SENIOR HEALTH NEWS

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AmeriHealth 65 Medicare SNP Terminating At End of the Year

AmeriHealth 65, a Medicare Special Needs Plan (SNP) for dual eligibles in Berks, Lancaster, Lehigh, Northampton, and York Counties, will no longer offer coverage after the end of the year. The plan currently has approximately 4500 members, most of whom have Medicare and Medical Assistance. All members should have received a notice earlier this month to let them know that the plan's coverage will end December 31, 2008 and telling people about their options.

The letter consumers received from AmeriHealth 65 is 12 pages long, is not written in a consumer-friendly way, and includes information that is not relevant to the members of the AmeriHealth 65 SNP. The Centers for Medicare & Medicaid Services (CMS) and AmeriHealth 65 plan representatives told PHLP that CMS created the letter for plans across the nation that are terminating at the end of this year and that AmeriHealth 65 could not change this letter to better address their member population. The letter includes a listing of other Medicare Advantage Plans individuals can join; however, the letter does not include a list of the stand-alone Prescription Drug Plans that individuals can choose to join for coverage starting January 1, 2009.

Member Options

Because of all these factors, PHLP is concerned that consumers may not understand their choices and what they need to do in order to make sure they have drug coverage starting January 1, 2009. **Everyone should join a different plan by December 31, 2008**. AmeriHealth 65 members have several Medicare Part D options:

- They can return to Original Medicare and join a stand-alone drug plan (zero-premium plan for individuals with the full low-income subsidy or other stand-alone prescription drug plans available in 2009);
- They can join a different Medicare Special Needs Plan in their Area that covers prescription drugs; or
- They can join a Medicare Advantage Plan (managed care plan) that covers prescription drugs and is offered in the county in which they live.

Individuals who do not make a choice on their own may have a gap in their prescription coverage at the beginning of next year. **Only AmeriHealth 65 members who will be getting the low-income subsidy in 2009 who do not make a plan choice on their own will be auto-enrolled into a stand-alone Part D plan by CMS.** These individuals will receive a reassignment notice in early November on blue paper. This notice will tell individuals which

(Continued on Page 2)

(Continued from Page 1)

plan they will be put into for coverage starting January 1, 2009 if they do not make any other choice on their own. Remember, a consumer's choice trumps any auto-enrollment by Medicare. If an individual joins a plan on her own before the end of the year, then she should be enrolled in the plan of her choice for coverage starting January 1, 2009.

Other important information that AmeriHealth 65 members should know:

- AmeriHealth 65 members have a right to buy certain Medigap (Medicare Supplemental Insurance) policies (Plans A,B,C,F) for up to 63 days after the AmeriHealth 65 coverage ends. This means that AmeriHealth 65 members who buy a Medigap Plan A, B, C, or F by March 4, 2009 cannot be denied a policy, cannot be charged more because of their health status, and cannot have pre-existing condition exclusions imposed on them. ***Note***: This option is for those whose only insurance is Medicare. Since AmeriHealth 65 is a SNP for dual eligibles, most members have Medicare and Medical Assistance. The Medical Assistance is secondary coverage and covers the Medicare cost-sharing. Individuals with Medical Assistance do not generally need to have a Medigap policy.

- Individual with End-Stage Renal Disease (ESRD also called permanent kidney failure) who are members of AmeriHealth 65 qualify for a one-time right to join a new Medicare Advantage plan (including a Medicare Special Needs Plan). Generally, individuals with ESRD cannot join Medicare Advantage plans; however, because AmeriHealth 65 is terminating, members with ESRD qualify for a special right to join a Medicare Advantage Plan.

AmeriHealth 65 members who have questions or need additional assistance with their 2009 plan choices are encouraged to call our HELPLINE at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

CMS Announces 2009 Medicare Costs

The Center for Medicare & Medicaid Services (CMS) recently announced the changes to Medicare premiums, deductibles and co-pays that will go into effect January 1, 2009.

Medicare Part A

Part A covers inpatient hospital care, care in a skilled nursing facility (up to 100 days), some home health care, and hospice services. In 2008, the Part A hospital deductible will be $1,068 (up from $1,024 in 2008). If someone is in the hospital longer than 60 days, their cost-sharing in 2009 will be:

- $267/day for days 61-90 (up from $256/day in 2008)
- $534/day for days >90 (up from $512/day in 2008)
- Medicare beneficiaries who are in a skilled nursing facility for more than 20 days in 2009 will pay $133.50/day for days 21 through 100 (compared to $128 in 2008).

Medicare Part B

Part B covers physician's services, outpatient hospital services, ambulance services, durable medical equipment and some home health services. The standard Part B monthly premium will

(Continued on Page 3)

(Continued from Page 2)

not increase in 2009 and will remain at $96.40 as it is in 2008. Single individuals with income over $85,000/year and married couples with income over $170,000/year will pay a higher premium for Part B depending on their income. The Part B annual deductible will also remain the same as it is in 2008-$135.

Medicare Part D

Part D costs differ from Plan to Plan. Stand-alone Part D Plan monthly premiums in 2009 range from $13.70 to $108 per month. The "benchmark premium" for Part D plans in Pennsylvania is $29.23. In addition to their Plan's premium, consumers who do not qualify for a Low Income Subsidy will pay the following costs for a Standard Part D Plan in 2008:

- An annual deductible of **$295** (up from $275 in 2008);
- During the initial coverage period consumers pay a 25% co-pay for each medication until total drug costs reach **$2700** ($2510 in 2008);
- During the coverage gap (referred to as the "donut hole") consumers pay 100% of their drug costs until their total out-of-pocket expenses reach **$4350** ($4050 in 2008); and
- During the catastrophic coverage period, consumers will pay co-pays for their medications of either $2.40/generics or $6.00/brand names, or a 5% co-pay, *whichever is greater* (the co-pays in 2008 were $2.25/$5.60).

More information about the costs of Medicare coverage in 2009 can be found in the Medicare & You 2009 Handbook.

Do you currently get the Senior Health Law News through the mail? Please consider switching to e-mail!!

Contact staff@phlp.org to change the way you get the Senior Health News!

Medicare Expected to Reassign Thousands in PA to Part D Plans

This Fall, Medicare will be reassigning certain people who qualify for the Low-Income Subsidy (LIS) to new Medicare Prescription Drug Plans effective January 1, 2009. Medicare does this to protect certain low-income beneficiaries who are currently in Plans that either will no longer participate in Medicare next year or that will no longer be "zero-premium plans" in 2009. As a reminder, "zero-premium plans" are standard Part D Plans whose monthly premium is at or below the benchmark premium ($29.23 in 2009). If a person with a full LIS joins one of these plans, they will have no premium, no deductible or donut hole, and will only pay small co-pays for their Part D medications.

Because the number of zero-premium plans available to Pennsylvanians is going from 18 plans in 2008 to 9 plans in 2009, the result will be the reassignment of thousands of persons who had initially been assigned by Medicare to one of those plans that will no longer be zero premium next year. Please see our website for a list of 2009 zero-premium plans (www.phlp.org).

Medicare will reassign Medicare beneficiaries who fall into one of two groups:

1) Those who qualify for an LIS in 2009 and who are now enrolled in a Part D Plan that is leaving the Medicare program effective December 31, 2008.

2) Those who:
   a. qualified for an LIS in 2008 and who will continue to qualify in 2009; and
   b. who are now in a Part D Plan to which Medicare enrolled them through the auto-enrollment or facilitated enrollment process; and
   c. whose current Part D plan will no longer be a zero-premium plan in 2009.

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Medicare will send a reassignment notice out to beneficiaries on Blue paper in early November. The notice will inform the person that they will be reassigned to a new Part D Plan (and they will be given the name of the new Plan) effective January 1, 2009 unless the person joins a different plan on their own by December 31, 2008. Medicare beneficiaries are encouraged to check whether the plan they are being reassigned to will cover all their medications and allow them to continue to use their pharmacy of choice. If not, consumers should choose and enroll into a different zero-premium plan that will better meet their needs.

For questions about the reassignment process or about choosing among the zero premium plans available, call PHLP's Helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY).

Please note: Individuals with the full LIS who joined a zero-premium plan on their own will receive a notice on Tan paper if their plan will no longer be zero-premium in 2009. A list of the 2009 zero-premium plans will be included with the letter. These individuals need to join one of the new zero-premium plans by December 31, 2008 or they will begin paying a portion of their plan's premium in January. Enrolling in a Part D plan by early December will help ensure that the application is fully processed and coverage is in place by January 1, 2009. If people wait until the end of the month to enroll, their coverage may not be in place if they need it in early January.

Redetermining Eligibility for the Low Income Subsidy

Every year Medicare redetermines whether Medicare beneficiaries who currently qualify for the Low Income Subsidy (LIS) will continue to qualify for the next calendar year. That process is now underway for 2009.

LIS Applicants

Many Medicare beneficiaries receive the LIS because they applied and were found eligible for a full or a partial LIS. Every year, the federal government selects a certain number of these consumers for review to make sure that they continue to be eligible for the LIS. A Redetermination letter was sent to the selected individuals in late August that included an Income/Resources Summary Sheet and an LIS Form. The Form had to be completed and returned to the Social Security Administration within 30 days or the person's LIS may be terminated.

If SSA decides that the consumer remains eligible for the LIS, their LIS will simply continue throughout calendar year 2009. No confirming notice is sent to the consumer. If SSA decides that the person is no longer eligible for the LIS, or that the LIS must change (the person will go from a full to a partial subsidy, for example), the consumer is sent a written notice of the determination and told how they can appeal the decision if they disagree.

Dual Eligibles

Dual eligibles (those on Medicare who receive any help from Medical Assistance) automatically receive the full LIS and do not need to apply for it. CMS has already reviewed dual eligible data files sent in by the states in July and August to determine who will continue to automatically qualify for the LIS in 2009. If a consumer who had been dual eligible in the past was not in PA's files during those months, CMS sent the consumer a letter in September

(Continued on Page 5)

(Continued from Page 4)

telling them they no longer automatically qualify for an LIS as of 12/31/08. These notices were printed on Grey paper. Enclosed with the letter was an LIS application. The consumer can complete the application and mail it in to see if they will financially qualify for an LIS in 2009. Individuals can also apply for the LIS online at http://www.ssa.gov/prescriptionhelp/. Keep in mind that if the consumer goes back onto MA before the end of the year, they will again automatically qualify for a full LIS that will last throughout 2009.

If a consumer who had been a dual eligible in the past was in PA's files during these months, CMS automatically renewed the LIS for 2009. The consumer will not receive any written notice of this renewal unless their co-pay level will change in 2009 (for example, he will be going from $1.05/$3.10 co-pays to $2.40/$6). The change in co-pay level notices are printed on Orange paper.

Fall Mailings to Medicare Beneficiaries

Now is the time of year when Medicare beneficiaries receive lots of mail about Medicare in 2009. In addition to the various notices mentioned elsewhere in this newsletter, we wanted to remind folks about important mailings consumers receive in the fall.

Annual Notice of Change-every plan must send current members information about how the plan will be changing in 2009 (i.e., formulary changes, benefit changes, cost changes). Beneficiaries should receive this information from their current plan by October 31, 2008. Individuals should review this information to find out if the plan will continue to be affordable as well as continue to cover their drugs and allow them to go to their pharmacy. If an individual is enrolled in a Medicare Advantage plan, she should also check to be sure her doctors and other healthcare providers will continue to be in the plan's network. Individuals can decide to stay in their plan or change plans by the end of the year. Individuals who qualify for the LIS should receive additional information from their plan about how the LIS will help with their Part D costs in 2009.

Medicare & You 2009 Handbook-All Medicare beneficiaries receive this book in October. This is a thick booklet that includes information about Medicare benefits and about all the plan options available in PA in 2009.

Notice of Creditable Coverage-Individuals who receive prescription drug coverage through an employer/union or other group should receive information from the plan about whether the prescription coverage they get is creditable to Part D or not. This information should be sent in October to make sure individuals have the information before the start of the Open Enrollment Period on November 15, 2008. Individuals who continue to have creditable coverage do not need to enroll in Part D and they can join Part D within 2 months after they involuntary lose the creditable coverage without penalty. However, individuals whose coverage will no longer be creditable in 2009 need to join Part D during the Open Enrollment Period to avoid a penalty.

Please call our HELPLINE if you have any questions about mailings to Medicare beneficiaries or if you need assistance with your Part D plan options in 2009-1-800-274-3258 (voice) and 1-866-236-6310 (TTY).

PACE and Medicare Part D-2009

As if letters from Medicare, Social Security and Part D plans were not enough, Medicare beneficiaries who are in PACE/PACENET are also receiving letters from that program this Fall addressing the Part D Open Enrollment Period. Every year, the PACE/PACENET program partners with a number of Part D plans and will auto-enroll certain members who do not have Part D coverage into one of their "partner" plans. PACE/PACENET recently announced their 2009 partner plans. There are still 5 partner plans with the only difference being that Silver Script is no longer a partner plan and First Health Premier becomes a partner plan. PACE/PACENET is currently sending out notices to the members it plans to auto-enroll, identifying the partner plan they will be enrolled in for 2009. If the consumer does not want to be enrolled in any Part D Plan, or prefers a different plan than the one PACE/PACENET chose, he should call the PACE/PACENET Program by the date specified in the letter and make their wishes known. If the person does not respond to the letter, PACE/PACENET will proceed and auto-enroll the person into the specified partner Part D plan effective 1/1/09.

People who had been auto-enrolled into a Part D Plan by PACE/PACENET in the past will also receive notices. The Program is currently sending out letters to these members telling them whether PACE/PACENET recommends that they stay in the same partner plan next year, or whether PACE/PACENET intends to auto-enroll them into a different Partner Plan for 2009. These individuals should contact PACE/PACENET by the date specified in the letter if they want to decline the auto-enrollment or choose a different plan.

Keep in mind that PACE/PACENET uses an "intelligent assignment" process which means it reviews the medications consumers take, and the pharmacy(ies) they prefer and auto-enrolls members into the partner plan that will best meet their needs. Also keep in mind that PACE and PACENET are "creditable" coverage (prescription coverage as good as or better than Part D) which means that members can choose not to enroll into Part D when it is offered and that they will not pay a delayed enrollment penalty should they lose PACE/PACENET and decide to enroll into a Part D plan at a later date. For more information on PACE/PACENET auto-enrollment and how PACE/PACENET coverage work together, go to the Department of Aging website at www.aging.state.pa.us.

Are you an advocate or provider working with dual eligible clients over 60 years old in Southeastern PA who wants to stay up to date on Part D developments? Join the PHLP e-mail list serve! To join, e-mail staff@phlp.org with subject "join Part D list serve".

PHLP staff are also available in SE PA to conduct trainings on Part D related issues to help social service agencies and their dual eligible clients navigate their healthcare coverage. Trainings focus on eligibility for Medicare Savings Programs and the Low-Income Subsidy, healthcare access for dual eligibles, rights of dual eligibles under Part D, and the appeals and grievance processes. Contact the PHLP Helpline to schedule a training at 1-800-274-3258 or 1-866-236-6310/TTY.

Please feel free to copy and post or distribute this announcement.

PHLP Pennsylvania Health Law Project

Medicare Part D: 2009

Update on Recent Changes and Enrollment Information

These trainings will discuss: 2009 Plan Choices, Enrollment Information and Updates, Subsidy Redetermination Processes, and Medicare Developments

Call The Pennsylvania Health Law Project
Help-Line to Sign Up —1-800-274-3258 or 1-866-236-6310/TTY

November 3, 2008-10am-12pm
Bucks County Free Library, Pennwood Branch*
301 S. Pine St. (Rt. 13 and Flowers Ave.)
Langhorne, PA 19047-2887

November 7, 2008-11am-12pm
Benjamin H. Wilson Senior Center
580 Delmont Ave.
Warminster, PA 18974

November 13, 2008-12pm-1:30pm
Levittown Regional Library*
7311 New Falls Road
Levittown, PA 19055-1006

November 19, 2008-11-12:30pm
Southwest Senior Center
6916 Elmwood Ave.
Philadelphia, PA 19142

December 3, 2008-12:30-2pm
Senior Adult Activities Center of Montgomery County
536 George Street
Norristown, PA 19401

*The Bucks County Free Library does not endorse or advocate the views of any group using its Meeting and Conference Rooms

SPANISH LANGUAGE PRESENTATION
December 4, 2008 10:30-12pm
Lillian Marrero Library
601 W. Lehigh Ave.
Philadelphia, PA 19133

RSVP to our Helpline or through E-mail: sgupta@phlp.org

Visit us online at www.phlp.org!!

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Call The Pennsylvania Health Law Project
Help-Line to Sign Up —1-800-274-3258 or 1-866-236-6310/TTY

November 7, 2008-9:00-10:30 am
Carnegie Library of Pittsburgh
612 Smithfield St.
Pittsburgh, PA 15222

November 10, 2008-9:00-10:30 am
Westmoreland County Area Agency on Aging
200 S. Main St.
Greensburg, PA 15601

November 12, 2008-1:00-2:30 pm
Monessen Public Library
326 Donner Ave,.
Monessen, PA 15062

November 18, 2008-9:00-10:30 am
Butler Area Public Library
218 N. McKean St.
Butler, PA 16001

November 20, 2008-9:00-10:30 am
Monroeville Public Library
4000 Gateway Campus Boulevard
Monroeville, PA 15146

RSVP to our Helpline or through E-mail: fchervenak@phlp.org

Visit us online at www.phlp.org!!

Assisted Living Final Form Regulations Delayed until 2009

The Department of Public Welfare recently announced that it will not be submitting final-form regulations for state approval by the original deadline of November 30th, but instead will delay this until early 2009. The Department cited the large volume of comments to the proposed regulations received from various stakeholders and the Department's desire to consider and respond to the comments as the main reason for the delay. It is not yet known whether the regulations will take effect on July 1, 2009 as originally intended.

Legislators need to continue to hear from consumers, family members, and advocates about the importance of training for staff, requiring facilities to be accessible to wheelchair and walker users, requiring facilities to meet fire safety standards, the need for consumer rights and appeals processes, and more. Legislative support will be necessary when the final regulations are released.

The PA Assisted Living Consumer Alliance (PALCA) continues to collect stories from consumers and family members through their website at http://www.paassistedlivingconsumeralliance.org/. Individuals are encouraged to share all stories (good and bad) about residing in a personal care home or assisted living residence.

The following story was told by a woman whose Mother currently resides in an assisted living residence. This information was originally presented as testimony before the House Aging and Older Adult Services Committee on the Department's Proposed Assisted Living Regulations. What appears below is an excerpt of the testimony given; we have left out some information from the original testimony due to space constraints but we have not otherwise changed the content.

> *My name is Barbara R. I am the daughter of a resident of Sunrise Assisted Living at Haverford located in an affluent Main Line area outside of Philadelphia. My mother has been a resident at the Sunrise of Haverford for more than three years. Over that time, we have had ongoing problems with Sunrise; issues with care not being provided, staff not being trained, management being aloof and disinterested in our concerns, and conditions in the facility being disgusting. I write to share my experience in the hopes that it will support the need for adequate standards to ensure that consumers of all income levels are prevented from ever having to experience what we have.*
>
> *It is important to note that not only are we paying Sunrise to provide my mother with care, my family has also had to hire private outside aides in order to guarantee that my mother will receive the services she needs.*
>
> *Now, let me describe my mother and her care needs. My mother is 88 years old. She has dementia however, she is able to dress, bathe and feed herself! She is very social and interacts well with staff and residents. We have been paying private outside aides to 1) wake my mother up in the morning, 2) accompany her on walks so she can stay active, 3) do my mother's laundry and 4) clean her room. All four of*

(Continued on Page 10)

(Continued from Page 9)

these services are things that we already pay Sunrise to provide. We cannot afford to keep the aides but when we have tried to reduce their hours my mother falls back into the cycle of not waking up in the morning, missing breakfast, becoming agitated and disoriented. So far, Sunrise is not stepping up to do their job. And, ironically, there are regular errors in billing charges for services my mother does not receive.

A large group of different residents' family members have been complaining about a broad range of problems to the local directors up to corporate. It has taken a lot of screaming and we have gotten mostly lip service. We are very frustrated and seeing little improvements. Problems include cleanliness, nutrition, understaffed, some staff unqualified, not receiving services, inaccessibility to outdoor walking or van travel, poor communication, billing, pain management, etc.

With regard to the care managers, it must be noted that there are many wonderful care managers at the Sunrise of Haverford. They are caring and hard working. Unfortunately, they are understaffed and overworked. And we have just been told that workers hours have been recently reduced.

The care managers have too many responsibilities. They are responsible for giving medications, serving in the dining room and caring for residents. Their duties are stretched thin. During meals it can be very difficult to find someone outside the dining room. When the directors are absent which seems too often, the lead care manager is in charge of the director's job.

Furniture in the commons areas are soiled with urine and maybe worse. Residents can be found with dirty clothing. The same care managers serving food are expected to change a soiled resident and then return to their dining room duties! How can that pass health code??

My mother was barely over 100 lbs for her entire adult life until she arrived at Sunrise. She has gained 30 pounds from a combination of poor nutrition and lack of exercise. The food is salty, fried, high fat, large dessert portions and usually unappetizing. The new director told me there is a nutritionist in charge of their menu, which I find difficult to believe. We were told up until recently that they couldn't serve egg-beaters! Their choices of foods they serve to an elderly population are baffling.

For the past few years the residents have sat all day and slept. The single improvement is in the activities. It went from zero to a new activity director trying very hard. But, when she isn't there very little to nothing happens, the van's wheelchair lift is broken and the residents have been without activities for so long it is hard to get a lot of them involved. The new activity director is trying to get them active but one person cannot do the job alone especially after conditioning them to be so sedentary. There is no outside patio area that the residents can walk or wheel around other than the porch where they go from sitting inside to sitting outside. Some days you can find residents left inside to sit even when the weather is beautiful. There is a

(Continued on Page 11)

(Continued from Page 10)

walkway that goes around the building. My mother who is a good walker cannot walk this alone as the walkway is not level and is impossible for a wheelchair. Without the private companion or family member there is no one to walk with. Once outside on the porch, residents are routinely not checked on, asked if they need to use the bathroom or are cold.

There has been no handicap accessible van for years. A new van has been in the parking lot for months. There are finally tags for it. Now they are waiting for corporate to send a check to file the tags. So still no handicap accessible vehicle available. Crazy. How hard is that?

How would such an understaffed night shift get three floors of residents out for a fire? No nurse on duty for extended times? The list goes on.

Considering such a large number of family members have complained loudly for a long time, you would think the new directors would be there more, have their shifts covered when gone for a week's time and have contact numbers. Over the course of several months, many of us have complained to the past executive director, to her supervisor, then the supervisor's boss, to the Vice President of East Coast Operations, Human Resources and directly to Corporate. The new executive director has promised changes and asks for patience. It is very frustrating.

Here's the big question - why are we still there? We chose this Sunrise because it's location to family and the facility is small enough that my mother who has dementia can find her way around. We also chose Sunrise because it is a national assisted living chain and it promised us it could meet my mother's needs. Why should we subject my mother to the trauma of relocating? We unmistakably believe that Sunrise should make the needed improvements and provide the quality of care we are all paying for and that the residents deserve. As a consumer, there is no question in my mind that the standards need to be raised for how care is provided in these Assisted Living facilities. There must be better trained staff and more of them. They need to be held to provide the services consumers need, even if it isn't easy. They need to be required to keep the facility clean and the residents engaged and stimulated. We have been told that because Sunrise is a for-profit facility that there is little oversight and leaves us with little more to do than keep complaining.

Initially, most of us were afraid of repercussions just from complaining to management. Many people still are. The proposed regulations permitting facilities to evict residents and giving the residents no recourse or appeal rights would be a disastrous problem and keep the majority of people from complaining. My mother still uses her own doctors she has seen for years prior to arriving there. I don't understand the state regulation that would eliminate that choice.

I urge the state to make necessary additions to the proposed regulations and I urge the legislature to support nothing but improvements to a system that can permit all this to happen in one facility.

REMINDER—Earlier this month, we e-mailed the Senior Health Newsletter mailing list a notice about the Public Input meetings being held across the state this Fall by the Senior Care and Services Commission. The purpose of the sessions is to receive comments about current long-term care, services, and resources for Pennsylvanians 65 and older, as well as to seek input about meeting the long-term care needs of older adults in the future.

The two remaining meetings are:

- **Wednesday, October 29, 2008 from 9:00 am to noon at the Center in the Park, 5818 Germantown Avenue, Philadelphia, PA.**

- **Wednesday, November 5, 2008 from 9:00 am to noon at Luzerne County Community College, Educational Conference Center, Building #10-Auditorium, 1333 S. Prospect Street, Nanticoke, PA 18634**

Individuals who wish to attend and those who wish to comment should notify the Office of Long-Term Living by e-mail or by phone (see below).

If you have been unable to attend the meetings, but you would like to submit comments, the Office of Long-Term Living will be accepting comments through **November 14, 2008.** Comments can be submitted via e-mail at RA-LTL-Commission@state.pa.us, via US mail at P.O. Box 2675, Attn: OLTL POLICY, Harrisburg, PA 17105, or by phone at (717)705-3705. Consumers and groups working on behalf of consumers are encouraged to submit their comments and recommendations to ensure that the consumer voice is heard!

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