participating in Pennsylvania's Medical Assistance Program and serving Medical Assistance Beneficiaries ("MABs") under Title XIX of the Social Security Act, 42 U.S.C. § 1396-1396v, in the counties of Bucks, Chester, Delaware, Montgomery, and Philadelphia (the "Five County Area").

To participate in the program, the Named Pharmacy Plaintiffs entered into standard provider agreements ("Agreements") with the Department, which cover the provision of brand-name and generic prescription drugs to eligible beneficiaries. Under the Agreements, the Department is obligated to insure that the Named Pharmacy Plaintiffs are reimbursed in accordance with state and federal law.

On December 31, 1996, the Department secured a waiver, effective February 1, 1997, from the United States Department of Health and Human Services, Health Care Financing

Administration (“HCFA”) to certain provisions of the Social Security Act<sup>1</sup> in order to implement Pennsylvania’s Medicaid Managed Care Program called HealthChoices.<sup>2</sup> Pursuant to the waiver, the Department contracted with four health maintenance organizations (“HMOs”)<sup>3</sup> to administer the HealthChoices Program. These HMOs then subcontracted with pharmacy benefits managers to administer the outpatient pharmacy benefit under the respective HealthChoices Plan. The pharmacy benefits managers in turn contracted directly with participating pharmacies, including Plaintiffs, to provide outpatient pharmacy services to beneficiaries in the Five County Area. The basis of Plaintiffs’ complaint is that the pharmacy benefits managers, without oversight from the Department, systematically decreased the outpatient pharmacy benefit rates to unreasonably low levels and that the Department’s method of implementing the HealthChoices program to permit this result violated the waiver, the Agreements, and applicable federal law.

Specifically, Plaintiffs allege that the outpatient pharmacy rates are now set below the cost of acquisition and the cost of dispensing drugs that Named Pharmacy Plaintiffs supply to MABs enrolled in HealthChoices. They contend that this has resulted in a situation that is inconsistent with efficiency, economy, and quality of care and has decreased MABs’ access to retail pharmacies under HealthChoices in violation of the Social Security Act, specifically

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1. The waiver from the HCFA applies to the following sections of Title XIX: Section 1902(a)(1), 42 U.S.C. § 1396a(a)(1), relating to state wideness; Section 1902(a)(10)(B), 42 U.S.C. § 1396a(a)(10)(B), relating to comparability of services; and Section 1902(a)(23), 42 U.S.C. § 1396a(a)(23), relating to freedom of choice.

2. The Medicaid managed care program now administered in the five county area described above is now called “HealthChoices Southeast” to distinguish it from a similar program operating in the southwestern portion of Pennsylvania (“HealthChoices Southwest”).

3. The four HMOs are Keystone Mercy Health Plan (“Keystone”), Health Partners, Healthcare Management Alternatives, Inc. (“HMA”) and Oxford Health Plans (now known as Oaktree Health Plan)(“Oaktree”).

§ 1902(a)(30)(A), 42 U.S.C. § 1396a(a)(30)(A) (“Section 30(A)”)<sup>4</sup>. Section 30(A) provides that a state plan for medical assistance must:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

In addition, the regulation at 42 C.F.R. § 431.12, which was adopted pursuant to § 1902(a)(4), 42 U.S.C. § 1396a(a)(4) (“Section (a)(4)”), requires a state plan to provide for a medical care advisory committee that must have the opportunity to participate in policy development and program administration. Plaintiffs assert that the Department has failed to comply with this regulation as well.

## II. LEGAL STANDARD

Under Federal Rule of Civil Procedure 56(c), the test is whether there is a genuine issue of material fact and, if not, whether the moving party is entitled to judgment as a matter of law. Gray v. York Newspapers, Inc., 957 F.2d 1070, 1078 (3d Cir.1992). In evaluating a summary judgment motion, the court may examine the pleadings and other material offered by the parties to determine if there is a genuine issue of material fact to be tried. Fed. R. Civ. P. 56(c); see also Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986). When considering a motion for summary judgment, a court must view all evidence in favor of the non-moving party.

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4. The Supreme Court has found that medical providers can be the beneficiaries of parts of the Medicaid Act. See Wilder v. Virginia Hospital Association, 496 U.S. 498, 110 S.Ct. 2510 (1990) (in the context of the Boren Amendment). At least one Circuit Court has extended this to the equal access provision that is central to this case. See Arkansas Medical Society v. Reynolds, 6 F.3d 519, 526 (8th Cir. 1993).

See Bixler v. Central Pa. Teamsters Health and Welfare Fund, 12 F.3d 1292, 1297 (3d Cir. 1993).

A movant “bears the initial responsibility of informing the court of the basis for its motion, and identifying those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any which it believes demonstrate the absence of a genuine issue of material fact”. Celotex, 477 U.S. at 323. When movants do not bear the burden of persuasion at trial, they need only point to the court “that there is an absence of evidence to support the nonmoving party’s case. Id. at 325. A fact is material if it might affect the outcome of the suit under the governing substantive law. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255 (1986). For the dispute over the material fact to be genuine, “the evidence must be such that a reasonable jury could return a verdict in favor of the non-moving party.” Id. To successfully challenge a motion for summary judgment, the non-moving party cannot merely rely upon the allegations contained in the complaint, but must offer specific facts contradicting the movant’s assertion that no genuine issue is in dispute. Kline v. First West Government Securities, 24 F.3d 480, 485 (3d Cir. 1994).

### **III. DISCUSSION**

- A. Was the Procedure used by the Department when formulating the HealthChoices reimbursement scheme Department used Arbitrary and Capricious?

The Third Circuit has recently decided that §30(A) does not require any particular methodology for satisfying the substantive requirements of a modified state Medicaid plan. See Rite Aid v. Houstoun, 171 F.3d 842, 851 (3d Cir. 1999). However, since a state may not act in

an arbitrary and capricious manner, the state must have some objective basis by which it determines Medicaid reimbursement rates. Id. It is the responsibility of this Court then, to determine whether the Department has acted in an arbitrary and capricious manner in setting its reimbursement rates in the HealthChoices Southeast geographic area.

The Court may find that an action is arbitrary and capricious if the Department relied on factors other than those intended by Congress, did not consider "an important aspect" of the issue confronting the agency, provided an explanation for its decision which "runs counter to the evidence before the agency," or is entirely implausible. See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43, 103 S.Ct. 2856, 2867 (1983).

The scope of review is narrow as the Court should uphold the Department's decision of less than ideal clarity if the Department's path may reasonably be discerned. Id. at 43, 103 S.Ct. at 2867 .

The Department, in formulating payments and methods to be used in the Medicaid Program, must consider whether payments are consistent with efficiency, economy, quality of care and access to services, although it need not consider every factor to the same degree. Rite Aid, 171 F.3d at 851-853.

(1) Access to Services

The Department's procedure for deciding whether MABs had sufficient access to services was not arbitrary. The Department considered information from "other states" concerning reasonable "access provisions" and established a policy requirement that each HealthChoices HMO have available at least two participating pharmacies within 30 minutes travel time in urban areas, or within 60 minutes travel time in rural areas, via public or county transportation services (the "30/60 Standard"). (Def. Br. at 8). The Department developed the

30/60 Standard after reviewing its own data and that of other states who had received HCFA approval for modifications of their Medicaid plans. Standards similar to the 30/60 Standard have been considered favorably by HCFA.<sup>5</sup> The Department continued to consider access when the HealthChoices HMOs lowered their pharmacy reimbursement rates in 1998 and 1999. It regularly receives lists of providers and maps showing provider access from the four HMOs.

The Plaintiffs point out that the 30/60 Standard was made without serious consideration of whether HealthChoices participants would have access to services at least to the same extent as those within the same geographic area with private insurance. It is certainly not clear whether the Department's methodology considered whether MABs would have access to services to the same extent as would the general population of the Five County Area.<sup>6</sup> Nevertheless, the Department did not disregard the access issue. Therefore, even if the Department's approach led to substantive inequalities, which will be determined below, the Court can not find that its consideration of "access" was arbitrary and capricious.

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5. See 63 Fed. Reg. 52,043 (proposed September 29, 1998).

"In proposing § 438.306(d)(1)(v), we recognize that standards vary across states with regard to geographic access. Some state agencies contracting with MCOs have established maximum travel and distance times that include a 30-minute travel time standard. Other states have established alternative standards such as a 10-30 mile travel distance, depending on the local terrain. *Both are examples of geographic access standards that would comply with this provision.* For instance, a state agency could require that all primary care services and commonly used specialty and referral services be available within 30 minutes driving time or bus time from any point in the service area, *with possible exceptions for certain rural areas or other low-population/low-density areas where residents customarily travel greater distances to obtain specialty and referral services*".

6. The district court in *Rite-Aid* did not address the "access issue" when declining to hold that the Department had acted arbitrarily and capriciously. However, as the Third Circuit noted, the standard of access by which a program is judged is not absolute access, but the access to services relative to the general population. See *Rite Aid*, 171 F.3d at 854, n.13.

(2) Quality Pharmacy Services

The Department also contends that it properly considered the quality of the services provided by the HealthChoices HMO before its implementation and subsequent lowering of reimbursement rates. It requires that all contracting pharmacies comply with federal and state pharmacy law. The Department also monitors pharmacies to insure that HealthChoices members receive the same quality services that other pharmacy customers do. The Court finds the Department did not act arbitrarily when considering quality of services that would be provided under the HealthChoices program.

(3) Economy and Efficiency

The Plaintiffs, like the district court in Rite Aid, contend that the Department's price survey and analysis failed to properly consider efficiency and economy. The Third Circuit has found that using comparative data from third party payers and other states shows that the Department has made a reasonable effort to anticipate the effects of its actions. Rite Aid, 171 F.3d at 855. The Department followed similar methods to those which were challenged, but found not to be arbitrary and capricious, in formulating prices under the Fee-for-Service program. Id. The factors the Department used in this case to determine efficiency included the rates paid by private health plans. The Court understands Plaintiffs' contention that the Department's analysis is flawed. However, using the arbitrary and capricious standard for evaluating the Department's methodology as outlined in Rite Aid, the Court can not find as a matter of law that the Department procedurally violated 30(A).

B. Does HealthChoices's Reimbursement Schedule Substantively Violate 30(A)?

The Third Circuit in Rite Aid was not asked to determine whether the Department had substantively violated provisions of § 30(A). In this case, the Plaintiffs allege that the Department has substantively violated Section 30(A). The Court has found that the Department did not act arbitrarily in establishing the HealthChoices reimbursement schedule. However, the Department will still be liable if its policies have fallen short of the requirements of § 30(A).

The Plaintiffs claim that there are two distinct substantive rights under § 30(A): the right to require a State Medicaid program to use reimbursement "methods and procedures" which (1) will "safeguard against unnecessary utilization of such [medical] care and services and assure that payments are consistent with efficiency, economy, and quality of care," and (2) are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area". See Visiting Nurse Ass'n v. Bullen, 93 F.3d 997, 1003 (1st Cir. 1996). In other words, the Department must be both economical and efficient, while insuring that MABs receive quality service and access equal to that of the general population.

The Plaintiffs have spent a good deal of time arguing that the reimbursement rates are too low. They provide evidence suggesting that the rates are not reasonable and adequate.<sup>7</sup> According to Plaintiffs, the statute's requirement that there is a reasonable rate at which they are entitled to be reimbursed is supported by the case law. See Orthopaedic Hospital v. Belshe, 103

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7. Under the provisions of the now-repealed Boren Amendment ("former § 13(A)"), the "right" asserted by Plaintiffs was more apparent. The Boren Amendment required the Department to set inpatient reimbursement rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services ... and to assure that individuals eligible for medical assistance have reasonable access ....

F.3d 1491, 1499 (9th Cir. 1997) (For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs, unless there is some justification for rates that do not substantially reimburse providers their costs).<sup>8</sup>

However, the Court finds that an independent conclusion concerning whether the rates are reasonable or adequate is not necessary to decide whether the Department is in compliance with § 30(A). The Court understands that certain courts outside this Circuit have found a substantive requirement within § 30(A) that essentially incorporated the substantive requirement of adequate and reasonable from the Boren Amendment. See e.g. Moody Emergency Services v. City of Millbrook, 967 F.Supp. 488, 493 (M.D. Ala. 1997); Sobky v. Smoley, 855 F.Supp. 1123 (E.D. Ca. 1994). To the extent that these cases are on point, though, they seem to rely on the spirit of the Boren Amendment. The Boren Amendment has, of course, been repealed. “With the repeal of the Boren Amendment nothing remains that remotely resembles a federal right to reasonable and adequate rates.” See Children’s Seashore Hospital v. Waldman, 197 F.3d 654, 659 (3d Cir. 1999) quoting HCMF Corp. v. Gilmore, 26 F.Supp.2d 873, 880 (W.D.Va.1998). Plaintiffs correctly point out that the issue in Waldman concerned plaintiffs attempt to seek redress under § 13(A) rather than § 30(A). However, there is no reason to assume that the Third Circuit’s holding would not equally apply under § 30(A). The Third Circuit does not appear to have ever adopted a standard that required reimbursement rates to be adequate and reasonable under the efficiency and economy language of § 30(A). While the

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8. The Ninth Circuit noted that § 30(A) was more flexible than the Boren Amendment (former § 13A). Although the court recognized that § 30(A) did not have explicit “reasonable and adequate” language, it held that the same requirement could be incorporated into § 30(A) by means of insuring that payment rates bear a reasonable relationship to provider costs.

language of Rite Aid refers only to procedural requirements that are no longer required, the Third Circuit in both Waldman and Rite Aid indicates that Congress has signaled a change away from requirements towards results. Therefore, the Court declines to adopt a standard that requires an independent conclusion concerning the adequacy of reimbursement rates to Plaintiffs under the efficiency and economy provisions of § 30(A).

The state's desire to save costs by using managed care can only be commensurate with the necessity of being economical and efficient. The Plaintiffs have not argued that the quality of care provided to Medicaid recipients has suffered as a result of the Department's methods and procedures, or that they have fostered the unnecessary utilization of medical resources. However, the payments made by the Department must still be sufficient to enlist an adequate number of providers. The most relevant consideration is whether MABs have access to care and services to the same extent as the general population within the same geographic area. If the Plaintiffs can show that access "to the same extent" is not available, then the reimbursement plan approved by the Department will likely be in violation of § 30(A).<sup>9</sup> Therefore, the Court must find whether MABs in the HealthChoices HMOs have similar access to pharmacy services as are available to the general population of the Five County Area.

(1) Equal Access

The general population to which Medicaid access is compared is the access of other individuals in the same geographic area with private or public insurance coverage. See

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9. In other words, it is premature to decide whether the reimbursement rate paid by the HealthChoices HMO's are adequate in a sense that they allow pharmacists a fair profit. The real issue presented here is whether the pay is sufficient to provide MABs with equal access. If the MABs have "equal access", then the Court will assume that payments are sufficient to maintain equal access. Then, plaintiffs will have to seek redress for the allegedly low payments elsewhere.

Arkansas Medical Society, Inc. v. Reynolds, 6 F.3d 519, 526 (8th Cir. 1993). Therefore, the Court must compare the access to care and services, including pharmacies, that HealthChoices members have compared to other individuals within the Five County Area. The Department recognizes that the waiver under which the HealthChoices program was implemented does not modify this responsibility, at least with regard to access to prescription drugs. However, there does not seem to be any accepted standard for determining access to services.<sup>10</sup>

One method for determining whether MABs have access to the same extent as privately insured individuals would be to count the number of pharmacies participating in the HealthChoices network compared to the number of overall pharmacies in the Five County Area. But it is indisputable that not every pharmacy participates in the HealthChoices network. Therefore, it would be an impossible standard for the Department to satisfy, as it would likely be for any state in which at least some pharmacies do not accept Medicaid reimbursed prescriptions. A second method would be to determine the average distance a privately insured individual must travel to get to a pharmacy and compare that to the distance the average MAB must travel.<sup>11</sup> This second standard was used by the Department, although it is not clear whether it was established after determining the distance for the average privately insured person.<sup>12</sup>

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10. For purposes of this discussion: services will be considered access to pharmacies. Although Plaintiffs state that the Department did not consider access to pharmacies in establishing the 30/60 Standard (access to primary service providers was the foremost consideration), the Department testifies that the 30/60 Standard is used by the Department to judge whether the HealthChoices HMO networks are maintaining their contractual duties.

11. The HCFA regulations support this approach. HCFA encourages state agencies to consider “distance, travel time, and the means of transportation normally used”. Also, “the assessment of capacity necessarily should consider the volume of service being provided to patients other than MCO enrollees”. See 63 Fed. Reg. 52,042 (proposed September 29, 1998).

12. The Department claimed that it developed the standard based on information from “other states”. However, it fails to explain whether access in other states was based on distance and/or travel time to pharmacies.

A third method of comparison is to measure the access of the average privately insured person, based on healthcare realities, compared to a MAB enrolled in one of the Healthcare HMOs. The average privately insured person does not have access to every pharmacy in the Five County Area. A member of the general population likely belongs to either an HMO or a medical plan that allows her to fill prescriptions only at certain pharmacies. Using this method, the Department draws comparisons between the number of pharmacies accessible to a privately-insured Independence Blue Cross (“IBC”) plan member and those available to a person using the Keystone plan through HealthChoices.<sup>13</sup> The Plaintiffs seem to favor an absolute standard, where if a cash customer can pay, a Medicaid beneficiary should be able to receive services as well.<sup>14</sup> Neither side provides case law to help determine what the proper access standard under § 30(A) should be. The Court favors a standard that compares accessibility for MABs and privately insureds by travel time and distance as well as total number of pharmacies available. After reviewing the evidence provided by both parties, the Court was able to make certain findings, as well as discount certain contentions made by the various parties.

The Department stipulates that, as of February, 1997, there were 1,192 pharmacies within the Five County Area participating in the pre-HealthChoices fee-for-service Medicaid

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13. The number of participating pharmacies in each plan has varied, but as of April 1, 2000 there are:

1) IBC:	963 serving 1,900,000 members
2) Oaktree:	864 serving 56,000 members
3) Keystone:	794 serving 220,000
4) HMA:	635 serving 73,000 members
5) Heath Partners:	600 serving 113,000 members

14. Plaintiff encourages the Court to use a high standard to measure access; that of the Medicaid fee for service patient, who presumably could have prescriptions filled at any pharmacy. But this high standard is not likely to be the equivalent of access to services available to the general population. Also, the HCFA regulations state only that a member of HealthChoices should not have to travel an *unreasonable distance beyond* what is customary in a Medicaid fee-for-service arrangement. See 63 Fed. Reg. 52,042 (proposed September 29, 1998).

program<sup>15</sup>. Today there are approximately 800-900 participating pharmacies in the Oaktree and Keystone plans, which are the two largest of the HealthChoices HMOs in terms of pharmacy participation. Therefore, if one were a present HealthChoices Oaktree member, one would have access to approximately 25% less pharmacies than prior to the HealthChoices. The Court might have found this decrease significant if it were the only standard by which access could be judged. But a decrease does not necessarily lead to access below that of the general insured population. The Plaintiffs have demonstrated a decrease in the number of independent pharmacies. However, the closure of a pharmacy would limit access for both MABs and privately insureds. It would be more significant if the pharmacy continued to function but stopped dispensing Medicaid prescriptions.

The general population does not have access to every pharmacy in the Five County Area. A typical medical consumer's choices are limited by the HMO, or medical plan, to which he belongs. Relatively few individuals have access to the equivalent of a fee for service plan. In any event, the Court can not claim that the Department has violated the access provisions of § 30(A) merely because there might be a pharmacy that some privately insured person would have access to that a Medicaid recipient would not. Assuming that the 1192 pharmacies that participated in the fee for service program represented all of the pharmacies in the Five County Area, then a privately insured person enrolled in IBC would not have access to

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15. It can be presumed that not all of these pharmacies exist today. However, neither party has directed the Court's attention to the total number of pharmacies that are in business today or were in business in January, 1997. For illustration purposes, the Court will assume that the 1192 represented all possible pharmacy locations in the Five County Area at the time of the HealthChoices implementation.

prescriptions at approximately 230 pharmacies (or 20% less pharmacies than would an individual using a fee for service plan). This is not a significant disparity in access.

Plaintiffs use IBC access as the standard for a privately insured person. They then compare the number of participating pharmacies accessible to IBC members to the number available to members of HMA and Health Partners. Since the number available to members of these two HealthChoices HMOs are approximately 300 less than the number available to members of IBC, the Plaintiffs conclude that access for Medicaid recipients is significantly less than for private individuals. However, the access situation would be reversed if one were to use as the standard a private insurer that had significantly less available pharmacies (approximately 600) compared to IBC (950+). Then, if the number of Oaktree or Keystone available pharmacies were used as the MAB accessible standard, the MABs would actually have greater comparative access.

The Defendant has also provided evidence showing that between August, 1998 and April, 1999, the number of participating pharmacies in the Health Partners Network increased throughout the five county area from 403 to 541 (as of April 1, 2000 the number is 600 pharmacies). This is a 34% increase and the number of pharmacies increased fairly proportionally throughout the five counties.

It is true that the Department was concerned that the number of participating pharmacies in the Keystone network would decrease by approximately 50% upon implementation of EMC as the pharmacy benefits manager for Keystone in 1998 (and the subsequent reduction of reimbursement rates). However, today there are over 800 participating pharmacists in the Keystone plan. The letter from Vivienne Bowser of August 1998 to Health

Partners is similar to the letter sent in April, 1998 to Keystone. It mentions the Department's concern that pharmacists are leaving the network, but there is no mention of a 50% decrease in available pharmacies. But as discussed above, the expected decrease did not materialize to any great extent, and by April, 2000, Health Partners had increased its pharmacy participation rate by almost 50% since August, 1998.

The Plaintiffs claim that access "to the same extent", is denied MABs in Northern Bucks County because there are two pharmacies that exist, but do not belong to either the HMA, Oaktree or Health Partners network. The Plaintiff does not provide information about whether the pharmacies participate in the Keystone HMO network, but the Court will assume that they do not. The documents cited by Plaintiff give no indication of why these particular pharmacies do not participate in HealthChoices. Also, the Plaintiffs use a cash paying customer as the "general population" standard for judging Medicaid beneficiary access. The Court has already expressed its wariness concerning the appropriateness of this standard considering the fact that so many individuals today participate in non-Medicaid managed care plans. Plaintiffs fail to demonstrate that the average privately insured individual, such as an IBC member, would have access to these two facilities.<sup>16</sup>

The Court will also look, as the Department did, at comparative access in terms of travel time. There does not seem to be any evidence provided concerning travel time prior to February, 1997 for MABs compared with the general population. But the Department has provided some evidence of present travel time for MABs. In Bucks County, the area of greatest

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16. It is possible that MABs in these rural parts of Chester and Bucks may have more convenient access to pharmacies in Lancaster and Northampton Counties.

concern for the Plaintiffs, 92% of Keystone members were within three miles of a pharmacy provider, while 98% were within five miles. In Chester, the numbers are 66% and 89% respectively. These numbers definitely seem “reasonable distances” to travel to obtain necessary prescriptions. “Reasonable distance”, however, is not the absolute standard by which access is to be judged. Plaintiffs has the burden of showing access is not equal. They have not provided any information concerning the privately insured population’s average distance from a participating pharmacy in Northern Bucks County or Northwestern Chester County. Therefore, since the Plaintiffs have failed to meet their burden of showing that access for MABs in the Five County Area is not available to the same extent as it is for private insureds, summary judgment will be entered for the Defendant.

C. Did the Department fail to comply with the MAAC and publication requirements of the Medicaid Act?

The Plaintiffs also claim that the Department violated § 1902(a)(4) of the Act by failing to meet with the Medical Assistance Advisory Committee (“MAAC”) before allowing reimbursement rates to be lowered by the HealthChoices HMOs. According to the implementing regulation of § 1902(a)(4), the MAAC “must have opportunity for participation in policy development and program administration”. See 42 C.F.R. § 431.12. Although it is not clear how far the Department’s duty stretches to give MAAC the “opportunity to participate”, the Third Circuit has held that the Department must consult with the MAAC prior to final HCFA approval of a plan amendment. See Rite Aid, 171 F.3d at 856. It is undisputed that the Department met with the MAAC prior to the final approval of HealthChoices by HCFA. The Court need not decide whether §431.12 requires the Department to consult with the MAAC whenever the

HealthChoices HMOs lower reimbursement rates. Assuming that such consultation is necessary, the Department has violated the requirement. However, this does not require the Court to issue an injunction against the HealthChoices program. Id. at 856-857 (holding that Department's violation of § 431.12 was not grounds for an injunction and reversing the district court's grant). The Court likewise finds that the Department's probable violation of §431.12 does not warrant an injunction.

The Department also has a duty to give public notice of changes in Statewide methods and standards for setting payment rates. See 42 C.F.R. § 447.205. This Regulation requires that notice of the change be published before the proposed effective date in either the Pennsylvania Bulletin, or a major newspaper, and must "describe the proposed change....explain why the agency is changing its methods and standards.... and give an address where written comments may be sent and reviewed by the public". Id. The Court agrees with the Defendant that the Regulation only places a duty of public notice when a statewide practice of the Department is changed. The HealthChoices Southeast HMOs' reimbursement rates apply only within the Five County Area.<sup>17</sup> Also, as the Department argues, it did not change any policy when the HMOs lowered reimbursement rates.<sup>18</sup> These reductions were instituted by the HMOs

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17. On the record, there is no evidence of whether the four HMOs participate in HealthChoices Southwest (in Western Pennsylvania), and if they do, whether the reimbursement rates in that program are the same as those paid to pharmacists in the HealthChoices Southeast region. Also, clearly these rates do not apply in those parts of the Commonwealth that do not fall under either HealthChoices program.

18. The Third Circuit found that the Department did have a public notice duty when it changed its reimbursement schedule for the fee for service program prior to the implementation of HealthChoices. See Rite Aid, 171 F.3d at 857. But in that case, the Department itself was changing the reimbursement rate and these changes were to have effect throughout the Commonwealth.

themselves and were consistent with already approved contracts and the waiver granted by HCFA. The Court finds, therefore, that the Department did not violate its duty under §447.205.

#### **IV. CONCLUSION**

Pennsylvania's Medicaid program presents the Department with great challenges. The Department instituted HealthChoices as a means of furthering the program's efficiency and economy, while maintaining quality services and access for MABs. Plaintiffs have produced evidence that suggests it has become increasingly difficult for pharmacists, especially independent pharmacists, to run profitable businesses. But they have failed to demonstrate that the Department has violated the Medicaid Act. Therefore, summary judgment will be granted in favor of the Department and against Plaintiffs.

An appropriate Order follows.

**IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

PENNSYLVANIA PHARMACISTS	:	CIVIL ACTION
ASSOCIATION, et al.,	:	
	:	NO. 99-491
Plaintiffs,	:	
	:	
v.	:	
	:	
FEATHER O. HOUSTOUN,	:	
	:	
Defendant.	:	

**ORDER**

AND NOW, this 7<sup>th</sup> day of June, 2000, upon consideration of Plaintiffs' Motion for Summary Judgment (Docket No. 48), and the Defendant's Response thereto (Docket No. 51), as well as Defendant's Motion for Summary Judgment (Docket No. 49) and Plaintiffs' Response (Docket No. 50); it is hereby **ORDERED** that the Plaintiffs' Motion is **DENIED** and the Defendant's Motion is **GRANTED**. Judgment is entered in favor of defendant and against all plaintiffs.

This case shall be marked **CLOSED** for statistical purposes.

BY THE COURT:

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RONALD L. BUCKWALTER, J.