// Health Law PA News

Newsletter of the Pennsylvania Health Law Project
Harrisburg Philadelphia Pittsburgh
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On the Internet: www.phlp.org
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Medicare Durable Medical Equipment Competitive Bidding Program in Western Pennsylvania Delayed

A recent law passed by Congress has delayed the implementation of Medicare's Durable Medical Equipment (DME) Competitive Bidding Program. We reported on this Program in our May PA Health Law News. The Competitive Bidding Program began on July 1st and was being piloted in 10 areas of the country, including the Pittsburgh area. Medicare mailed notices to all beneficiaries in the Pittsburgh Competitive Bidding Area (CBA) in late June describing the new program which affected how beneficiaries in Traditional Medicare obtained certain durable medical equipment and supplies. In essence, the Competitive Bidding Program restricted beneficiaries to a very limited network of providers awarded a contract from Medicare when trying to obtain items like oxygen and supplies, power wheelchairs and scooters, walkers and hospital beds.

On July 15th, however, Congress overrode a Presidential veto and passed H.R. 6331, "Medicare Improvements for Patients and Providers Act of 2008". Under this law, the DME Competitive Bidding Program is now delayed for 18 months. As a result, Medicare beneficiaries in the Pittsburgh CBA can again use **any** Medicare-approved supplier for their medical equipment and supplies. If a beneficiary changed suppliers when the Program started on July 1st, he can continue to use the new supplier, go back to his old supplier, or choose another Medicare-approved supplier. The original DME payment rates to suppliers in effect prior to July 1st are reinstated retroactively.

Medicare will be mailing new notices out to all beneficiaries in the Pittsburgh CBA within the upcoming weeks telling them of the Program's delay. If you or your clients have any questions or problems resulting from the start, and then stop, of the Competitive Bidding Program, please contact our Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

See the article on the next page about how this new law will help Medicare consumers who receive mental health services!

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Medicare Beneficiaries to Pay Less for Mental Health Services

Consumers of mental health services scored a victory this month when Congress overrode President Bush's veto and enacted H.R. 6331, "Medicare Improvements for Patients and Providers Act of 2008". Under the Act, Medicare beneficiaries will see decreases in their co-pays for outpatient mental health services over the next 6 years.

By 2014, Medicare beneficiaries will have the same co-pays for outpatient mental health services as they have always had for outpatient physical health services under the Medicare program. Since the inception of the Medicare program in 1965, Medicare paid 80% of the cost for outpatient physical health services but only 50% of the cost for outpatient mental health services. H.R. 6331 decreases, over 6 years, the co-pays for mental health services to the same 20% co-pay rate as Medicare-covered physical health services.

National organizations including Mental Health America and NAMI applauded Congress for passing legislation to improve Medicare benefits for persons with mental illness. Many advocates agree that this law is a significant step toward decreasing stigma against mental health illnesses and increasing access to mental health services.

There are a number of other provisions in H.R. 6331 that will benefit Medicare beneficiaries. One provision extends the Medicare Qualified Individuals (QI-1) Program for another 18 months through December 31, 2009. The QI-1 program is one of the Medicare Savings Programs that allows Medical Assistance to pay the Medicare Part B premium for low-income beneficiaries. A second important provision increases the assets test for the Medical Savings Programs (MSP) effective 2010. We will have a more detailed article about the impact of this new law on Medicare beneficiaries in our August Senior Health News.

You can view the newsletter on our website at www.phlp.org. If you are not already on the Senior Health Newsletter mailing list, please call or e-mail us to sign up (see page 8)!

Alert for Waiver Applicants and Recipients!

If you were recently terminated from, or denied eligibility for, the Aging, Attendant Care, Independence, or COMMCARE Home and Community Based Services Waiver Programs, contact PHLP immediately for free legal advice and possible representation on appeal.

Individuals must be determined Nursing Facility Clinically Eligible (NFCE) in order to be qualify for any of these waiver programs. An NFCE determination requires the consumer to have either skilled or intermediate care needs. A person with "skilled care needs" is someone who requires the hands-on activity of a medical professional, such as a physician or a nurse. Someone with "intermediate care needs" does not require such complex care that it can only be administered by or under the supervision of a medical professional. Instead, many of these persons receive services through a home health aide or attendant.

The Office of Long Term Living (OLTL), which is charged with overseeing waiver implementation, previously issued rules that combined the two standards, effectively requiring that applicants have skilled care needs in order to be eligible for the waivers.

More recently, OLTL issued a bulletin that claims to clarify the standard and differentiate between skilled and intermediate care needs. Although it contains a better definition of NFCE, the interpretive text of the bulletin negates any improvement to the definition by inserting a skilled care requirement into the definition of "intermediate care." The bulletin was issued without notice or an opportunity for public comment. It was effective July 1, 2008 and

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1,700 Area Agency on Aging assessors have already been trained on how to implement the clarified standard.

PHLP is concerned that the conflicting language of this bulletin will result in wrongful terminations of individuals currently receiving waiver services, especially those on the Aging and Attendant Care waivers. Any termination can be appealed to a Fair Hearing. If you have recently been terminated from a waiver program, or if you applied for and were denied waiver services, PHLP may be able to provide free representation at an appeal. Please contact our HELPLINE (1-800-274-3258 or 1-866-236-6310/TTY) for more information or if you need assistance with the appeal process.

Autism Insurance Act of 2008 (HB 1150) Summary

This Act was signed into law on July 9, 2008. Its prime sponsor was Speaker of the House, Dennis O'Brien. Here is a summary of the law:

Who is covered:
Children and young adults under age 21 who are:

- Covered under a employer group health insurance policy (including HMOs & PPOs)
  - that has at least 51 employees; and
  - is not a "self insured" or an "ERISA" policy; or
- On Medical Assistance; or
- On CHIP (Children's Health Insurance Program); or
- On adultBasic (age 18 or older).

What is covered:

- Diagnostic assessments of autism spectrum disorders
  - Defined as: "medically necessary evaluations, assessments or tests performed by a physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder."
- Treatment of autism spectrum disorders

What treatments are covered:

- Prescription medications and blood level tests
- Services of a psychiatrist (direct or consultation)
- Services of a psychologist (direct or consultation)
- Applied Behavioral Analysis (ABA)
  - Defined in the law as: "the design, implementation and evaluation or environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior."
- Other "rehabilitative care"
  - Defined in the law as "professional services and treatment programs…provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function."
- Therapies
  - Speech/language pathologists
  - Occupational therapists
  - Physical therapists

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Coverage limits:

- $36,000 per year in autism diagnostic and/or treatment costs (to be adjusted annually for inflation beginning 2012);

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- No limit on number of diagnostic/treatment visits (until $36,000 cap is reached);
- Autism coverage "shall be subject to copayment, deductible and coinsurance provisions, and any other general exclusions or limitations…to the same extent as other medical services covered by the policy or program…." (*This language appears to give insurers authority to deny some autism treatments (other than ABA) on grounds they are experimental*).

Treatment requirements:

- Must be for an autism spectrum disorder:
  - "any of the pervasive developmental disorders defined in the most recent edition of the …DSM…including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified."
  - "diagnostic assessment of autism spectrum disorder shall be valid for a period of not less than 12 months, unless a licensed physician or licensed psychologist determines an earlier assessment is necessary."

- Must be medically necessary:
  - no definition is provided in the Act
  - however, service definitions, especially of ABA and "rehabilitative care" provide some guidance: For ABA and "rehabilitative care", progress need not be shown. It is sufficient if these services are needed to "prevent loss of attained skill or function".

- Must be "identified in a treatment plan":
  - Developed by a physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation
  - Treatment plan may be reviewed by insurer every 6 months. The child's phys cian or psychologist who signs off on the treatment plan may agree to a more frequent review.

- Must be "prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner."

- Must be provided by an "autism service provider" or "a person, entity or group that works under the direction of an autism service provider". "Autism service provider" means any of the following:
  - A person, entity or group providing treatment of autism spectrum disorders that is "licensed or certified" in PA;
  - A person, entity or group currently providing treatment of autism spectrum disor- ders that is enrolled in Medical Assistance before (grandfather clause);
  - A behavioral specialist in PA providing treatment of autism spectrum disorders (until 1 year after regulations are issued or July 2011, whichever is later)

When coverage begins:

- For commercial health policies, CHIP and adultBasic: the date the policy or contract is renewed on or after July 1, 2009.
- For Medical Assistance, no start date is specified.

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Grandfathering current providers:

- Insurers must contract with any autism service provider who:
  - Is in the insured's "service area"; and
  - Is enrolled in Medical Assistance; and
  - Agrees to accept the payment levels and other terms and conditions applicable to the insurer's other participating autism providers.

Appeals:

- Families can appeal any denial of an autism diagnostic or treatment service to the insurer and obtain a decision within 48 hours (expedited review).
- If the appeal is denied by the insurer, the family can appeal to the PA Dept. of Insurance and obtain a decision in 4 days (expedited external review).
- If the Insurance Department denies the appeal, the family can appeal to Common Pleas Court.

Other provisions:

- Insurers are not required to cover services just because they are listed in an IEP. However, coverage may not be contingent upon coordination of insurance covered services with services listed in an IEP.
- The Act sets out criteria for being licensed or certified as a "behavioral specialist".

Stay tuned to future newsletters for updates on developments as this law is implemented.

PHLP Wins Inglis Foundation Award

PHLP was one of five organizations to receive the 2008 Inglis Foundation Award for Continuing Excellence. These awards "recognize effectiveness and innovation, and honor the outstanding performance of non-profit organizations in the Philadelphia region that provide direct services, products, and/or advocacy for people with physical disabilities as a focus and mission." The mission of Inglis Foundation is "to work with people with physical disabilities to create and provide practical solutions so they may pursue their life goals." Each year, the Foundation recognizes a few organizations that work with adults with physical disabilities in southeastern PA. The award includes a $20,000 grant to further the efforts of the organization to "enhance the quality of life and increase opportunities for independence for people with physical disabilities who are at risk for negative health outcomes or for institutionalization because of unmet service needs, lack of resources or severe disabilities." PHLP is grateful to Inglis Foundation for their support of our work and honored to receive this prestigious award.

PHLP staff are available in Southeastern PA to conduct trainings on Medicare Part D to help social service agencies and their clients navigate the Part D system. Trainings focus on the rights that dual eligibles have under Medicare Part D and the appeals and grievance processes that are available to all Part D enrollees.

To learn how to help get your clients' needs met through Medicare Part D, contact the PHLP HELPLINE to schedule a training (1-800-274-3258 voice or 1-866-236-6310/TTY). Please let us know if you require any special accommodations for hearing and/or visual impairments.

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New Process Makes It Easier For Women to Apply for BCCPT Coverage

Starting July 1, 2008, women who are diagnosed with breast or cervical cancer will no longer have to go to a Healthy Woman Program (HWP) provider to apply for coverage under the Medical Assistance (MA) Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program. This new process is known as ***Direct Access***.

BCCPT provides full MA coverage to women under 65 years old who: are diagnosed with breast or cervical cancer, are uninsured or underinsured, and have incomes below 250% of the Federal Poverty Level ($2,168/month for a single woman in 2008). Previously, in order to enter the program, women had to be seen at a clinical site affiliated with the Healthy Woman Program, a public health cancer screening program, even if they were diagnosed elsewhere. The HWP then completed the necessary paperwork and forwarded the information to the Department of Public Welfare (DPW) for an eligibility determination.

Under the Direct Access process which began July 1, 2008, **any** medical provider can complete the simple forms needed for a woman to apply to the BCCPT program. The process is described at www.pahealthywoman.com (under health care providers) and is as follows:

1) A physician office needs to print out the Healthy Woman enrollment form.
   - The woman completes Part A, the one page form with information regarding income and insurance, and
   - The physician completes Part B of the form with the date of diagnosis, and a check-off of pertinent diagnosis codes.

2) The forms are then faxed to 412-201-4702, the Pennsylvania Department of Health's Healthy Woman management team at Adagio Health.

3) Adagio Health will process the form, and transmit it to the Department of Public Welfare.

4) The Healthy Woman team at Adagio Health will contact a woman within two days of receipt of the form if additional information is needed before submitting the forms to DPW.

This process should speed up a woman's ability to obtain insurance and enter treatment. The Healthy Woman website noted above has direct links to the needed forms. If the health care provider is not willing to help the woman complete Part A of the form, she can call the team at Adagio Health 1-800-215-7494 for assistance.

The Healthy Woman Program and the Department of Public Welfare recently sent information to providers who do not participate in the Healthy Woman program, but who may see and diagnose women with breast or cervical cancer, to notify them of this change.

As of the publication of this newsletter, DPW has not updated their website to include information about the Direct Access process and does not have Part A of the application form available online.

For advocates, the Healthy Woman Program and the BCCPT program have two key components: free mammograms, breast exams, and pap smears for eligible uninsured women under the Healthy Woman Program, and now direct access to MA coverage if breast or cervical cancer is diagnosed and treatment is needed. In 2006-2007, over 10,000 women were screened by the HWP program, and 1,800 cases of breast cancer and 100 cases of cervical cancer were diagnosed.

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Changes May Be Coming to the ACCESS Plus Program

Earlier this month, the Department of Public Welfare released a draft Request for Proposal (RFP) document for the ACCESS Plus program that includes some recommended changes of interest to consumers. As a reminder, ACCESS Plus is the Medical Assistance physical health program that operates in the 42 counties throughout the state that do not have HealthChoices mandatory managed care. Individuals in ACCESS Plus choose a Primary Care Physician (PCP) to manage their care. The ACCESS Plus program also includes a disease management component for certain chronic conditions including Asthma, Diabetes, Coronary Artery Disease, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disorder (COPD).

Once the draft RFP is finalized, DPW will seek bids from interested companies. They will then choose the ACCESS Plus program Contractor from all the bids submitted. McKesson is the current Contractor for the ACCESS Plus program. So far, DPW has not released timeframes for when the RFP will be finalized and released to potential bidders.

Some of the major changes proposed in the draft RFP are:

- Expanding the disease management program to include more conditions than those five listed above (including additional cardiovascular and respiratory diseases, gastrointestinal diseases, rheumatic disorders and neurological disorders).

- For Disease Management enrollees, expanding the Contractor's responsibility to manage physical health conditions that are outside the scope of the disease management program (for example, an individual with diabetes who develops a wound) and to coordinate services with the Behavioral-Health Managed Care Organizations (BH-MCOs) for enrollees who also have behavioral health conditions such as schizophrenia, bi-polar disorder, schizo-affective disorder, major depression, and substance abuse. DPW hopes this change will result in disease management enrollees receiving a more holistic approach to their health care.

- Improving physical health and behavioral health coordination for all ACCESS Plus enrollees. DPW hopes that this change will improve compliance with both physical health and behavioral health treatment. In addition, improved coordination between the systems will help ensure that physical health providers understand how behavioral health medications affect someone's physical health and help providers make better treatment decisions.

- Establishing standards for determining and monitoring provider network adequacy. This will include PCP access standards that mirror those in effect for HealthChoices (i.e., choice of 2 PCPs located within 30 minute travel time in urban areas and 60 minute travel time in rural areas) as well as strengthening the requirements around recruitment of physicians to serve as PCPs in the ACCESS Plus program.

- Improving enrollee access to physician specialists. The Department hopes to have the ACCESS Plus contractor outreach to specialists and dentists to take ACCESS Plus and MA Fee-for-Service recipients. The Contractor will be expected to create and maintain a Physician Specialist Resource and Referral database that includes information about physician specialists and dentists who are willing and available to serve ACCESS Plus enrollees.

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DPW released the draft to the public and asked for comments back by July 17th. DPW shared information about the preliminary recommendations included in the draft RFP as well as the rationale for the program changes with members of the ACCESS Plus Regional Advisory Committees and the Consumer Subcommittee of the Medical Assistance Advisory Committee. PHLP submitted written comments to the draft RFP on behalf of the Consumer Subcommittee. You can view the draft RFP as well as a chart of the recommended changes included in the draft RFP on DPW's website at: http://www.dpw.state.pa.us/business/default.htm. We'll keep you updated about ACCESS Plus developments in future newsletters!

United Way Supports PHLP

After an intensive competition involving almost 550 agencies, the Pennsylvania Health Law Project has been awarded $14,226 by United Way of Southeastern Pennsylvania. This is the first time that PHLP has been a recipient of United Way General Operating Support.

The grant, expected to be renewed for two additional years pending the results of future United Way campaigns, is to help with the general operating expenses of the organization rather than directed to a specific program. The agency said that while United Way placed no restrictions on the use of the funds, it provided the funds because of PHLP's success in developing and enlisting public support for public policy changes and increased public resources to assure that seniors have access to supportive services they need for healthy aging at home.

PHLP has a long history of public education through its website, www.phlp.org, its bi-monthly publication "Senior Health News," and public education seminars for consumers, advocates, social service agencies and health care providers. PHLP actively participates with, and on behalf of, consumers on the Long Term Care Delivery System Subcommittee of the Medical Assistance Advisory Committee, the Pennsylvania Intragovernmental Long Term Care Council and a host of other entities which seek to assure that seniors can age at home.

United Way's *Investing in Results* process was its first competitive funding process in many years. Previously, United Way supported a selected group of high-quality agencies that had been chosen over the course of its 87 year history. But several years ago, United Way announced that it was revitalizing its funding model and beginning with its most recent fundraising campaign, it would look for and fund organizations that have a strong track record aligned with United Way's three areas of focus – supporting children to enter school ready to learn and stay on track to graduation, supporting families in achieving financial self-reliance, and helping seniors remain healthy and safe in their own homes.

United Way considered over 2,100 proposals from 546 agencies in the *Investing in Results* process, ultimately selecting 137 agencies, an increase of sixty agencies over its former list of 77. Ninety-three of the agencies selected had not previously received United Way funding.

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If so, contact staff@phlp.org to change the way you get the Health Law PA News!

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Stories of the Uninsured

Starting in May, we added a regular feature to our newsletter highlighting stories of the uninsured in Pennsylvania

Hope's Story

"My heart was beating so fast I couldn't count it, and it wouldn't stop." Hope tells her story, clearly and methodically, reflecting her background as a retired high school science teacher. "But I thought of myself as completely healthy, so I waited for it to slow down. When it didn't, a friend told me I had to go to the emergency room. I walked the six blocks to the emergency room. I didn't want to attract attention by calling 911. I couldn't believe it when the doctor said I had to stay in the hospital. I kept telling myself I was a healthy person."

Hope needed to be a healthy woman. In 1999, eight years before this hospitalization, she had retired from her teaching job in a suburban Philadelphia school district. At that time, she had the sole responsibility for caring for her elderly mother as well as a severely disabled aunt. She was commuting from her home to school, then two hours round trip to care for the older women, then back to work to teach science to 135 adolescents. The emotional and physical stress got the better of her, and she retired on disability at age 52.

She knew the importance of health insurance, and she continued to pay for it herself for the two years after she retired. But $347 per month was almost 20% of her monthly income and she could not continue to make the payments. In 2001, she got a mammogram and a colonoscopy, to keep up on her preventive care, and reluctantly gave up her health insurance. She hasn't had a mammogram since. She went to a neighborhood physician twice a year who charged her $50 and gave her a "check-up" and a clean bill of health. When she injured herself trying to lift her stove in 2006, she was treated at an emergency room. Unable to pay the bill she received, she called the hospital's financial office and was found eligible for their charity care program.

She tried to find other insurance, but was told her income was too high for public programs. Private insurance was too expensive. She has been seeking employment outside of the teaching field for the last four years, but has found few companies who want to hire a woman in her late 50's.

Then her heart took off for the races, and she discovered that she wasn't as healthy as she had hoped and believed. She had an irregular beat and an enlarged heart. She also had lung disease. The cardiologist who saw her in the hospital told her, at discharge, to come see him when she had insurance. The lung doctor told her the same thing. They gave her prescriptions for medications totaling over $200, but she could not afford to buy all of them. She proudly says that she threw away her credit cards when she retired, and she has no credit card debt, so that was not an option for medications.

Both doctors naively believed that because she was uninsured, she would qualify for Medical Assistance (MA). But Hope is a retired school teacher. Her income, enough to live on if she lives frugally, is too high to qualify for MA. Even if she could afford private insurance, no one will sell her a policy now that she has a heart condition.

"I was born and raised here in this country; I've been working since I was 14. Here I am, one of the 40 million Americans without health insurance. It doesn't seem right."

Maraline's Story

If the sentence, "we are all just one job away from being uninsured" hasn't hit home, you might want to speak with Maraline.

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Maraline is a 52-year-old woman who was working as a laboratory technician in a health care setting. She has had diabetes for 20 years, often very difficult to control. Diabetes can be especially hard to control when work hours, or meal breaks, are unpredictable. If sugars go too high, fatigue, or blurry vision can set in. If sugars go too low, a person can lose consciousness.

In 2006, Maraline had a job with extremely variable hours. One day she started at 9 am, the next day at 5:30 am. She had a hard time adjusting her eating schedule and her insulin. In December of 2006, her sugars went too low and she had a seizure at work. She broke her wrist, and required surgery. She wasn't able to continue working.

This wasn't the first time Maraline had difficulties working full time. In the 1980's, she had back and neck surgery and was unable to work. She fought back, recovered from surgery, went back to school, and re-entered the work force.

This time, her job encouraged her to go on disability. On disability, she receives $1,280 per month. But she doesn't get health insurance, and that income is too high to qualify for Medical Assistance. Maraline was offered a COBRA extension of her health benefits at the time she stopped working. But COBRA – a federal requirement that allows ex-employees to purchase the same plan they had when working, but at full cost, meaning they pay the employer and employee share – would have taken more than half of her disability check. The remaining half of a disability check was not enough for food, rent, utilities, transportation, and other necessities. She, like almost 80% of those offered COBRA, declined the coverage because of cost.

So Maraline is now uninsured with diabetes, complications from her wrist fracture, chronic pain problems from her diabetes and spinal surgeries, and several additional medical problems. She needs insulin, thyroid medication, cholesterol medication, and blood pressure medication. These are just the ones she is currently taking. "I quit taking a few medications that I was on before; ones that I thought I could stop without it killing me." She is on two kinds of insulin, with combined costs of $170 or more per month. In addition, she must buy the syringes and needles needed to inject the insulin and the test strips needed to check her sugars. One hundred test strips can cost between $50 to $100, depending on the machine; and a person whose sugar is unstable may need to check up to 4 or more times per day. Taking proper care of diabetes is expensive.

What has Maraline done? She acknowledges that she has not been to the doctor, and she has skimped on medications. In November of 2007, she was hospitalized. The high hospital bill made her eligible, for six months, for Medicaid under a "spend down" program. All but $5,000 of her hospital bill was covered. Because of an address mix-up, she did not realize she had Medicaid until the six months was almost up.

She needs to go to a pain clinic, and she needs cataract surgery. She hasn't had a mammogram in more than 3 years. She is applying for charity care at the hospital where she owes the money. She has applied for Social Security disability but was turned down; she is awaiting a decision on the appeal. Even if she obtains Social Security disability benefit, there is a more than two year waiting period before she is eligible for Medicare. She knows about free clinics in Pittsburgh, but would like to remain with her own physician, and doesn't believe that most free clinics will have on staff the specialists she currently needs.

Maraline has tried to buy other insurance, but she was turned down because of pre-existing conditions. She didn't understand that she could be on the waiting list for Pennsylvania's adult-Basic program without paying, and she thinks she may have missed another opportunity for low cost health insurance. But, she said when talking to us, "I'm a pretty intelligent person. I have a college education. And I can't figure this out."

Maraline, just like many of us, was only one job away from being uninsured.

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Assisted Living Update

Proposed Regulations Available for Review and Comment

The Assisted Living Residence Proposed Regulations have been submitted to the PA Bulletin for publication on August 9th at www.pabulletin.com. The regulations have also been submitted to the Independent Regulatory Review Committee. Interested persons need not wait until publication in the PA Bulletin as the proposed regulations can be immediately downloaded for review from the IRRC website at: http://www.irrc.state.pa.us/Documents/SRCDocuments/Regulations/2712/AGENCY/Document-10301.pdf. Public comments will be due by September 8, 2008.

A preliminary glance at the proposed regulations prompts concerns that many provisions do not adequately protect the residents of assisted living facilities. The participating organizations of the Pennsylvania Assisted Living Consumer Alliance (PALCA) will soon have a full draft of comments and other proposed regulations summary materials available on the PALCA website: www.paassistedlivingconsumeralliance.org. Interested persons should contact PALCA through the website or via ahalperin@phlp.org to get more involved.

PALCA is Seeking Assisted Living Stories

You have a story to tell. We want to hear it. Nothing is more valuable than your personal story. Real examples help regulators and lawmakers understand the need for concrete solutions. We want to hear about your personal experience with a family member or friend that involves an assisted living or personal care facility Pennsylvania. PALCA wants to know the issues and challenges associated with assisted living for older persons and persons with disabilities in Pennsylvania. Let us know if you, a friend, or a loved one:

- needed services that a facility was not equipped or willing to provide;
- were discharged for running out of money;
- were discharged for needing more care;
- were discharged for complaining about conditions;
- received poor quality care due to lack of staff or staff training;
- were unaware of their rights or afraid of exercising them;
- did not receive first aid, assistance in obtaining prescriptions or other healthcare, or assistance in securing transportation to medical appointments;
- were not provided with complete or accurate information about points at which the facility might ask them to leave; or
- have any other experience (good or bad) with an assisted living or personal care facility.

We value your privacy and will not use any stories without permission. Share your story with us at http://www.paassistedlivingconsumeralliance.org/index.php/tell-us-story.

PHLP's Philadelphia Office Has Moved!

PHLP's Philadelphia Office has the following new address. All phone numbers and emails will remain the same.

Pennsylvania Health Law Project
The Corn Exchange
123 Chestnut St., Suite 400
Philadelphia, PA 19106

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A Change in Leadership at PHLP

We are sad to announce that Michael Campbell has resigned as Executive Director of the PA Health Law Project to accept a teaching position at Villanova Law School. Mike has been the Executive Director of PHLP since 2003. Under his exceptional leadership, our budget has grown and our staff expanded, allowing us to now handle over 350 calls per month through our Helpline. Mike has been a dedicated and tireless advocate for low income families, persons with disabilities, and the elderly at the federal, state and local levels. Some of the highlights of Mike's work including fighting for policies that would: increase consumer access to publicly-funded health insurance programs, regulate and monitor hospital uncompensated care (a/k/a "charity care") programs, and track and address racial discrimination in nursing home admission policies and practices.

We will miss Mike's humor and wisdom as well as his enthusiastic commitment to PHLP's mission. Although we are sorry to lose Mike, we are glad he is being given the opportunity to teach and to mentor the next generation of public interest lawyers. Mike will be leaving PHLP at the end of July. PHLP's Board of Directors has announced that until a new permanent Director is hired, Leonardo Cuello, a staff attorney in our Philadelphia office, is appointed as Interim Director.

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