Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

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Governor Rendell Announces Plan to Provide Health Care Coverage for All Pennsylvanians

On January 17, 2007, Governor Rendell announced his "Prescription for Pennsylvania: Right State. Right Plan. Right Now." At a briefing at the Governor's Residence in Harrisburg on January 17th, PHLP learned the following:

The Prescription for Pennsylvania is a two pronged plan to address the drastically increasing healthcare costs impacting the Pennsylvania economy (such as the 75.6% increase in healthcare premiums over the past 6 years versus a 13.3% increase in median wages) and to address the problem faced by Pennsylvania's 900,000 uninsured turning to emergency rooms for care that would have been far less costly if delivered before their conditions worsened.

The first prong of the plan is an array of steps designed at driving down health care costs in

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Philadelphia MATP Update

On Dec. 1, 2006, Logisticare assumed its role as the Medical Assistance Transportation Program (MATP) contractor for Philadelphia County. Logisticare is required by its contract to have a local Advisory Committee that it reports to on a regular basis and that identifies problems and raises issues of concern to the community. On December 15, 2006, the MATP Advisory Committee met at the Philadelphia County Assistance Office headquarters. Among the issues and problems discussed were the following:

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Medicare Adds New Special Election Periods in 2007 to Allow Certain Individuals to Change Their Part D Plan

The second year of the Medicare Prescription Drug Benefit (Part D) started January 1, 2007. Anyone who had a Part D plan in 2006 had from November 15, 2006 through December 31, 2006 to change their plan for 2007. If an individual made a change during this period, their new plan should have started on January 1, 2007. Generally, individuals are now "locked" into their Part D plan for all of 2007 and cannot change plans during the year. Individuals can only change plans during the year if they qualify for a Special Election Period.

There are a number of different Special Election Periods (SEPs) that individuals may qualify for depending on their situation. Here are some examples of Special Election Periods allowing individuals to change their plan outside of standard enrollment periods:

- If someone has both Medicare and Medical Assistance, they automatically qualify for a Special Election Period and can change their Part D plan at any time during the year.
- If an individual enters or leaves a nursing home, they qualify for a Special Election Period to change their Part D plan.
- If an individual moves out of their plan's service area or moves to an area where there are new plan options, they qualify for a Special Election Period to change Part D plans.

Individuals who want to find out if they qualify for a Special Election Period to change their Part D plan can contact 1-800-MEDICARE (1-800-633-4227 or 1-

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Behavioral HealthChoices Expands to the 23 North/ Central State Option Counties

As reported in our July 2006 Newsletter, DPW is continuing as scheduled with the rollout of the HealthChoices Behavioral Health (BH) Program throughout the remainder of the state. Beginning January 1, 2007, the 23 NorthCentral State Option Counties implemented the Behavioral HealthChoices Program. The 23 North/Central State Option Counties include: Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntington, Jefferson, Juniata, McKean, Mifflin, Montour, Northumberland, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren and Wayne.

This means all persons on Medical Assistance (MA) in these counties now receive behavioral health services through a managed care plan, Community Care Behavioral Health Organization (CCBHO). Those mental health and drug & alcohol services requiring prior authorization must now be approved by CCBH. Members must receive services from providers in the network of CCBH unless otherwise approved. Members will have 90 days to transition to an in-network provider.

There are more services available under HealthChoices Behavioral Health than are covered under the MA-FFS system. Mental health services covered in MA-FFS include: outpatient services, partial hospitalization, inpatient hospitalization, intensive case management and resource coordination, as well as residential treatment services, family based mental health services and behavioral health rehabilitative services for kids under 21. In addition, HealthChoices covers: crisis ser-

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DPW Updates *Consumer's Guide to Health-Choices Plans*

DPW has recently issued its most recent version of its "A Consumer's Guide to the Health Choices Health Plans" document. This guide provides consumers with a wide range of criteria on which plans are rated based on consumer satisfaction and measurable outcomes. It is an excellent way for new and current HealthChoices enrollees to evaluate the plan options in their region. The guide allows consumers to compare plans on topics such as "Satisfaction with Plan", "Seeing a Specialist", "Regular Prenatal Care", and many other topics.

The MAAC Consumer Subcommittee has worked with DPW to help develop the guide and make it focus on information that is important to consumers.

This new Consumer Guide is available at: http://www.dpw.state.pa.us/Resources/Documents/Pdf/Publications/HealthChoices/OmapProfile-English.pdf

Consumers can also contact PHLP at 1-800-274-3258 for a copy or to suggest recommendations to the Subcommittee for future versions of the Consumer Guide. ✸

Do you currently get the Health Law PA News through the mail? Would you like to get this newsletter by e-mail? If so, contact Jennifer Nix at jnix@phlp.org to change the way you get the Health Law PA News!

Help for Medicare Rx consumers

With the beginning of Year 2 of the Medicare Prescription Drug Plan, many expected problems for dual eligibles and other consumers in getting medications. Fortunately, there has so far been far fewer problems with the Medicare Prescription drug plan than anticipated. However, in anticipation of possible dual eligible problems throughout the year, below are several scenarios and some possible solutions.

Example: A dual eligible consumer's Medicare Rx plan has started charging her a premium (i.e. is no longer a zero premium plan) or has dropped her.

Dual eligible individuals are able to enroll in one of 20 stand-alone Part D plans that will not charge them any monthly premium in 2007. These plans are called zero premium plans. But, some plans that were zero premium in 2006 are either 1) no longer offering coverage in 2007 or 2) no longer zero premium in 2007.

Dual eligibles who are currently enrolled in a plan that is increasing its premium or dropping out of the program should have received information from the plan telling them about the changes. They may have also received a notice from Medicare. If Medicare initially enrolled a dual eligible into a plan that is increasing their premium or dropping out of the program, Medicare will auto-enroll the dual eligible to a different zero-premium plan for coverage starting January 1, 2007 unless the dual eligible makes a different choice by the end of the year. This process is called reassignment and the notices Medicare sent out about this

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Bank fees as MA Deduction

Reminder! Consumers can deduct reasonable bank fees and transportation costs from their unearned income when applying or during re-determination for Medical Assistance and Medicare Part B Buy In programs.

Bank fees include but are not limited to:

- Costs of standard checks,
- Annual ATM fees,
- Minimum balance fees,
- ATM withdrawal fees, and
- Per check fees.

Transportation costs include the actual roundtrip cost of the bus, subway, paratransit, taxi or the cost of using the automobile of another individual (i.e if the driver charges you a flat fee) to get to the bank/ ATM. If a consumer uses his own vehicle, the deduction is 44.5 cents per mile roundtrip. If a consumer incurs annual bank fees or purchases checks, then the expenses should be divided by 12. This amount will be deducted from the monthly unearned income in addition to the other monthly costs. Receipts and bank statements should be submitted to the County Assistance Office to verify these costs. For reoccurring costs, just submit one month of receipts. For annual fees, submit one copy and indicate that the amount is for the full year.

If a caseworker is not aware of these deductions, print out a copy of the Ops Memo and give to the caseworker. The Ops memo is available at: http://www.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ops/ops-04-09-01.htm ✸

(Continued from page 2- Behavioral Health Choices)

vices and clozapine services. Drug & alcohol services covered in MA-FFS include: outpatient, hospital detoxification, hospital rehabilitation, and methadone maintenance. In addition, HealthChoices covers: intensive outpatient, partial hospitalization, halfway house, non-hospital detoxification and non-hospital rehabilitation. Members must be provided a choice of at least 2 providers for each in-plan ambulatory service within 30 minutes travel time in urban areas and within 60 minutes travel time in rural areas. Access standards for inpatient and residential services is at least two providers for each in-plan service, one of which must be within 30 minutes travel time in urban areas and within 60 minutes travel time in rural areas.

CCBHO's provider network must be able to provide face-to-face treatment intervention within one hour for emergencies, within 24 hours for urgent situations, and within seven days for routine and specialty referrals.

Access to services from the Medical Assistance Transportation Program (MATP) is also improved for MA recipients in HealthChoices. In the MA-FFS system, MATP is only required to provide transportation or reimbursement for transportation to the closest MA provider. In HealthChoices-BH, MATP is required to provide transportation or reimbursement for transportation to any network provider no matter the distance.

HealthChoices members in the 23 county area who have questions or concerns regarding mental health or drug & alcohol services should contact the CCBHO Member Services Line at 1-866-878-6046. If you or someone you are working with is having a problem accessing mental health or drug & alcohol services, please the PHLP Helpline at 1-800-274-3258 (ph)/ 1-866-236-6310

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877-486-2048 TTY).

Special Election Periods in 2007

The Center for Medicare & Medicaid Services has created new Special Election Periods that are in place for 2007. These new SEPs are described below:

SEP for individuals who received their Annual Notice of Change Document (ANOC) from their Part D plan after November 15, 2006: Medicare requires that prescription drug plans and Medicare Advantage plans send information to individuals every year that explain how the plan's benefits and costs will be changing the following year. This information is supposed to be received by beneficiaries by October 31st of each year. Some plan sponsors did not get this information out in a timely manner in 2006. Therefore, Medicare created this Special Election Period for individuals who did not receive the ANOC information from their plan until after November 15, 2006. Individuals who qualify for this SEP will have one opportunity to change Part D plans by February 14, 2007 with the new coverage starting the first of the month after the change is made.

SEP for individuals who no longer automatically qualify for the low-income subsidy in 2007: Individuals who have both Medicare and Medical Assistance automatically qualify for the low-income subsidy. Individuals who lost their Medical Assistance during 2006 may no longer automatically qualify for the subsidy for 2007. These individuals were supposed to have received a notice from Medicare in November of 2006 telling them about the change and encouraging them to apply for the subsidy through the Social Security Administration. Individuals who were automatically eligible for the LIS in 2006 but who are no longer automatically eligible for the LIS in 2007 will have an extra 90 days to change plans (until March 31, 2007). This should only impact folks who lost their dual eligible status before June or July 2006 and have not gone back on MA since then.

SEP For Individuals Who Qualify for the Low-Income Subsidy: Individuals with limited income and assets who do not get Medical Assistance but were approved for the low-income subsidy for Part D qualify for a SEP allowing them one opportunity to change plans through the end of 2007.

If an individual wants to change their Plan using one of these Special Election Periods, they should contact the new plan they wish to join and tell them about the Special Election Period that applies to them. Individuals can also call 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048 TTY) to change plans under the Special Election Periods described above.

Other Important Enrollment Information

In late 2006, CMS added a Special Election Period for full dual eligibles (individuals with both Medicare and Medical Assistance) who enroll in a Part D plan before Medicare auto-enrolls them. These individuals can request that their plan make their enrollment retroactive to the first day of the previous un-covered month(s) (back to the first day of the month when the individual became a dual eligible).

Here's an example of when this Special Election Period may help a dual eligible individual: An individual who has been receiving Medical Assistance be-

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* Dialysis social workers requested that Logisticare honor its commitment to provide a monthly transpass to dialysis patients who use public transportation. The workers noted that their patients attend dialysis 13 times/month and oftentimes have other medical appointments. They argued that a monthly pass is a cost-effective way to address the medical transportation needs of this population.

A recommendation was made by Committee members that Logisticare provide taxi cabs for dialysis patients and other consumers on weekends since only one van provider is contracted to provide this transportation and consumers have complained that the van provider is often late or does not show up. Dialysis workers noted that The van companies are coming extremely late for return rides-with some drivers as much as 2-3 hours late. The dialysis social workers also reported that these late vandrivers sometimes try to get dialysis staff to sign off on the log verifying that the drivers came to pick up consumers even if the consumer already found alternate means of transportation.

* MATP consumers who cannot get to the curb and who need door to door transportation have had problems in the past with getting their needs met through MATP. Logisticare reported to the Committee that it will transport consumers door to door up as long as there are no more than 10 steps to navigate. Consumers just need to let the call center staff know how many steps they have and if they need assistance. If consumers with 10 or less steps are denied a ride, they should ask for a supervisor or file a complaint with Logisticare. Logisticare has a van provider who has been designated to transport these clients. Consumers with more than 10 steps will not be transported by Logisticare and will need to contact Medical Assistance (either their MCO or DPW) to obtain transportation. DPW stated that a policy is being developed regarding door to door transportation and the steps issue, and they will share it soon and post it on their website. (Ed. Note: **Persons denied door to door coverage because they have more than 10 steps should consult an attorney.**)

A recommendation was made by Committee members again for an automated system to check the status of the rides to prevent misunderstandings of the pick up time. It was noted that consumers are not getting calls the night/day before their medical appointment confirming what time the MATP provider will be coming to pick them up as outlined in the Logisticare brochure. There was an objection to have calls made to everyone and after some discussion the consensus was that everyone who DOES NOT have a standing order will get a confirmation ride. Currently, Logisticare can only schedule standing orders for consumers who go to an appointment to the same location at least once a week because of the way its computer system is set up. Consumers who have an appointment at the same time every other week must call in once a week to schedule a ride. Logisticare and DPW will look into whether this system can be changed.

* Logisticare has 5 facility representatives and one Health Care manager designated to cover 300 facilities. Some facilities serve mainly public transit users, so those facilities would contact public transit reps. Logisticare does not have a facilities manual and they will be working with DPW to get that out.

* Committee members raised the issue that MATP drivers are showing up to facilities without uniforms or any type of ID. Consumers are afraid to go with these drivers because they do not know where they will be

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the Commonwealth**.** The Governors Office of Health Care Reform has identified numerous areas where it says unnecessary healthcare dollars are being spent, and savings can be achieved.

A. **Reducing Unnecessary Emergency Room Use.** Tremendous dollars are spent on this most costly care, often when the needs of the patient require urgent but not emergent care. As part of the Prescription for Pennsylvania, the Governor would require every hospital to have a non-emergent care center open for 24 hours a day to complement the emergency room and improve efficiencies. The urgent care center would be staffed by nurse practitioners for half the cost. Pennsylvanians use the emergency room 11% more than the national average. Similarly, financial incentives would be created for medical practices to maintain weekend and evening hours for patients with urgent but not emergent problems to deliver care but avoid the costly and unnecessary emergency room visit.
B. **Increasing Disease Prevention and Management.** The Governor proposes incentivizing or requiring insurers to engage in greater disease management to reduce the unnecessary hospitalizations of individuals with chronic disease. The adoption of the "wagner model" of chronic care management would be implemented with a projected savings in the millions.
C. **Reducing Hospital Acquired Infections.** Because large sums are spent on unnecessary readmissions or extensions of hospital stays as a result of Hospital Acquired Infections (an additional $150,000 cost per stay), the plan would work to require reductions and, eventually, impose financial penalties for failures to reduce Hospital Acquired Infection rates.
D. **Maximizing Healthcare Professionals Scope of Practice.** Another area for cost-savings proposed includes maximizing the practices of nurse practitioners, pharmacists, and other healthcare professionals so that the scope of practice takes advantage of the full range of skills and training these professionals have had.
E. **Encouraging workforce development and healthcare access in underserved areas.** Money would be spent to facilitate development or expansion of FQHCs or nurse managed health centers in underserved areas. Money would be used to provide loan forgiveness to healthcare professionals as well.
F. **Paying Insurers and Providers for performance.** The plan would undertake payment shifts to hinge payment levels on quality of care.
G. **Insuring quality of care.** The plan would require all hospitals to have quality management and error reduction systems as a condition of state licensure.
H. **Communicating Healthcare Costs.** The plan would call for transparency in pricing of pharmaceuticals – so that pharmacists would publish their price to consumers.
I. **Reducing health insurance premiums.** Coupled with the steps in the second prong of the plan, the Prescription for Pennsylvania would require that insurance premium rates be devised without reference to certain demographic characteristics, and for small businesses, insurers would have to spend at least 85% of premiums to pay for health care.
J. **Making Pennsylvania SMOKEFREE.** The plan would prohibit smoking in all workplaces, restaurants, and bars to improve overall health and reduce second hand smoking deaths.
K. **Improving wellness.** The plan would incentivize reduced healthcare costs based on achieving wellness goals. Additionally, public education curricula would be revised to include wellness education and public

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school breakfasts and snacks would be revamped to include more nutritious foods.

The second prong or part of the Prescription for Pennsylvania is the Cover All Pennsylvanians or "CAP" program. The Governor framed that as an expansion to adults of the new Cover All Kids program and explained CAP as relying on the same basic principles. Because 770,000 of the 900,000 uninsured Pennsylvanians are adults and 71% of these are employed but low-wage earning adults, the plan would subsidize the low-wage earners' employers purchase of CAP insurance. The CAP insurance would be available through the Blue Cross Plans, and would include coverage similar to that which is currently available to working adults under 200% of the federal poverty level through the adultBasic program. However the benefit package would be expanded to include prescription drug coverage and behavioral health coverage. The existing adultBasic coverage program would be subsumed by the new Cover all Pennsylvanians program.

The CAP program would be available to small employers, individuals, and self-employed persons. Individuals under 200% of the Federal Poverty Level (FPL), would have to have been uninsured for at least 3 months to be eligible and individuals under 300% would have to have had no insurance for 6 months or more to dissuade employers from simply discontinuing health coverage. For employers with less than 50 employees and an average wage less than the state average, CAP could be purchased at an employer cost of $130 for each employee. Employees would pay a monthly premium of between $10 and $70, depending on income and family size. And, the state would pay the remainder of the premiums. Uninsured spouses could also purchase the coverage. Individuals with household income under 300% of the federal poverty level could purchase the insurance directly with premium amounts ranging from $10-70. (Under 100% FPL at $10/month; from 100%-200% FPL at $40/month and from 200-300% at$60/month). And, individuals with household income over 300% of the federal poverty level could purchase the insurance at the state's cost which is reported as being approximately $280/ month.

The revenue source for the state premiums would be:

- federal dollars available through a state Medicaid 1115 waiver for serving individuals up to 300% FPL
- a new tax on smokeless tobacco and cigars
- an increased cigarette tax
- an assessment of 3% of payroll that would be charged to all "free riders" i.e. employers who do not provide health insurance
- Tobacco Settlement dollars for adultBasic and uncompensated care

The Governor commented that this plan is more comprehensive than the Massachusetts or California plans. At this point, the Commonwealth would like to encourage everyone to get health insurance by making it affordable; however the Governor noted that he is not ruling out a mandate that all individuals with income over 300% of the Federal Poverty Level, and 4-year college and graduate students purchase health insurance.

Governor Rendell described his plan as a work in progress. He will be going to 25 localities in the coming weeks to explain the plan, and additional workgroups and planning meetings will occur. The plan has many parts, and will require, he says, some 47 separate pieces of legislation for full implementation. More information from the Governor's Office of Health Care Reform is available on the GOHCR website www.ochr.state.pa.us. And, more detail is said to be forthcoming in the Governor's February 6th budget announce-

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comes eligible for Medicare on January 1, 2007. This individual goes to the pharmacy on January 15, 2007 to get a prescription refill and finds that they have no prescription drug coverage (once individuals with Medical Assistance become eligible for Medicare, they lose most of their drug coverage through MA). The individual really needs the medication and pays out of pocket for the medication. The individual can enroll in a Part D plan for coverage starting February 1, 2007 and ask their Part D plan to make their enrollment retroactive to January 1, 2007 in order to have the pharmacy bill the Part D plan and reimburse the money the individual paid out of pocket. Of course, the premium would have to be paid retroactively as well.

Currently, there is a Medicare Advantage Open Enrollment Period that lasts from January 1, 2007 to March 31, 2007. During this time, individuals can enroll in a Medicare Advantage plan, change Medicare Advantage plans, or disenroll from a Medicare Advantage plan and go back to Original Medicare (red, white, and blue card). Individuals cannot initially enroll in Part D or disenroll from Part D coverage during this enrollment period. The following types of changes are allowed during this enrollment period:

- An individual in a Medicare Advantage Plan that includes prescription drug coverage (MA-PD) can switch to a different MA-PD or go back to Original Medicare and join a stand-alone Prescription Drug Plan (PDP).
- Individuals with Original Medicare and a PDP can join an MA-PD.
- Individuals who are in a Medicare Advantage Only plan (no drug coverage) can only switch to another MA-only plan or go back to Original Medicare (but they can't join a PDP).
- Individuals with Original Medicare but no Part D drug coverage can join an MA-only plan but not an MA-PD.

If you have any questions about these Special Election Periods, or if you are having problems using these Special Election Periods, please call the PA Health Law Project helpline at 1-800-274-3258 (voice) or 1-866-236-6310 (TTY). ✸

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taken. Logisticare agreed to work with its contractors to ensure that drivers have IDs.

* DPW asked the Committee to recruit more MATP consumers to participate at these meetings. Minutes from the advisory meeting will be posted on DPW's website in the Philadelphia MATP section. Timeframes will be listed to accomplish the recommendations from the Advisory Meeting.

The next Phila. MATP Advisory meeting will be on January 26, 2007 at HealthPartners at 901 Market St., Philadelphia.

The brochure is available online in 6 languages (English, Cambodian, Chinese, Russian, Spanish, and Vietnamese). Go to: http://www.dpw.state.pa.us/LowInc/MATP/003673043.htm

Important Logisticare Numbers
Reservation (Call 3 days in advance for non-urgent rides): 1-877-835-7412
Where's My Ride (for Late Rides): 1-877-835-7420
Quality Assurance/Complaints: 1-877-835-7428

If you are denied a ride or day-passes/transpasses from Logisticare, call the PHLP Helpline at 1-800-274-3258/ 1-

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were on blue paper.

Consumers who are not sure if they were auto-enrolled into a new plan should call 1-800-MEDICARE [(1-877-486-2048) (TTY)] or check www.medicare.gov to find out 1) if they were autoenrolled into a new plan and 2) if so, which one. If a consumer was auto-enrolled into a new plan, the individual should contact the plan to get their membership information in order to access medications after January 1, 2007.

If someone remains enrolled in their current (2006) plan that will no longer be a zero-premium plan in 2007, they will have to start paying a premium in 2007. Remember that dual eligibles can change plans at any time, so those faced with a premium may want to consider switching to a different plan that will not charge a premium.

If the plan that a dual eligible was enrolled in for 2006 is no longer participating in Part D in 2007, it should have the member enrolled into a different plan offered by the same company or auto-enrolled into a new zero-premium plan by Medicare.

Example: A consumer goes to the pharmacy and is told that he does not have any Part D coverage.

If the consumer is dual eligible but the pharmacy's computer reports no prescription drug coverage, she should ask the pharmacy to bill Wellpoint. This is a back-up plan for full dual eligibles who do not have coverage through a Part D plan. The pharmacist can find out how to bill Wellpoint by contacting Medicare or looking on the Pennsylvania Health Law Project website, www.phlp.org. If the consumer needs assistance with this or is not able to get prescriptions, please call the Pennsylvania Health Law Project at 1-800-274-3258 (phone)/ 1-866-236-6310 (TTY).

Example: A consumer's new plan does not have her listed as enrolled with them.

If the consumer chose a new plan or was auto-enrolled by Medicare into a new zero premium plan, she may experience problems with enrollment. If, for some reason, she does not show up as listed in the plan she joined, she should contact 1-800-MEDICARE [(1-877-486-2048)(TTY)] and file a complaint for follow-up by the Regional Office. If she needs medications immediately, she can buy the medications herself and get reimbursed from the plan once the problem is resolved. In the alternative, if she has the ACCESS card, she can ask the pharmacy to bill Wellpoint (see above). If Wellpoint doesn't work, she can ask the pharmacist to ask MA Fee- for-Service to do a super prior authorization to cover medications through MA until the plan can cover her. MA will approve this if the pharmacist can show MA that he or she has been unable to get your medications covered using the consumer's plan or Wellpoint. The MA phone number for pharmacists is 1-800-558-4477.

Example: A consumer had the low income subsidy (Extra Help) in 2006 and nothing has changed, yet Medicare tells her that she doesn't have it in 2007.

If a consumer had the low income subsidy in 2006 because she had MA, as long as she had MA at some point between July 2006 and December 2006, she should qualify for the subsidy for all of 2007. She should not be charged a deductible and her copayment should be between $1 and $5.15. The consumer should show her ACCESS card to the pharmacy and have the

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pharmacy call the plan to verify that she is a dual eligible and should get the subsidy.

If a plan will not update their system with the subsidy information, the consumer should call 1-800-MEDICARE [(1-877-486-2048)(TTY)] to find out if it has a record of the consumer having the subsidy. If Medicare shows her as having the subsidy, she should ask them to call the plan with the consumer on the line and authorize her as a person with the subsidy. If Medicare does not have record of the consumer having a subsidy, but she has Medical Assistance (MA), she can show the pharmacy her ACCESS card. Then she can ask the pharmacist to call the plan to see if they will update their system to show that the consumer has the subsidy. If the plan will not update their system, the pharmacist can call MA Pharmacy to have the medications covered until the plan gets information about her subsidy. If a consumer has MA and is having problems getting the subsidy, call PHLP at 1-800-274-3258 (phone)/ 1-866-236-6310 (TTY).

If the consumer got a notice that she no longer automatically qualified for the subsidy in 2007 because she lost MA, she can apply for the subsidy through the County Assistance office or through the Social Security Office. If she lost the subsidy, but is still receiving MA, call PHLP at 1-800-274-3258 (phone)/ 1-866-236-6310 (TTY).

Example: The consumer is in a new plan but it doesn't cover all of her medication.

If a consumer goes to the pharmacy and is told that the medication is not covered by her Part D plan, she should ask the pharmacy about a one-time fill (30 day supply). Part D plans are required to cover a one-time fill of medications during the first 90 days of coverage in a plan. This will give the consumer time to get a prior authorization if necessary or seek an exception to the plan's formulary.

If the consumer needs a medication that is not covered under Part D (for example, benzodiazepines, barbiturates, or some over-the-counter medications) and she has the ACCESS card, she should have the pharmacy try to bill the non Part D covered medication through the ACCESS card.

If the plan refuses to cover the medication in this transition period, call the Pennsylvania Health Law Project at 1-800-274-3258 (phone)/ 1-866-236-9310 (TTY). ✷

PHLP staff are available in Southwestern and Southeastern PA to conduct trainings on 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 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 persons with hearing and/or vision needs.

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Searching the Preferred Drug List

There is now a quick search site for the Pennsylvania Preferred Drug List. The site is maintained by the PDL contractor, Provider Synergies. You can search medications by therapeutic class, brand name or generic and find out which medications are preferred. The PDL is available at: http://www.providersynergies.com/services/medicaid/Pennsylvania/PAM_PDL_Lookup.asp.

Jim Hardy resigns as Deputy Director of Medical Assistance Programs: Mike Nardone to be new Deputy Director

Jim Hardy resigned as head of OMAP, effective February 1, 2007 to become President of Sellers Feinberg, a national consulting company that specializes in Medicaid issues. Mike Nardone will replace Mr. Hardy as Deputy Director and will begin on February 5, 2007. Mr. Nardone most recently served as Director of the PA Long Term Living Council.

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