Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

Statewide Help Line: 1-800-274-3258 On the Internet: www.phlp.org TTY: 1-866-236-6310

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New Documentation Requirements for MA Recipients and Applicants

Under the federal Deficit Reduction Act of 2005, Medicaid recipients and applicants will have a new documentation requirement that could be a problem for many consumers. Beginning July 1, 2006, those claiming to be US citizens or nationals will have to provide documentation of citizenship and identity at the time of Medicaid application. Current recipients must supply documents at the annual re-determination. This will be a one-time verification. This requirement does not change who qualifies for Medical Assistance. A person does not have to be a citizen to qualify for Medicaid. However, it will be very hard for many citizens to get the necessary documentation to prove citizenship.

Under the federal law, a US Passport, Certificate of Naturalization, or Certificate of US Citizenship can be used to document both citizenship and identity. In some states, a driver's license will be enough to show proof of identity and citizenship. That is not the case in Pennsylvania. Since many Medical Assistance consumers do not have a passport, they will have to prove citizenship and identity separately. A birth certificate can be used to prove citizenship. A driver's license or government issued ID, such as PENNDOT issues to persons without a driver's license, can be used to document identity The Secretary of Health and Human Services through a letter to the state Medicaid Agencies , called a "Dear Medicaid Director" letter will issue the list of other documents that can be used to prove citizenship or personal identity. The letter is also expected to identify groups that do not have to comply with the requirement.

In an early draft of the "Dear Medicaid Director" letter from the Secretary of HHS, citizen-

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INSIDE THIS EDITION

Dual Eligibles Still Experiencing Widespread Problems in Medicare Part D

People with Medicare and Medicaid (dual eligibles) are still experiencing significant problems enrolling into Part D plans, paying the correct amount at the pharmacy, and accessing their medications.

Consumers are being terminated from their plans with no notice.

Many consumers who were passively enrolled into a Medicare Special Needs Plan (a Medicare HMO for people with both Medicare and Medical Assistance) are finding out that they no longer have coverage through their Special Needs Plan. Often times, they receive no notice about their coverage ending. Instead, they find this out at the pharmacy when they try to get their refills.

PHLP has learned that this is happening to many consumers who have End-Stage Renal Disease (ESRD). According to Medicare rules, people with ESRD typically cannot join a Medicare HMO. The Medicare Special Needs Plans have passively enrolled these consumers into their plans and are now terminating them from coverage with no advance notice. In addition, individuals who only have Medicare Part A or who only have Medicare Part B were passively enrolled and are now being terminated. In order to join a Medicare HMO, a consumer must have both Part A and Part B. The Special Needs Plan passively enrolled these individuals by mistake, covered them for a

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Using the Medicare Part D Appeals Process

The Medicare Part D legislation requires all Part D Plans to have an appeal process in order to ensure that consumers have access to medically necessary medications. If a consumer disagrees with their Part D Plan's decision to not cover a drug, or with the amount the Plan charges for the drug, he can pursue an appeal.

Seeking a non-formulary drug

Every Medicare Part D Plan uses a drug formulary-that is, a list of medications that it will cover for its members. Many plans also impose a step therapy, under which a drug is not available until other, less expensive drugs would be ineffective. If a consumer needs a medication that is not on their Part D Plan's formulary, or which is subject to step therapy. Please note that this appeal process cannot be used to seek coverage for drugs not covered by Part D: benzodiazepines, barbiturates, and over-the-counter (OTC) medications.

If a consumer is prescribed a medication that is off formulary or subject to step therapy, the consumer (or their prescribing doctor) can ask the Plan for a "program exception." The prescribing doctor must provide an oral or written statement (depending on the Plan's requirements) indicating that the requested medication is "medically necessary" because:

- all the formulary drugs would not be as effective as the non-formulary drug and/or would have adverse effects on the consumer, *or*
- the formulary drugs required to be used

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"Facilitated" Enrollment of MSP and LIS Recipients into Prescription Drug Plans Started May 1

In April, Medicare began to "facilitate" enrollment into prescription drug plans of consumers for whom the has been State paying Medicare Part B premiums under the Medicare Savings Program (MSP), and those who have been approved for a low-income subsidy (LIS, or "extra help"). "Facilitated" enrollment is another term for auto-enrollment.

Consumers who fit into these two groups and who were enrolled in Original Medicare should have received notices from Medicare in early April. The notices told consumers into which stand-alone Prescription Drug Plan they would be enrolled starting May 1, 2006, unless they did chose a plan on their own by April 30. These notices were printed on **green** paper. The notices also told consumers whether they were approved for a full or partial subsidy and how much they would have to pay for the Part D coverage. It is important that consumers keep this notice in case they have any problems with their Plan charging them a higher premium, deductible or co-payment than was stated on the notice.

Enrollees of Medicare HMOs who were either in the Medicare Savings Program or approved for a low-income subsidy, should have received a letter directly from their HMO. This letter should have told the member that they would be enrolled into a different plan within the same company that included Part D drug coverage, unless the consumer enrolled in a different plan on their own.

Special Election Period Granted to Consumers Who Qualify for the Low-Income Subsidy

Beneficiaries who were enrolled in Medicare on January 1, 2006, faced a May 15, 2006 deadline to enroll in Medicare Part D without premium penalty. Those who did not enroll in a Medicare Prescription Drug Plan by that date cannot now enroll until the open enrollment period (November 15, 2006 through December 31, 2006), unless they qualify for a Special Election Period.

The Medicare program has announced that consumers who are approved for a low-income subsidy after May 15, 2006 will have a one-time chance to join a Medicare Part D Plan before the open enrollment period. Medicare will facilitate enrollment (i.e. automatically enroll members into a Part D Plan) if they do not join one on their own.

Consumers can apply for the subsidy at any time.

Call the PA Health Law Project Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY) with questions about facilitated enrollment or Part D or if you are having problems accessing your medications under this benefit.

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!

Centers for Medicare & Medicaid Services Changes Policy Regarding Part D Plan Formulary Changes

Part D Plans are allowed to make changes to their formulary (list of covered drugs) during the year. Formulary changes could include taking drugs off their formulary, changing the preferred status of a drug, and changing requirements about special rules such as prior authorization. Plans must get approval from the Centers for Medicare & Medicaid Services (CMS) before making most formulary changes and Plans must provide 60 days notice to affected enrollees.

In late April, CMS changed its policy regarding formulary changes. CMS now expects that Plans who change their formulary during the year will not apply the changes to individuals currently taking the affected medications. Individuals currently taking medications that are impacted by a formulary change will be exempt from the change for the remainder of the year. Under CMS' previous policy, there were no exemptions to formulary changes for consumers taking affected medications at the time of the change.

If you have any questions about this policy change, please contact the PA Health Law Project Helpline at 1-800-274-3258 or 1-866-236-6310 (TTY).

"MA Cares" Program Should Help Locate MA Providers

Many people in Fee for Service Medical Assistance need help locating providers who accept the Access Card. This is especially true for dual eligible (Medicare and Medicaid) recipients who were in HealthChoices up until January 1, 2006. These consumers, who were previously able to find providers through their HealthChoices plan.

To help consumers find providers (other than dentists) in Fee-for-service Medical Assistance, the Department of Public welfare is revitalizing MA Cares program. Each County Assistance Office has an "MA Cares" worker who is supposed to help consumers find Medical Assistance providers, by using DPW's "Promise" system. DPW will be releasing an Ops Memo to the CAOs soon to clarify responsibilities. The MA Cares program is available to those who are in the fee-for-service program. Those who are in AccessPlus should be contacting the AccessPlus program. Below is a handy list of where to turn for help finding a provider:

If a consumer is in HealthChoices:
Physical Health services:
HealthChoices plan
Behavioral Health Services
HealthChoices plan
Dental:
HealthChoices plan

If a consumer is in AccessPlus:
Physical Health services:
AccessPlus- 800-543-7633
Behavioral Health Services:

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DPW Will Carve out Pharmacy from HealthChoices

The Department of Public Welfare is planning to take the pharmacy benefit away from the HealthChoices plans and manage the benefit directly. The state expects to save about $110 million per year ($55 million in state dollars) by this move, through a combination of manufacturer rebates and discounts. This means that all recipients who get their drug coverage through MA will be subject to the state's Preferred Drug List (PDL), instead of the drug formulary of their Medicaid HMO. Currently, the PDL is only in place in the Fee-for-Service portion of the state.

The detailed plan to carve pharmacy out of managed care will be released later this month. The implementation date is January 1, 2007. There will be a transition plan and notices to consumers and providers before the carve out takes effect.

The managed care plans are opposed to this change, arguing that this will adversely affect profits and their ability to manage a patient's care. DPW has indicated a willingness to allow the plans to continue to administer the drug benefit, but federal law is being interpreted by the Center for Medicare and Medicaid Services as preventing the state from getting the manufacturer rebates unless the state directly administers its drug program. Some managed care plans are suggesting privately that they may discontinue providing optional benefits, or drop out of the medical assistance program if this program change is implemented.

DPW to begin applying Spousal Impoverishment Rules to HCBS recipients

Last year, the State amended the Public Welfare Code to apply spousal impoverishment provisions for a married Medicaid recipient eligible for Home and Community Based Services (HCBS) under Pennsylvania's Waiver programs. Spousal impoverishment provisions in Pennsylvania have historically applied to applicants, recipients and their spouses applying for and receiving long term care services in an institutional setting such as a nursing home. These provisions were applied to ensure that the spouse who remains in the community (referred to as the "community spouse") is not impoverished and receives a "protected share" of the couple's assets when one spouse is admitted to a nursing facility.

The change in the law will now affect the methodology of calculating available income and resources for married applicants and recipients of Waiver services. DPW has recently provided new guidelines on how it will apply spousal impoverishment provisions to current married individuals who were in Waiver programs on October 1, 2005. Up to $99,540 in countable resources (for 2006, the number goes up each year) can be set aside for the community spouse. Also, if the income of the community spouse is below a specific level (determined by an income assessment), then resources can be set aside through the purchase of an annuity to benefit the community spouse.

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DPW To Start "Selective Contracting" for Specialty Pharmacy, Home Care, Durable Medical Equipment and Supplies

What is Selective Contracting?

DPW intends to reduce the number of providers it uses for certain services, and work more closely with smaller network of preferred providers. DPW has stated that Selective Contracting will enable the Department to: get better rates through volume contracting, reduce administrative costs by dealing with fewer contractors, and improve the quality of services by dealing with providers who deliver better quality. According to DPW, selective contracting will not reduce any services, but will re-shape certain provider networks.

What services will be affected?

DPW is currently moving ahead with Selective Contracting of three services, by issuing Requests For Proposals for:

Specialty Pharmacy.

The state would contract with at least 2 providers for anything that is considered a pharmaceutical product delivered at home, by injection or infusion (directly into a vein through tubing that has been placed in the vein at a prior time). This would not include nutritional products . These medications can be thought of as falling into three broad categories: acute, such as antibiotics that might be needed for a few weeks; chronic, such as medications used to treat hemophilia, rheumatoid arthritis, RSV virus in high risk children, that might be needed every few weeks or less but on an ongoing basis; and cancer chemotherapy.

Home Care Services.

DPW is looking to contract regionally or statewide with preferred providers who would provide all home care services. DPW has not decided how many providers they will contract with.

Durable Medical Equipment and Medical Supplies.

This category can range from simple equipment available in any drug store to complex equipment especially designed for the particular beneficiary.

This can include the supplies that the nurse might need for a home care service such as a dressing change, or even the supplies needed for home infusion.

How will consumers be impacted?

Consumers are very interested in the impact of this initiative on quality and accessibility of services. For instance, Oxygen must be readily available for those who depend on it. Some consumers have service contracts for complex wheelchairs, which must be protected. DPW is expected to release a draft of the work statement of the Request for Proposals this month. The Consumer Subcommittee of the Medical Assistance Advisory Committee will be reviewing these draft RFP provisions and offering recommendations to help protect consumers.

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under the Plan's step therapy regime have been ineffective or caused adverse effects or are likely to have those results, *or*

- **the formulary dosage was, or is likely to be, ineffective or will adversely affect the drug's effectiveness or patient compliance**

The Plan has 72 hours (24 hours in an expedited case*) to decide whether or not to grant the exception. The exception must be granted if the Plan agrees with the doctor that the drug is medically necessary. It is then up to the Plan to decide what the tiering/co-pay level will be for the drug.

If the Plan fails to make a timely decision, that is considered a denial and it is forwarded to the IRE review stage (see below)

If the Plan makes a timely decision and the program exception is denied, the consumer can request a Redetermination (a paper review) by the Plan.

The Plan has 7 days to make a Redetermination decision (72 hours in an expedited case*). At the Redetermination stage, the plan must provide the enrollee or doctor a reasonable opportunity to present evidence and allegations of fact or law, in writing or in person.

If the consumer is not satisfied with the Plan's Redetermination decision he/she can request Reconsideration by an Independent Review Entity (IRE) under contract with Medicare. The IRE has 7 days to make a decision (72 hours in an expedited case*).

If the consumer is dissatisfied with the IRE's decision, and the amount in controversy meets or exceeds the threshold level annually set by Medicare (currently $110), the consumer can appeal further to an Administrative Law Judge, Medicare Appeals Council, and ultimately, to Federal Court.

Exceptions to a Plan's co-pay structure

Many Part D Plans use a "tiering" system to determine the copay their members will pay for a particular drug. Under a tiering system the Plan places the drugs it covers on certain levels-for example, tier 1 may be generic preferred drugs, tier 2 name brand preferred drugs, tier 3 name brand non-preferred drugs. Tier 1 would have the lowest copays, tier 2 higher copays, etc. Some Plans may even have a "specialty tier" in which it places high cost and unique items.

Consumers can also use the exception and appeals process to obtain a "non-preferred" drug at a lower co-pay level. The consumer (or the prescribing doctor) can request an exception to the Plan's tiered co-pay. The prescribing doctor must provide an oral or written statement (depending on the Plan) that the "non-preferred" drug is medically necessary because:

- the preferred drug would not be as effective for the consumer; *and/or*
- the preferred drug would have adverse effects for the consumer

The Plan has 72 hours (24 hours in expedited cases*) to make a determination. The Plan's failure to decide in a timely manner is considered to be a denial that is forwarded to the IRE appeals stage (see above). If the Part D Plan agrees that the non-preferred drug is medically necessary for the consumer, it must grant the exception and the consumer's co-pay for the non-preferred drug is reduced to the "preferred drug" level. If the Plan denies the request for an exception, the consumer has the same appeal rights and appeals process as if they were seeking coverage for a non-formulary drug. *Please note*: if the Plan has a "specialty tier" for very high cost and unique items it can exclude those drugs from the tiering exception process.

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If you or your spouse were receiving Waiver services on October 1, 2005, you will be asked to complete a Resource Assessment Form this month. However, this form is not required if one spouse: (1) currently receives or was receiving SSI benefits on October 1, 2005 or (2) currently is a Medicaid recipient or was an active Medicaid recipient as of October 1, 2005 and the resources of the married couple are already known, verified and are within Medicaid limits for a married couple.

The completed Resource Assessment Form will be used to evaluate the total resources owned by you and your spouse. Documentation will also be required to verify the value of certain resources owned by you and your spouse (individually and jointly). Although some resources are exempt, countable resources include amounts you have in savings accounts, retirement accounts and other assets. Instructions will be included with the form; however, it may be a confusing or complicated process to navigate on your own. If you are in the Aging Waiver, please call your Area Agency of Aging for assistance and if you receive services through the Attendant Care, COMMCARE, Independence or OBRA waivers, call the program office for assistance. These contact telephone numbers will be provided on the letter accompanying the Resource Assessment Form.

After the CAO determines the protected share for the community spouse, an additional letter will be sent out on how this will impact your eligibility for Waiver services and what steps you can take to continue to receive Waiver services. The letter may instruct you to do one or more of the following: (1) transfer or retitle certain assets to be solely in the name of your spouse, (2) pre-pay for some weeks or months of services out of pocket or pay other outstanding medical bills, (3) purchase an annuity to earn income for your spouse or (4) take other action steps.

Unless appropriate steps are taken you will receive an Advance Notice of Discontinuation (PA 162A) that your Medicaid and Waiver benefits will be terminated. Remember your appeal rights! Appealing within 10 days assures continuation of services if you disagree with a notice of termination for any of the following reasons: (1) a failure to return the Resource Assessment Form (2) a failure to provide necessary information or failure to verify resources or (3) a determination that your resources are in excess of the resource limits after applying the spousal impoverishment provisions. You or your spouse may request a fair hearing by returning the Request for a Hearing section of the PA 162A notice. Call us at 1-800-274-3258 if you would like free legal assistance in reviewing your denial.

Governor Vetoes Nursing Home Payment Legislation

The Governor has vetoed SB 997, which would have rescinded the authority, given to DPW last year, to revise the Medicaid rate-setting process for nursing homes by July 1, 2006 without going through the regulatory review process. The bill, which was heavily supported by the nursing home industry in the hope of higher reimbursement rates, was opposed by a number of advocacy groups, including AARP and the Statewide Independent Living Council, who contend that the legislation would reverse the Administration's attempt to shift Medicaid dollars from institutional to non-institutional care. In vetoing the legislation, the Governor said it would have created a $100 million shortfall in the 2006-'07 budget. It is unclear at this point whether there will be an attempt to override the veto.

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ship could be documented by "a religious record of birth, recorded in the United States or its Territories within three months of birth, which indicates a U.S. place of birth," or by "an affidavit made by two blood relatives… who have personal knowledge of the event(s) establishing the applicant's claim of citizenship." In addition, proof of identity could be shown by any document that the state finds establishes the true identity of the applicant or recipient.

Obtaining the required documentation could be extremely difficult for poor persons, especially the elderly, people born out of state, people not born in a hospital, the homeless, people who have lost records in a disaster, and people with mental illness. DPW is looking into ways to get birth certificate information from the Department of Health and driver's license information from PENNDot electronically. Unfortunately, this would only help Medical Assistance applicants and recipients who were born in Pennsylvania or who have identification from PennDot.

Once the requirement comes into effect, the CAOs will be required to assist people to obtain the documentation. No one should be terminated right away for not being able produce the documentation. However, there could eventually be notice and termination of consumers who are not able to obtain the necessary documents.

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* an expedited process should be requested when the standard timeframes may jeopardize the consumer's life or health or ability to regain maximum function. Either the member or the doctor can request the expedited process, but if the doctor makes the request and includes justification, the plan must expedite the review.

Pat Stromberg Writes in Support of "Cover All Kids"

On April 30, 2006, the Harrisburg Patriot News published an Op-Ed article by former Deputy Insurance Commissioner Pat Stromberg, supporting the Governor's proposed "Cover All Kids" initiative. Stromberg, who directed the Children's Health Insurance Program (CHIP) before her retirement last year, wrote in favor of the initiative, which would provide subsidized CHIP coverage to families with income below 350% of the poverty level. A family of four would pay between $20 and $35 per month for the coverage. Those families with income above 350% of the poverty level could purchase CHIP coverage at cost (about $145 per month). Stromberg pointed out the fact that more than 133,000 children in Pennsylvania are without

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if in a Behavioral Health plan, then the plan. If not, the county MH/MR
Dental:
AccessPlus 800-543-7633

If a consumer is in FFS:
Physical Health services:
MA Cares at CAO
Behavioral Health Services:
If in a Behavioral Health plan, then the plan. If not, the county MH/MR
Dental:
Call Center- 866-542-3015

If a consumer is in a HealthChoices county and has only just become eligible for MA, he or she is generally in Fee for Service for the first few weeks of eligibility, until enrollment into a HealthChoices plan begins. In this situation, the consumer should call the HealthChoices enrollment line to find providers who will take his or her HealthChoices plan. That number is 800-440-3989.

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couple months, and is now terminating them from coverage.

Dual eligible consumers who are enrolled in stand-alone prescription drug plans are also having similar problems. Many consumers who chose a plan on their own and enrolled in that Plan have also been auto-enrolled into a different plan by Medicare. Consumers find out when they go to the pharmacy that the plan they chose is no longer working and that they have coverage through another plan. Again, consumers often do not receive notices about this. Medicare sent out notices over the last couple months to individuals who were enrolled in two plans telling them to make a choice. However, many consumers never received these notices. Therefore, these consumers were often terminated from the plan of their choice.

New dual eligibles experiencing gap in coverage:

Individuals who newly become dual eligibles often have a gap in prescription drug coverage. This includes individuals who were on Medicaid as of January 1, 2006 and later became eligible for Medicare as well as individuals who had been on Medicare and became eligible for Medicaid after January 1, 2006. Individuals who were on Medicaid who become eligible for Medicare may lose their drug coverage through Medicaid before they are auto-enrolled into a Part D plan. According to guidance from the Centers for Medicare and Medicaid Services (CMS), Medicare is to auto-enroll them into a plan retroactive to when they first became eligible for Medicare. However, this is not happening and many consumers are left without drug coverage for a period of time. Individuals who have Medicare and later become eligible for Medicaid are supposed to be auto-enrolled into a Part D plan retroactive to their Medicaid start date.

Dual eligibles who change plans not recognized as low-income subsidy eligible:

Dual eligibles can change plans at any time. They also automatically qualify for the low-income subsidy which means they have no annual deductible and only small co-pays for their medications. When dual eligibles change plans, especially if they change late in the month, their new plan often does not get information about their low-income subsidy. This means that consumers go to the pharmacy to get their medications and are often charged full price or extremely high co-pays for their medications. Plans are reluctant to update their system to reflect the low-income subsidy without proof from the consumer that they have been approved for the low-income subsidy. However, many consumers do not have any such proof because they were automatically eligible for this benefit.

Back-Up Plans Still In Place to Help Consumers Access Medications:

For consumers who have Medicare and full Medicaid who find themselves without Part D coverage, the pharmacy can still use the point-of-service process to bill the back-up plan (Wellpoint) for medications. Many pharmacists and advocates think that this back-up process has ended, but it has NOT ended. If the point-of-service process does not work, then Pharmacists can bill Medicaid for an emergency 5 day supply of medications. Both the point-of-service process and the emergency 5 day supply through Medicaid can be used multiple times.

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If full dual eligibles are being charged too much at the pharmacy, Medicaid's back-up process to cover excessive co-pays is still in effect. Pharmacists can bill Medicaid for excessive co-pays above $5 per drug. Please see PHLP's website for links to instructions for all the back-up processes: www.phlp.org.

Please contact PHLP's HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY) if you are having trouble getting your medications as a result of these problems or if you need more information about the back-up processes.

30,000 on adultBasic waiting list to receive coverage offers

Later this month 30,000 people on the adultBasic waiting list will receive offers of coverage. The offers will go out to eligible people who got on the waiting list on or before June 6, 2005. Notices will be sent by mail. The monthly premium is $33.50 per month.

This is a reduction in the waiting list- with these offers of coverage, the adultBasic waiting list will be reduced to about 40,000 people. This is the lowest level for the waiting list in over 3 years. Currently, there are 49,743 individuals enrolled in the adultBasic program.

PHLP urges uninsured Pennsylvanians to sign up for adultBasic. Those who need treatment while on the waiting list can purchase coverage at cost- about $305/ month. For more information, see the PHLP website at www.phlp.org or call the helpline at 1-800-274-3258 or 1-866-236-6310 TTY.

State Pilots Effort to Increase Dental Providers

The Department of Public Welfare has hired consultants in a pilot project to help increase the number of dental providers for Fee for Service (FFS) MA in the Philadelphia area. The consultants, who began working in March 2006, have local contacts in the dental community and have already gotten initial commitments from over 100 dentists who participate in HealthChoices to also participate in FFS. There are over 450 dentists in the Philadelphia area who only participate in the HealthChoices plans. In many HealthChoices counties, there has been an increased need for dentists who participate in FFS because dual eligible consumers were shifted from Medicaid managed care into FFS on January 1, 2006. Since Medicare does not cover dental, these consumers can only use MA providers for dental services.

The Department has indicated that if this pilot is successful, it would like to replicate it in other counties.

In related news, DPW has announced that following a meeting with officials from the Dental School at the University of Pennsylvania, the school's Chestnut Street clinic will accept the Access card for non-urgent care cases. Previously, the Access card was only accepted for dental emergencies.

PHLP Staff available for Medicare Rx trainings

Staff members from the PHLP Pittsburgh and Philadelphia offices are available to provide trainings on Medicare Part D to advocates and consumers in the Southwest Region and in the 5- county Philadelphia area. The trainings provide information to help individuals better understand the changes and address problems they may be having. For example, the trainings can explain how dual eligibles access care now through Medicare and Medicaid. Trainings can also include information about the appeals processes available under Part D in order to help consumers understand their rights when a Plan denies their medications.

Please contact the PHLP Helpline if you are interested in scheduling a training in the Southwest or in the 5 county Philadelphia area (1-800-274-3258 (voice) or 1-866-236-6310 (TTY)).

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