Health Law PA News

Newsletter of the Pennsylvania Health Law Project

Harrisburg Philadelphia Pittsburgh

Statewide Help Line: 1-800-274-3258/ TTY: 1-866-236-6310

On the Internet: www.phlp.org

Volume 9, Number 3 July 2006

PACE Plus Medicare Bill Signed: Autoenrolls PACE Consumers into Medicare Rx Plans

On July 7th Governor Rendell signed into law Senate Bill 1188 which created the PACE Plus Medicare program. The Bill revised the PACE statute to allow the existing PACE/PACENET program to "wrap-around" the Medicare Prescription Drug Program. Under the PACE Plus Medicare Program, the PACE program will:

- Auto-enroll PACE/PACENET members into Medicare Part D plans;
- Help cover the costs of the Part D program for PACE/PACENET members;
- Continue to provide PACE/PACENET covered medications that are not on an individual's Part D Plan's formulary;
- Continue to provide PACE/PACENET covered medications through Part D coverage gaps such as the donut hole period.

(Continued on page 8)

INSIDE THIS EDITION

State Budget Passes With Few Surprises For Low-Income Health Consumers 3

Behavioral HealthChoices Expansion 4

Medicare Part D Updates 4

PHLP Develops Guide to Advocacy for Consumers of Mental Health Services 6

Selective Contracting Going Forward for DME and Radiology 6

PHLP List-serves for dual eligible populations in SE and SW 8

UPMC Pulling out of Voluntary HealthChoices Counties 12

DPW Announces Details for Implementation of Federal Citizenship Documentation Rule

DPW has issued details on how it will implement the new federal requirement that MA applicants and recipients claiming US citizenship provide documentation. The details are contained in an Operations Memorandum, which can be reviewed on PHLP's website, www.PHLP.org. DPW developed its plan on the heels of CMS' publication of interim final regulations which appeared in the Federal Register on July 12, 2006. The Federal regulations contained several major changes from the guidance which it issued to state Medicaid

(Continued on page 2)

Pennsylvania Health Law Project Copyright © 2006

State Budget Passes With Few Surprises For Low-Income Health Consumers

The Governor and General Assembly reached agreement earlier this month on a budget for fiscal year 2006-07. Again this year, there were no cuts in categories of persons who qualify for Medical Assistance and no reductions in the services that are offered under the Medicaid state plan. One of the few surprises was the refusal of the legislature to go along with DPW's proposal to carve the pharmacy benefit out of the HealthChoices program. The managed care companies had argued that the carve-out would severely damage their financial viability, and would interfere with their ability to manage care. DPW had contended that the carve-out was necessary in order to save money through manufacturer rebates. The HealthChoices plans did not get a rate increase beyond the 4% that the governor had proposed.

In other budget news, the hospitals avoided funding cuts that had been proposed. Also, there is funding for 1,500 additional persons to be served in the Independence and Commcare waivers and the Attendant Care programs, 2,800 persons in the Over 60 waiver, and 1,360 persons in the Long-term Care CAP. MATP get a 10.6% increase. The budget act speaks of increased use of recipient "lock-in" to a single provider as a way of reducing fraud and abuse. Consumers have criticized this measure as misguided in the managed care context, and excessive.

In budget news not related to Medicaid, funding for the governor's Cover All Kids initiative was included, with 15,000 kids to be added to the CHIP program in

(Continued on page 11)

(Continued from page 1)

directors on June 9th. Of greatest significance are: 1) All SSI recipients and Medicare beneficiaries are exempt from the documentation requirements, and 2) States can use data matches with other government agencies to prove citizenship and/or identity.

The federal regulations establish a complex, cascading hierarchy of acceptable proofs, starting with a passport, and ending with a combination of two affidavits, executed by individuals only one of whom can be related to the Medicaid applicant/recipient, who can prove their own citizenship, and who have personal knowledge of the event establishing the claim of citizenship. These affidavits can only be used in "rare" circumstances, according to the regulation, and must be accompanied by another affidavit from the applicant/recipient explaining why documentary evidence cannot be readily obtained. CMS failed to carve out a broad exception for adopted children, which has been the subject of significant criticism by child advocates.

DPW has announced that it intends to assist all individuals applying for or currently receiving MA to obtain the necessary proof of citizenship (or nationality) and identity. If all other conditions of eligibility are met except documentation of citizenship and identity, eligibility for Medical Assistance will not be denied or terminated, so long as the individual is cooperating. DPW has developed a new form (PA 1809) to assist the department in locating the necessary documentation. The department has also established a DPW Verification Unit in Harrisburg, to do the legwork in tracking down documentation.

CMS has established a thirty day public comment period for its regulations. Comments will be posted as they are received,

(Continued on page 11)

Pennsylvania Health Law Project Copyright © 2006

OMHSAS Continues with Plan for Expansion of HealthChoices Behavioral Health Managed Care

As reported in our March Newsletter, DPW has decided to expand Health-Choices-Behavioral Health Managed Care throughout the entire state. In support of its decision, DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) notes that in the counties where Health-Choices-Behavioral Health currently exists:

- there is improved access to services for consumers,
- provider choice has increased;
- drug & alcohol services have expanded,
- $190 million in reinvestment funds were generated and approved, and
- alternate services such as psychiatric rehabilitation and mobile medication programs have been developed

Currently, there are 29 counties participating in behavioral health managed care. This includes Susquehanna, Wyoming, Lackawanna and Luzerne counties who just entered the program on July1st. .

The implementation for the remaining 38 counties will occur in two phases. The next phase of HealthChoices-BH expansion will be to the 22 counties that make up the North/Central State Option. The North/Central State Option is made up of Warren, McKean, Potter, Tioga, Bradford, Wayne, Forest, Elk, Cameron, Clarion, Jefferson, Clearfield, Centre, Mifflin, Juniata, Huntingdon, Union, Snyder, Sullivan, Columbia, Montour, and Schuylkill counties. These counties declined the state's offer to allow them to manage the behavioral health managed care contract directly, so the state will

(Continued on page 9)

Medical Assistance Has New Procedures for Coverage of Emergency Supply of Medications for Duals

Many dual eligible are still experiencing problems with enrollment into Part D plans. There is a back-up plan (Anthem/Wellpoint) that pharmacies can bill when a dual eligible person with full Medical Assistance benefits has not been enrolled in a Part D plan. However, in some cases, this back-up plan does not work. After all attempts to get prescriptions under a Part D plan and/or through Anthem/Wellpoint have failed, Medical Assistance may cover a temporary emergency supply of medication. As of July 19, 2006, pharmacies must call the DPW (1-800-558-4477) in order to get authorization for this temporary supply. DPW will not make pay if the claim was rejected by Medicare due to a billing error.

Medicare Special Needs Plans' Transition Period Ends

As of July 1, 2006, dual eligible consumers enrolled in the Medicare Special Needs Plans (SNPs) are locked-in to the plan's provider network, formulary, and rules for accessing care (i.e., referrals and prior authorizations). Persons experiencing any problems accessing services or medications should contact the PA Health Law Project HELPLINE at 1-800-274-3258 or 1-866-236-6310 (TTY).

Please see the fact sheet on the next page to learn what happens after June 30, 2006 to dual eligibles (those with Medicare and Medicaid) who were passively enrolled into Medicare SNPs.

Pennsylvania Health Law Project Copyright © 2006

Please Distribute or Post this Flyer

What Happens After June 30th to Passively Enrolled Dual Eligibles?

For the over 100,000 dual eligibles who were passively enrolled into a Medicare HMO as of January 1, 2006, June 30th meant the end of their "transition" or "grace" period. How does this affect their ability to access healthcare and prescription medications?

- **Starting July 1, 2006, Medicare HMO members can only see providers who participate in their Medicare HMO's network, unless they get approval to go out of network.** During the Transition Period (January 1, 2006 to June 30, 2006), passively enrolled individuals were entitled to see any Medicare providers they wished, regardless of whether the providers participated in the Medicare HMO plan network. Starting July 1, 2006, the Medicare HMOs only cover services by providers who participate in their plans.

- **Starting July 1, 2006, Medicare HMO members must obtain referrals to see specialists and prior authorizations for select services, as required by their Medicare HMO.** During the Transition Period, passively enrolled individuals were entitled to see specialists and obtain services without needing referrals or prior authorizations from their primary care providers (PCPs). Starting July 1, 2006, those who remain enrolled in a Medicare HMO can only see specialists who participate in their Medicare HMO plan, and they must follow their plan's rules referrals by their PCP and prior authorization.

- **Starting July 1, 2006, Medicare HMO members are limited to the prescription medications contained on their Medicare HMO's formulary (list of covered drugs), unless they obtain approval for a non-formulary drug.** During the Transition Period, passively enrolled individuals were entitled to continue to obtain any prescription medications that Medicaid was purchasing for them prior to January 1, 2006 even if the medication was not otherwise covered by their Medicare HMO. Starting July 1, 2006, those who remain in their Medicare HMO plan will only be able to obtain the medications on their plan's formulary, and are subject to any other limits or conditions imposed by their plan.

  Medications not on the Medicare HMOs formulary may be sought through a Medicare HMO by following the HMO's exceptions process. Medications on the Medicare HMO's formulary but denied to a member may be pursued through the Medicare HMO's appeals process. For more information, please see the Health Law Project's website at www.phlp.org or call us at 1-800-274-3258.

- **After July 1, 2006, Medicare HMO members can still change plans and leave their HMO.** Persons with Medicare and Medicaid can change plans at any time, effective the first day of the next month. Persons who did not change before June 30 but realize at any later time that the Medicare HMO does not work for them may elect another plan. 1-800-Medicare can help a person pick a plan that covers the medications they take. A list of the 15 stand-alone drug plans that are available to dual eligibles in Pennsylvania with no premium is available at our website www.phlp.org or by calling us at 1-800-274-3258.

Pennsylvania Health Law Project Copyright © 2006

Pennsylvania Health Law Project Copyright © 2006

PHLP Develops Guide to Advocacy for Consumers of Mental Health Services

Thanks to the support of the Staunton Farm Foundation, PHLP has developed a guide on consumer empowerment and systems advocacy for those who use the public mental health system in Southwestern Pennsylvania. If CSP, C/FST and SAP sound Greek to you, then the Consumer Empowerment Guide should be a helpful tool. This Guide, entitled "The Many Doors to Consumer Empowerment – A Guide to Advocacy for Mental Health Consumers in Southwest PA", introduces the reader to the fundamentals of how the county and state mental health systems work and how best to impact those systems. In Pennsylvania, and across the country, there is a shift away from the medical model of mental health treatment and toward a consumer-driven system of mental health recovery.

In order for consumers to impact the mental health system, it is necessary to understand how that system works. The Guide provides general information on the Community Support Program (CSP), the County Mental Health Plan, the Service Area Plan (SAP) and tools such as the Consumer/Family Satisfaction Team (C/FST). There are descriptions of consumer-driven programs such as drop-in centers, peer support specialists and psychiatric rehabilitation programs. Consumers learn about other advocacy organizations such as the Pennsylvania Mental Health Consumers Association, the Mental Health Associations and the Pennsylvania Recovery Organization Alliance (PRO-A). Readers can also learn about

(Continued on page 11)

Selective Contracting Going Forward for DME and Radiology

DPW announced plans this Spring to implement selective contracting for certain services available to beneficiaries in fee-for-service Medicaid. The original plan called for issuing RFPs in the area of home care services, specialty pharmacy, and durable medical equipment. However, selective contracting for home care services has been placed on hold. Selective contracting will not apply to dual eligibles or those with other third party coverage.

In addition, DPW has already issued an RFP seeking a contractor to implement a prior authorization program for high cost radiology studies. All of these programs have the announced goals of improving quality and decreasing costs.

What does this mean?

Prior Authorization of Radiology Services:

Each time a physician, nurse practitioner, or physician assistant orders any non-emergency designated radiology service, he or she will have to call an 800 number and get approval or DPW won't pay for the test. This will not apply in the hospital, or in emergency rooms. DPW wants to "manage" these services because they are expensive, and they are sometimes ordered when a less expensive test might be as good or better, or in situations where these tests are not helpful. There are 4 different services included: CAT scans, PET scans, MRIs,

(Continued on page 10)

Pennsylvania Health Law Project Copyright © 2006

Please post this notice

The Pennsylvania Health Law Project and Community Legal Services invite you to a presentation on:

New Citizenship Documentation Requirements for Medical Assistance

The Pennsylvania Health Law Project Help-Line
1-800-274-3258; TTY : 1-866-236-6310

Starting July 1, federal law began requiring additional documentation for US citizens receiving and applying for Medicaid.

Join us for a presentation by PHLP and CLS attorneys on those requirements and what they will mean for Medical Assistance recipients and applicants.

When:
Monday, July 31 from 10am—12pm

Where:
Philadelphia Bar Association
1101 Market St., 11th floor
Philadelphia, PA

How to RSVP:
Contact PHLP at 1-800-274-3258/
1-866-236-6310 TTY

We look forward to seeing you there!

Please Call the Pennsylvania Health Law Project to RSVP so that we know how many people to expect:
1-800-274-3258
TTY: 1-866-236-6310

Visit us online at
www.phlp.org

Logisticare to be Philadelphia MATP Contractor

The Department of Public Welfare is currently negotiating with Logisticare, an Atlanta-based company, to run the Medical Assistance Transportation Program (MATP) in Philadelphia, starting this Fall. If an agreement is reached, Logisticare will replace MTM (Medicare Transportation Management) as the MATP contractor. MTM has been on the job for less than a year, but the current contract was rebid following a legal challenge by a disappointed bidder. DPW has signed an agreement with MTM to continue to provide services until November 30, 2006. Consumers and advocates have raised many concerns about the upcoming transition and ongoing operational is-

Have you been terminated from waiver services?

The Pennsylvania Health Law Project has learned that many home and community based services waiver recipients are being terminated from waiver programs, although their health has not changed. This follows the Pennsylvania Department of Aging's initiative to centralize the waiver approval process. (See the Health Law PA News March 2006 for more information on the centralization). If you have been terminated from a waiver, please contact the Pennsylvania Health Law Project at 1-800-274-3258/ 1-866-236-6310 TTY for assistance and advice.

PHLP Part D List-Serve for Advocates and Professionals Working with the Disability Community in Southwestern PA

Starting in August 2006, PHLP's Pittsburgh office will maintain an e-mail list-serve on Medicare Part D available to advocates and other professionals working with consumers with physical, sensory, and/or developmental disabilities in the following 10 counties in Southwestern PA: Allegheny, Armstrong, Beaver, Butler, Fayette, Green, Indiana, Lawrence, Washington, and Westmoreland. The purpose of this list-serve will be to update professionals and advocates regularly on Part D developments and program changes. The list-serve will also be a forum for professionals and advocates to engage in ongoing discussions on Part D and to:

- raise Part D questions;
- identify specific problem areas for consumers with disabilities and collaborate on potential solutions to identified problems; and
- learn of local and statewide advocacy opportunities.

The primary focus of this list-serve will be on Medicare Part D; however, the list-serve will also address questions and issues on how dual eligible consumers access care as a result of the Part D changes (i.e, transition to fee-for-service Medicaid and enrollments in Medicare Special Needs Plans).

If are interested in joining this list-serve, please send an e-mail to Erin Guay at eguay@phlp.org.

PHLP already has a list-serve for advocates in the SE region for people working with dual eligibles 60 and older. For more information about that list-serve, see the April 2006 edition of the Senior Health News, available at www.phlp.org or email Jennifer Nix at jnix@phlp.org.

Pennsylvania Health Law Project Copyright © 2006

(Continued from page 1)

The PACE Plus Medicare program is mandatory for PACE members who must join a Part D plan to remain in PACE. However, the program is voluntary for those in PACENET. PACENET members are not required to join Part D in order to keep their PACNET benefits. Read on for more information on the details of the PACE Plus Medicare program…

Auto-Enrollment For Those Not in a Part D Plan

PHLP has learned that the Centers for Medicare & Medicaid Services granted Pennsylvania a Special Election Period (SEP) under Medicare Part D for all those enrolled in PACE/PACENET. This means that PACE/PACENET members can join Part D now without having to wait until the Open Enrollment Period at the end of the year. In addition, PACE/PACENET members who join a Part D plan will not incur a penalty.

PACE sent letters out on July 19, 2006 to 165,000 PACE/PACENET members (almost ½ of its membership) who were not yet in a Medicare Part D plan*. PACE will auto-enroll members into select Part D plans, trying to make the best fit for the individual based on: the plan's formulary and the consumer's need for medications; the plan's pharmacy network; and the plan's premium. The PACE letter notified consumers about the specific Part D plan that PACE chose to auto-enroll them into for coverage starting September 1, 2006. PACE members can choose a different Part D Plan than the one to which they have been assigned but they must join Part D to keep PACE benefits. PACENET members can decline the auto-enrollment altogether or choose to join a different Part D plan.

- If PACENET consumers do not wish to be auto-enrolled into a Part D plan they must call PACE at 1-800-225-7223 within 10 days of receiving the letter, and tell the program they do not want to be enrolled into a Part D plan.
    - These members will continue to receive their PACENET benefits. However, the $40 deductible is eliminated and instead they must pay a monthly premium to PACENET in an amount equivalent to the "regional benchmark premium" for Part D plans (currently $32.54). They will also pay the current PACENET co-pays of $8 for generic medications and $15 for brand name medications.
- If a PACE or PACENET consumer wishes to join a different Part D plan than the one PACE has chosen for them, they must call PACE/PACNET at 1-800-225-7223 within 10 days of receiving the letter. Read below for an explanation of how PACE will "wrap around" Part D coverage.
- If consumers agree to the auto-enrollment, they do not need to do anything. PACE will go ahead and enroll them into the designated plan effective September 1, 2006. Read the next section on how PACE will wraparound the Part D coverage

* please note: PACE is not sending this letter to PACE/PACENet members who are in Medicare HMOs, or who currently do not use prescription drugs or who do not qualify for Medicare.

Wrapping Around Part D Coverage

The PACE Plus Medicare Program will wrap-around Part D coverage to assist PACE/PACENET members with their Part D prescription costs and to help them access the medications they need.

PACE will do this by:

- paying the Part D plan premium for PACE members (up to the current regional benchmark premium of $32.54/mo.);
- eliminating the $40/mo deductible for PACENET members while the PACENET

(Continued on page 9)

Pennsylvania Health Law Project Copyright © 2006

(Continued from page 8)

member continues to pay their Part D plan's premium;

- paying any prescription co-pays that exceed those of PACE/PACENET;
- paying for medications covered by PACE/PACENET that are not on the formulary of the consumer's Part D plan; and
- paying for medications covered by PACE/PACENET during the Part D plan's coverage gaps (e.g. the "donut hole").

Help For Those Currently in a Part D Plan

The PACE Plus Medicare program will provide help with Part D costs and wrap around the Part D benefit for PACE/PACENET members who have already enrolled in a Part D plan-whether they are in a stand-alone plan or a Medicare Advantage plan (HMO). These individuals will receive a letter from PACE later this summer informing them of this help.

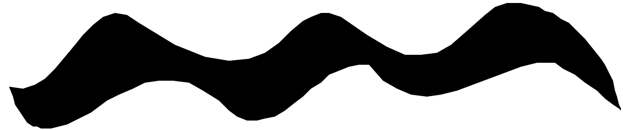
Low-Income Subsidy Enrollment

The PACE Plus Medicare legislation also authorizes PACE to apply for the Medicare Part D Low Income Subsidy (LIS) on behalf of PACE/PACNET members who may be eligible for this benefit. Specifically, PACE is authorized to obtain information on the financial resources of its members whose income is below the LIS limits, and complete an application to Social Security for those who appear to be eligible for the LIS.

Help with Part D Appeals

Under the PACE Plus Medicare Program, PACE will also act as the authorized representative for its members in regard to filing appeals with Part D plans on behalf of their members to assure they can access the prescription medications they need.

Please call the PA Health Law Project Helpline at 1-800-274-3258 (voice) or
1-866-236-6310 (TTY) if you have any questions about PACE Plus Medicare.



(Continued from page 3)

manage the contract. The state issued a Request for Proposals (RFP) in the Spring and 5 bidders responded. A Committee, comprised of state and county government officials, and a consumer and family member who reside in the 22 county zone, reviewed those five responses and made a recommendation to Welfare Secretary Richman. She will review the recommendation and announce a selection by the end of August. Behavioral Health managed care is scheduled to be implemented in the North/Central **State** Option on January 1, 2007.

The last HealthChoices-BH implementation phase will be to the remaining 16 counties in the state. These counties accepted the "right of first opportunity" to manage the contract for their residents. The North/Central **County** Option is made up of Erie, Crawford, Mercer, Venango, Cambria, Somerset, Blair, Bedford, Fulton, Franklin, Clinton, Lycoming, Northumberland, Carbon, Monroe and Pike. OMHSAS expects to issue an RFP for these counties by July 31, 2006. HealthChoices-BH is scheduled to be implemented in these remaining counties on July 1, 2007.

Pennsylvania Health Law Project Copyright © 2006

(Continued from page 5)
and a kind of MRI that can look at blood vessels called an MRA. The contractor, not DPW, will approve or deny tests, but denial letters will be issued by DPW. When the contractor denies a service, it must also educate prescribers of the most appropriate radiological study for the particular medical problem. The RFP requires the use of national published standards and requires the contractor to make these standards public.

DPW plans to select a contractor this summer and implement the program in the fall. When the program is up and running, beneficiaries may find they cannot get a test they want, or that their practitioner ordered. They will need to work with the practitioner to decide if they or the practitioner believes the x-ray is medically necessary, and to utilize the appeals process if necessary.

Selective Contracting: Specialty Pharmacy

DPW has shared a draft work plan with the Medical Assistance Advisory Committee , but has not yet issued an RFP for specialty pharmacy contracting. Specialty pharmacy refers to medications that are given at home, or in a doctor's office, that are either injected into skin or muscle or infused through an intravenous line. It does not include insulin. DPW is looking to contract with two providers statewide, in the hope that working with a smaller number of suppliers will improve quality and efficiency.

Impact on Consumers

This will affect consumers who regularly need home infusion, such as persons with hemophilia. It will also affect persons receiving chemotherapy, and treatment for hepatitis C. It will not apply to persons needing short-term antibiotic home infusion after discharge from the hospital.

Selective Contracting: Durable Medical Equipment

DPW has also shared a draft RFP for selective contracting for durable medical equipment (DME). DPW plans to divide the state into five areas, and select at least three providers in each geographic area. DPW's stated goal is to maintain access to the services via contracted fees rather than a fee-for-service model, to enhance prescriber and consumer satisfaction, to improve accountability in the system, and to provide a foundation for future partnership between DPW and the contractor for care management.

The RFP covers a wide range of equipment, including, but not limited to, ventilators and nebulizers, wheelchairs and assistive devices, wound care supplies, supplies needed for home infusion, and orthotics and prostheses. Few if any contractors statewide offer all these services, and subcontracting would probably be needed. The wide range of equipment and supplies will affect many consumers. DPW scheduled a series of "listening sessions" to get public input on this initiative.

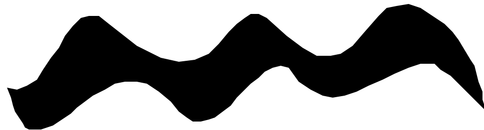
Impact on Consumers

According to DPW, Selective Contracting will benefit consumers by helping DPW control provider quality and operations. However, there is concern about accessibility and continuity of care for consumers who would be transitioned into the new Selective Contract networks. For many of these services, a strong local component is critical. There are many unanswered questions about how selective contracting will work out. DPW has indicated that it will include protections in the RFPs, to assure continuity and coordination during the transition processes. The Consumer Subcommittee of the MAAC will be commenting on these RFPS.

Pennsylvania Health Law Project Copyright © 2006

(Continued from page 5)
other ways to shape behavioral health services by serving on a Board of Directors or Advisory Council.

The guide will be distributed to consumers in drop-in centers in the Southwest 10 counties and trainings will be provided on the information contained in the guide over the next few months. Those in the Southwest who are interested in obtaining copies of the guide can contact Janice Meinert through the PHLP Helpline at 1-800-274-3258. The guide will also be available in the near future on the PHLP website at www.phlp.org.



(Continued from page 2)
and can be viewed at http://www.cms.hhs.gov/eRulemaking by clicking on the link "Electronic Comments on CMS Regulations." Persons who are denied Medical Assistance because they cannot provide the necessary documentation should contact their local legal aid

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!

UPMC Pulling out of Voluntary HealthChoices Counties

UPMC is pulling out of four counties where it operated voluntary MA managed care plans. The four counties are Blair, Cambria, Somerset and Venango. This will affect about 4,400 people in total, though about half are in Venango county. The pull-out is scheduled to be effective on October 1, 2006, though DPW has said that if necessary, the date could be extended to November 1, 2006.

Notices will go out to affected consumers letting them know their options. In counties where there are other voluntary managed care organizations, consumers will be giving the choice of moving into another voluntary HMO or moving into Access Plus. However, in Venango county, where the most consumers would be affected, there are no other managed care plans. In that county, all consumers will be moved into Access Plus/ Fee-for-Service. Nonetheless, affected persons in Venango County need to select a primary care practitioner (PCP).

(Continued from page 2)
the upcoming year. Legislation to authorize this program expansion is expected in the next few months.

The Fiscal Code bill and budget can be viewed online at: http://www2.legis.state.pa.us/WU01/LI/BI/BT/2005/0/HB1992P4516.pdf. and http://www.legis.state.pa.us/WU01/LI/BI/BT/2005/0/HB2499P4513.HTM

Pennsylvania Health Law Project Copyright © 2006

PHLP Staff Available for Free Medicare Rx Trainings

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.

In Memoriam

PHLP sadly notes the death of long time board member and consumer advocate, Shirley Beer. Ms. Beer served as vice chair and then chair of the Consumer Subcommittee of the Medical Assistance Advisory Committee for three decades, and on many boards, including that of the National Health Law Program. She passed away in June 2006. Her dedication, compassion, and support will be sorely missed.

Pennsylvania Health Law Project
Lafayette Building, Suite 900
437 Chestnut St.
Philadelphia, PA 19106