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

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Medicare Discount Drug Card Program Currently Underway

The Medicare Prescription Drug Card Program and Transitional Assistance (created as part of the Medicare Modernization Act of 2003) is now underway. This temporary program will provide consumers with some help with their drug costs before the prescription drug benefit (Medicare Part D) begins in 2006. Consumers who join a Medicare-approved discount card program now, will receive discounts starting June 1, 2004. This is a VOLUNTARY PROGRAM. Consumers can sign up for the discount card and the credit at any time between now and December 31, 2005. Consumers who sign up for a discount drug card will be locked-in to that discount card and can only change cards (for next year) during the open enrollment

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Impact of Medicare Discount Drug Card Program on PACE/PACENet Cardholders

The PACE and PACENet programs are operated by First Health Services Corporation. First Health also offers a Medicare discount drug card. Current PACE cardholders with annual incomes less than $12,569 (for an individual) or $16,862 (for a married couple) should by now have received a letter telling them they would automatically be enrolled into the First Health Medicare Discount Drug Card, and get a $600 credit, unless they "opted out". Once their income is verified by the Centers for Medicare and Medicaid services, they will be enrolled with the

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In This Edition

Governor Committed to Funding adultBasic

The week of May 10 was National Cover the Uninsured week. Various events were organized around the state to provide consumers, advocates, politicians and others the opportunity to discuss the issue of the uninsured in Pennsylvania.

There are currently 1.4 million uninsured Pennsylvanians according to the Robert Wood Johnson Foundation – that's 11.3% of the population. Nearly 20% of the uninsured are children and many are individuals who work for employers who do not offer health insurance.

On May 12, 2004, as part of National Cover the Uninsured Week, consumers and advocates organized a rally in Harrisburg to draw attention to the issue of the uninsured and to ask for more funding for the adultBasic health insurance program. They also met with Governor Ed Rendell and members of his cabinet to discuss adultBasic funding.

At the meeting, the Governor expressed a commitment to finding a way to both stabilize the current funding for adultBasic while also working towards a long term solution that will allow the program to serve more individuals.

The adultBasic program, which provides low cost

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period from November 15, 2004-December 31, 2004. Because of the lock-in feature, PHLP is recommending that no one sign up until they have fully explored their options.

Any Medicare beneficiary who does not have prescription drug coverage through Medical Assistance is eligible to purchase one of the Medicare-approved discount drug cards. Sponsors of the cards can charge an annual fee of up to $30/yr. If a consumer's annual income is less than $12,569 for an individual or $16,862 for a married couple, they will not have to pay the annual enrollment fee and may qualify for a $600 credit.

There are currently 38 companies approved to offer cards to PA residents. All but 4 of the companies are national. There are 2 more companies awaiting approval by the Centers for Medicare and Medicaid Services (CMS).

Consumers who are currently in a Medicare HMO which offers an "exclusive" discount card to their members must choose that company's card. Each Medicare-approved discount card will have a gray oval saying Medicare approved. Scam cards are on the market, so it is important to check for the oval.

Each Medicare-approved discount card offers discounts ranging from 10-25% on each drug. However, discounts are only available on drugs on the plan's "formulary" (also called discount drug list). The amount of the discount and the drugs on the formulary can change at any time. The cards are only good for discounts available at pharmacies that participate with that card sponsor's program.

Consumers with annual incomes below $12,569 for an individual or $16,862 for a married couple will qualify for a $600 credit as long as they do not have outpatient prescription drug coverage through TRICARE for Life (military health insurance), FEHBP (health insurance for Federal employees or retirees), or group-sponsored health insurance. If a consumer receives the $600 credit, they will generally pay a 5 or 10% co-pay for each drug (depending on their income), and the remaining balance of the price of their drug will be taken out of their credit. For example, if a consumer purchases a drug with a discount price of $100 and has a 10% co-pay, the consumer would pay the $10 co-pay and the remaining $90 would be subtracted from their $600 credit. They would then have $510 credit left to use toward future drug purchases. Some card sponsors are waiving the co-pay until the entire credit is spent. A consumer should first check with sponsor of a given card to see how the credit will work with that card .

The Medicare discount drug card program will not benefit everyone. The consumers who will benefit the most from the program are lower-income consumers who can qualify for the $600 credit to help with their drug costs. Whether or not a Medicare discount drug card will benefit a consumer depends on individual circumstances. It depends on what kind of drug coverage the consumer already has, how many drugs the consumer is taking, and how much the consumer is currently spending on drugs. For example, the First Health Card is charging $30 to enroll, and may not offer as high a discount as other cards. However, First Health has indicated that it will use the PACE formulary, which is extremely inclusive. A consumer may decide to pay more in return for the flexibility of having more drugs available. When selecting cards, consumers should ask:

- ?Does the card offer a discount on all the drugs I take?
- ?What is the discounted price for all the drugs I take?
- ?Does my pharmacy accept the discount card?
- ?What is the enrollment fee?

Have more questions? One can compare discount drug card plan prices at www.medicare.gov or by calling 1-800-MEDICARE. Also, a person can call the Pennsylvania Apprise program at 1-800-783-7067. Those who run into problems can call the Helpline at the PA Health Law Project at 1-800-274-3258.

DPW to Contract for "Managed" Fee for Service in Rural Pennsylvania

A year ago, DPW announced that it would not move forward with plans to expand its mandatory managed care program under Medical Assistance (called "HealthChoices") into rural Pennsylvania. Instead, beginning March 1, 2005, most Medical Assistance recipients outside the 3 HealthChoices zones will have to get their physical health care through a "managed" fee for service program, which the state is calling "enhanced primary care case management" (EPCCM). Under the program, medical assistance recipients must select (or be assigned to) a primary care case manager, through whom they must get referrals to specialists or the hospital.

Rather than using the HMO model, with its limited networks and capitated payments, the state will pay providers under a fee-for-service model. Higher rates of reimbursement are promised. DPW will employ a single contractor to manage the program across all participating counties, and to enroll recipients with the case managers. The contractor must develop a disease management program, focusing initially on asthma, diabetes, high-risk pregnancy, and congestive heart failure. Also under consideration are coronary artery disease, chronic obstructive pulmonary disease and neonatal case management. The contractor must guarantee savings to DPW from disease management. In the second year, the contractor must implement a special needs program such as the HealthChoices HMOs employ.

DPW has indicated that provider types will include physicians, specialists, nurse practitioners, physician assistants, midwives, federally qualified health centers and rural health clinics. Providers in the Family Care Network, which currently provides primary care case management services to children in non-HealthChoices areas, will be grandfathered into the program.

Recipients who are dually eligible for Medicare and Medicaid will have the option of enrolling in the program, but will not be required to do so in order to take advantage of disease management programs. In those counties where voluntary managed care programs exist, recipients will get to choose between the HMO and the EPCCM. Nursing home residents, persons in the Health Insurance Premium Payment (HIPP) program, residents of state institutions and long term care capitation program enrollees will be excluded from EPCCM.

The consumer Subcommittee of the Medical Assistance Advisory Committee (MAAC) will be making recommendations to DPW on EPCCM in upcoming months.

" Good cause" for Non-payment MAWD Premiums Expanded

Persons on Medical Assistance for Workers with Disabilities ("MAWD") have to pay a monthly premium (5% of their countable monthly income) in order to keep their Medical Assistance. However, under certain circumstances, these persons can keep their Medical Assistance under MAWD without paying their monthly premium. Those circumstances under which the consumer is excused from paying the premium are known as "good cause."

DPW has recently issued instructions to the County Assistance Offices regarding an expansion of "good cause" for failing to pay the MAWD premium. First, caseworkers can now excuse the non-payment of the premium for more than 2 months (previously limited to 2 months). Second, the situations under which good cause can be granted has been expanded to include "situations such as recipient was of the understanding that employer was paying premiums, recipient has overdue rent or utility bills and suspension of premiums would help the individual pay past due bills, recipient has a temporary health problem that is expected to last longer than 2 months or recipient is working with an agency to regain employment." (Policy Clarification - Medicaid - MAWD PMW 11508316, dated 1/28/04)

DPW Tears Down Barrier to Ongoing Medical Assistance for Persons who "Spend Down" for Prescriptions

Many adults on Social Security Disability lack prescription drug coverage. If they have monthly incomes above $776, they don't qualify for regular Medical Assistance and they can't qualify for PACE until they turn 65. There is a special form of Medical Assistance for which these individuals can, in some cases, qualify. It is called "NMP spend down". Under NMP spenddown, a person must spend a certain amount each month on medical expenses, such as prescription drugs, in order to qualify for Medical Assistance for the remainder of the month. The amount an individual has to spend is known as their "spend down" and is based on amount by which the individual's income is over the SSI payment amount. In essence, the amount being spent operates like a deduction from their income. So, if an individual's monthly income were $200 over the SSI payment amount, he or she would have to spend $200 each month toward medical expenses to qualify for Medical Assistance for the rest of the month.

One of the problems with this form of Medical Assistance has been that people using the "NMP spend down" for coverage often have a gap in coverage at the beginning of the month. This is because this form of Medical Assistance is automatically terminated at the end of each month and not reinstated until: 1) the consumer turns in receipts for paid medical expenses and 2) the caseworker enters the necessary codes in the computer to reopen the Medical Assistance. This is particularly a problem for persons who don't get their Social Security disability until the 3rd of the month and can't afford to spend the amount they need to on medical expenses to qualify for Medical Assistance, until they cash their check. If their caseworker is out of the office, or for some other reason fails to make the necessary computer entries to reinstate the Medical Assistance, the consumer could be without Medical Assistance for several days in the beginning of the month-affecting coverage for all services for which the consumer uses Medical Assistance.

DPW is now allowing persons on Social Security Disability, who use NMP spend down for prescription drugs which they expect to take for the foreseeable future due to a chronic condition, to keep their Medical Assistance without interruption each month. These individuals will still have to pay their monthly spend down amount and send in a paid bill every month to avoid being terminated, but they will still have their Medical Assistance, even in the beginning of the month, without having to wait for their caseworker to turn it back on. This means that if, in addition to getting their prescriptions, they to go to the doctor or get tests done in the beginning of the month, they can use their Medical Assistance for their doctor visits or tests at any time without having to wait until they get their Social Security check so they can buy their medications and then have their caseworker put them back on Medical Assistance.

This policy change has not yet been put in writing so caseworkers won't know about it. Therefore, if you are a person on Social Security disability and either use NMP spend down now, or would like to get on it for prescription coverage, and you take medication for a chronic condition, contact PHLP's helpline at 1-800-274-3258 for help qualifying for ongoing Medical Assistance under the NMP spend down category.

Community Choice Reaches Philadelphia

Community Choice is a pilot project that expanded to Philadelphia on January 30, 2004 . The goal of the pilot is to give consumers options other than nursing home placements, when they have long term care needs. The pilot expedites the application process for Home and Community Based Services (also known as Waivers) by permitting self-declaration of income and assets on a simplified application form. There also is a faster timeline for conducting functional assessments and starting services.

In Philadelphia county, Community Choice applies to the following waivers and programs: Commcare (for Persons with Traumatic Brain Injury), Independence, Attendant Care, PDA (Aging) Waiver, Long Term Capitated Care Assistance Program, OBRA, Michael Dallas (Vent-Dependent), and AIDS. Depending on the urgency of need, a functional assessment can be scheduled anywhere between 24 hrs to 11 days (or a date determined by the consumer) after a call is placed requesting . Under Community Choice, it is no longer nec-

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essary to use the MA 51 form in order to obtain the physician's determination of level of care. A verbal or written physician's order for nursing home level of care will be sufficient. If the order is verbal, the physician will have to submit a written order within 7 days. The completed assessment and application is faxed to the County Assistance Office within 24 hours of receipt. Upon receipt of the application, the CAO will issue an eligibility determination within 24 hours. If eligible, services may be implemented immediately. Within the next 60 days, the CAO will verify the income and assets stated on the application. The CAO will request any additional documents they need to complete the verification process.

As of early May, approximately 2800 applications were filed and over 1200 of those applications were approved. Currently, close to 800 consumers are receiving services in their homes. Over 500 persons avoided nursing home placements in Philadelphia due to the quicker Community Choice process.

The pilot will continue in Philadelphia and recommendations will be made to expand the pilot statewide. If you would like to apply for services or know more about Community Choice in Philadelphia, you can call the 24 hour hotline at 1-888-482-9060. The Community Choice Philadelphia Committee will also be sponsoring a community forum on Thursday June 17, 2004. If you are interested in attending, please call (215) 8354-1877 by June 10, 2004 to register. Space is limited.

Note: The Community Choice pilot is still operating in Fayette, Greene, Washington counties, where it began in October, 2003. One can call 1-800-734-9603 for more information on services in these 3 counties.

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DPW Reports Six-Month Study of Loophole Children Families

In rejecting a DPW initiative to impose a family income test on the PH-95 category eligib ility for Medical Assistance in 2002, the Pennsylvania General Assembly directed DPW to study and report on several characteristics of the families of eligible children. These included their family size and income, county of residence, length of residence in Pennsylvania, third party insurance and the type and cost of services being paid for by the MA program. PH-95 category recipients (sometimes referred to as "loophole" recipients) are children with severe disabilities, who do not qualify for SSI because of their parental income or resources, but whose individual income is below the Medicaid limit, when they are looked at as a "family of one", apart from their parents. DPW has issued a report based on sample data, for the period January 1 through June 30, 2003.

The report shows that there are 29,865 PH-95 category children, with some living in all 67 Pennsylvania counties. The highest counties are: Allegheny (2579), Montgomery (2234), Bucks (1880), Delaware (1637), York (1510), Lancaster (1437), Philadelphia. (1288), Chester (1235), and Lehigh (1046). Just over ten percent of these children live in families with income above $100,000. All but 6% of the families with income above $100,000 annually have other health insurance, to which Medical Assistance is secondary. Ninety-eight percent of the families have lived in Pennsylvania for at least a year, and eighty-eight percent have lived in Pennsylvania for at least five years.

The most commonly reported disabilities are attention deficit hyperactivity disorder, autistic disorder and other pervasive developmental disorders, mood disorders, organic mental disorders, multiple body dysfunction, hearing impairment, down syndrome and communication impairment associated with documented neurological disorder. The services most commonly paid for include behavioral health rehabilitation services, educational rehabilitation, ancillary physical health and pharmacy.

The average cost of providing Medical Assistance to these children is $747.49 per month. The total annual cost in state dollars is $63.3 million. At this time, DPW reports that it has no plans to recommend changing the eligibility criteria or imposing cost sharing on PH-95 category recipients.

Consumer Satisfaction Teams (CST) Having Trouble Reaching Consumers

Consumer Satisfactions Teams (CSTs) existed in PA long before the Department of Public Welfare implemented HealthChoices. So when the State was developing the contracts for the Behavioral Health MCOs consumers, families and advocates pushed for CSTs to be a requirement in the contract between the county and MCOs. As a result of this successful advocacy, the HealthChoices Behavioral Health Program Standards and Requirements include Appendix L: *Guidelines for Consumer/Family Satisfaction Teams and Member Satisfaction Surveys.* Appendix L, Fifth Edition, outlines the requirement that "the primary contractor either directly, or via a BH-MCO or other subcontractor, must have systems and procedures to routinely assess service recipient satisfaction". CSTs are a mechanism for behavioral health consumers and family members to gather input from other behavioral health consumers and family members about the effectiveness of their behavioral health services. The CST concept is built on the premise that behavioral health professionals should not create services in a vacuum, but are most effective when they incorporate the input, ideas, feedback and knowledge of consumers. In addition, the input is provided by consumers to consumer interviewers, so as to increase the likelihood of open and honest feedback in a safe environment. Consumers and family members have face-to-face interviews with others who have first hand experience in coping with and getting treatment for mental health and/or drug and alcohol disease.

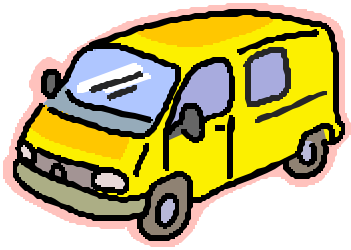
There are approximately 37 Consumer Satisfaction Teams serving 56 counties in Pennsylvania. There are only a handful of CSTs that operate as independent 501(c)3 organizations and a few more that are under the direct fiscal administration of the county. The remaining Teams are under contract with mental health associations or other social service agencies. Most Teams conduct face-to-face interviews with consumers and family members and also use phone interviews, mailed questionnaires and focus groups to gather their input about the services they receive. The information gathered can be used to troubleshoot individual problems a consumer is having, identify treatment approaches for providers that have been successful and make improvements in the overall system of care. The CST approach is an essential component in developing effective treatment programs with meaningful outcomes for behavioral health consumers.

However, CSTs are only effective if they are connecting with consumers. In the Fall 2001, the Consumer Satisfaction Team Alliance of PA (CSTAP) conducted a survey of the CSTs statewide. Of the 27 Teams that responded to the survey, 51% reported having problems accessing consumers. That 51% included 8 of the 10 HealthChoices SW Counties who are contractually bound to ensure that CSTs have access to consumers to interview. Unfortunately, in the almost three years since that 2001 survey CSTs across the state, including those in HealthChoices counties, continue to report difficulty in getting access to clients. In 2003, five of the 10 HealthChoices-SW county CSTs interviewed **less than 3%** of the members served.

Consumer Satisfaction Teams and behavioral health advocates are very concerned about why so few consumers and family members are getting the opportunity to discuss their services. They are questioning how quality of services can be assured when consumers and family members are not being interviewed in sufficient numbers. Questions are being raised about what the counties and OMHSAS are doing in the HealthChoices regions to ensure compliance with Appendix L. These issues are being raised and can be addressed in several forums. County and regional Community Support Programs (CSPs) are inviting CSTs to their meetings to learn how the Teams are functioning in their area and to address access issues they may be experiencing. The SW Behavioral Health Stakeholders group is focusing on access issues in their 10 HealthChoices counties and is beginning to strategize about who needs to do what to correct the problems. The Consumer Satisfaction Team Alliance of PA continues to work with the county CSTs and OHMSAS to identify why access to behavioral health consumers remains a problem, especially in the HealthChoices regions where access to consumers by the CSTs is a contract requirement.

DPW Secretary Estelle Richman has been clear and consistent in her message that services must be designed with "consumers at the table". Behavioral health consumers, family members, CST staff and other stakeholders can contact their county mental health and drug/alcohol offices and attend county and regional CSP meetings to voice their concerns and provice possible solutions. For further information or to address concerns regarding access issues of the CSTs contact, Janice Meinert at PHLP, 1-800-274-3258.

Consumer Advocacy Yields More Improvements to MATP!



The Medical Assistance Transportation Program (MATP) helps MA recipients across the state get to doctor's appointments and other medical services. MATP does this by paying for actual transportation (shared ride van, bus, etc) or through mileage reimbursement if the consumer uses their own or someone else's vehicle.

The Consumer Subcommittee of DPW's Medical Assistance Advisory Committee (MAAC) has consistently advocated over the years for changes and improvements to MATP to make it more consumer-friendly and more responsive to the needs of MA recipients. Recently, the Consumer Subcommittee convinced DPW to convene an MATP Workgroup comprised of consumers, MATP providers and Departmental staff to address chronic issues that arise within MATP and to recommend short term and long term changes to enhance MATP services.

The MATP Workgroup has been meeting regularly since the beginning of the year and these are some of the program changes now underway:

1. **Elimination of the requirement that consumers submit a signed application prior to using MATP services.** Currently, MA recipients cannot use MATP services until they obtain, complete and submit an application form to their county's MATP program. That requirement, which can take weeks, has often been a barrier to consumers getting transportation or mileage reimbursement when they needed it. The Department intends to change that and instead require that consumers must sign an application within 30 days of starting MATP services and cannot be denied services in the interim because a signed application has not been received.
2. **Allowing mileage reimbursement for <u>two</u> round trips if cost-effective.** This policy will address the situation where a consumer has someone available to drive them to and from a medical service, but it will involve two round trips (that is, the patient needs to be at the medical provider for a good part of the day and the driver takes them to the appointment, then goes back home and returns later to pick the patient up). Previously the state's policy had been that the driver could only be reimbursed for <u>one</u> round trip, not two. The new policy being proposed says that as long as reimbursing for two round trips is more cost-effective than the MATP transporting the consumer, the county program can reimburse for two round trips.
3. **Clarifying the county's responsibility for responding to urgent care transportation requests.** Though the current DPW guidelines require MATP to provide urgent care transportation, the county programs are not clear on what urgent care is and often have no process in place to respond to these requests for expedited service. DPW's proposal will require the counties to have mechanisms in place to respond to urgent care requests, and to provide information to consumers about what to do when their urgent transportation needs arise after hours or on the weekend.
4. **Developing a Complaint Tracking System to Ensure Quality of Services**. Beginning in July, 2004 DPW will require the county programs to develop a formal process for dealing with consumer complaints regarding the delivery of MATP services. The county must, among other things: document the complaint in writing; have someone not previously involved in the situation conduct a review and respond to the consumer within a specified timeframe; keep a copy of all complaints, responses and corrective action plans; and report the number, type and disposition of all complaints to DPW on a quarterly basis.

These are only a few of the changes and improvements to the MATP program being brought about largely as a result of the persistent efforts of the Consumer Subcommittee. PHLP will keep our readers informed of other changes and developments within the MATP program as they occur. For more information, or for help with any problems consumers may have accessing or using MATP services call our Helpline at 1-800-274-3258.

New Committee Structure Developed to Advise OMHSAS

Over the past 8 months, the Office of Mental Health and Substance Abuse Services (OMHSAS) has been working on significant changes to its advisory structure. These changes have occurred with the input of members of the current advisory structure as well as other interested consumers, family members and advocates. The standing committees that advised OMHSAS and that were charged with assisting the federally required Mental Health Planning Council were the Child and Adolescent Service System Program (CASSP) Advisory Committee, the Community Support Program (CSP) Advisory Committee, the Joint Committee on the Mental Health of Older People, the Cultural Competence Advisory Committee and the Behavioral Health Stakeholders' Advisory Committee. Within the standing committees, and within OMHSAS, there was general agreement that improvements should be made in how communication occurs and how stakeholders advise OMHSAS.

As a result, OMHSAS staff and the co-chairs of the standing committees began the re-structuring process with 2 day-long meetings last September and another meeting that followed in December. From those meetings a Draft OMHSAS Strategic Plan was developed that included a revised Vision Statement, Guiding Principles and Goals and a proposed structure for new advisory committees. This document was shared with the members of the Mental Health Planning Council and the five standing advisory committees, as well as other interested stakeholders for their input. After several meetings and much discussion, there was general agreement on the re-structuring of the advisory committees. The Mental Health Planning Council and the five standing committees will no longer exist. Instead, the new OMHSAS advisory structure will consist of three committees: the Children's Committee, the Adult Committee and the Older Adult Committee. The three Committees will fulfill the primary duties of the state mental health planning council as defined in the Federal Public Health Services Act. These advisory Committees will also directly advise the Deputy Secretary of OMHSAS, who is currently Joan Erney.

On May 10, 2004, a meeting was held in Grantville for consumers, family members, advocates and other stakeholders to self-select their membership into one of the three Committees. Each Committee will be limited to 30 people, with at least 51 % of the members being mental health and/or drug & alcohol consumers or family members. The Deputy Secretary of OMHSAS will ultimately appoint the members of each Committee. The three Committees will meet at the same time every other month. If you are interested in participating in one of the three Committees you must complete an application and return it to OMHSAS by June 4, 2004. To receive an application, available also in alternative formats, contact Shelley Bishop at OMHSAS at 717-787-2422 or at SheBishop@state.pa.us. For additional information/ questions about the OMHSAS Advisory Committees please contact Janice Meinert from the PA Health Law Project at 1-800-274-3258.

Transition Services Added to Waivers

Older adults and persons with different disabilities can obtain home and community based services through special Medical Assistance funded programs known as waivers.

However, in many of these waivers, services could not begin while the individual was still in a nursing home, ICF/MR or other institution. Soon, the waivers will be able to pay for assistance to individuals in nursing homes, ICF/MRs or other institutions to assist them with the planning they need to arrange for housing and other necessary services to leave the institution. Funds would also be made available for some costs necessary to move from an institution into the community such as rent and utility deposits and home modifications.

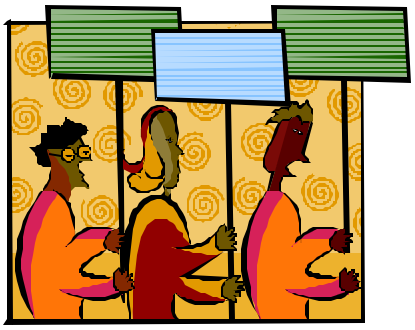
Additional MH Funds May be Available

County Mental Health agencies in the HealthChoices regions are required to "reinvest" unspent money they have received from the State for Medical Assistance funded mental health services. Some counties currently have unspent "reinvestment" money which they will have to spend on mental health services before July 1st. Persons living in the HealthChoices counties in need of mental health services which are not covered by Medical Assistance should contact their Resource Coordinator or Intensive Case Manager and ask about the availability of "reinvestment funds".

(Adult Basic, Continued from page 1)
health insurance to adults below 200% of the Federal Poverty Level ($18,620/year), is the only health insurance option for many Pennsylvanians. The program covers individuals who are unable to get private health insurance because of a pre-existing condition, persons who are unemployed, and those who work, but don't have coverage through their employer.

The need for the adultBasic program is remarkable. Over 42,000 individuals are currently enrolled in the program and over 85,000 are on the waiting list. The Pennsylvania Insurance Department has estimated that 300,000 to 350,000 individuals are eligible for the program.

The adultBasic program is facing a funding crisis in the upcoming budget year. The program is currently funded by the Tobacco Settlement Fund (TSF). Since the TSF is shrinking, there will be a funding shortfall of $12.1 million in the upcoming budget year. That means that approximately 9,000 fewer individuals will be served by the program in 2004-2005 unless funding is increased.



The goal of the adultBasic Rally was to draw attention to the funding shortfall and urge the legislature and the Governor to find new funding sources for adultBasic. Over one hundred consumers and advocates attended the rally with many traveling from as far as Philadelphia and Pittsburgh. A number of these consumers shared their stories and explained why they need adultBasic. Representatives Veon, Josephs, John Taylor and Wheatley and Senators Kukovich, Hughes and Ferlo also spoke at the rally – calling on their colleagues to recognize the importance of the adultBasic program.

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First Health Card, unless they have affirmatively opted out of the card or they have a Medicare HMO that offers an "exclusive" drug discount card. Members of a Medicare HMO that offers an "exclusive" card, cannot get the First Health Card. They can only choose to enroll in the discount card program offered by their Medicare HMO, unless they first disenroll from their Medicare HMO.

Pace recipients with the First Health Drug Discount Card, must show both the First Health card and your PACE card when they go to the pharmacy. If they qualify for the $600 credit, they will not have to pay a co-pay until that $600 credit is spent. For example, if you use the First Health Medicare Discount Drug Card to buy a generic drug with a discount price of $50, you will not have to pay the $6 PACE co-pay, but $50 will be subtracted from your credit balance. You will then have $550 credit left for future drug purchases. Once you spend all of the $600 credit, you then go back to paying the regular PACE co-pays of $6 for generic drugs and $9 for brand name drugs.

PACE cardholders who do not qualify for the credit, as well as PACENet cardholders, do not benefit from enrolling with a discount card. Those who have PACE but cannot get the First Health Medicare Discount Card because they are in a HMO offering an "exclusive" card, will not lose their PACE benefits. But, they can only use one discount card for each drug they buy. Talk to your HMO to see how they will handle the credit so you can decide whether to simply stay on PACE only or also enroll in your HMO's discount card program. Call the Apprise Program at 1-800-783-7067 or the PA Health Law Project Helpline at 1-800-274-3258 for more information or with any questions.

PHLP STAFF UPDATE

PHLP welcomes 3 new advocates: Mita Chatterjee, Grace Egun, and Erin Guay! Mita joined the Philadelphia office as our newest staff attorney in January 2004. Mita graduated from Villanova School of Law, where she developed a strong interest in health law and policy. She has researched and published articles on accessibility under the Americans With Disabilities Act and accessibility of the Indian legal system to victims of domestic violence. She continues to focus on access issues at PHLP where she serves as our eligibility specialist for Medical Assistance.

Grace joined PHLP in the Harrisburg office as a paralegal in January 2004. Grace holds an Interdisciplinary graduate degree with a major in Health Services Administration and a minor in Biological Sciences from Ohio University. Prior to joining PHLP, Grace has extensive experience throughout PA as an advocate for children and families through organizations such as Parent to Parent of PA, Special Kids Network, and Penn State University. She is excited to continue her work helping children, families, and service providers navigate the disability/health care delivery service systems.

Erin, our new paralegal in the Pittsburgh office, joined PHLP in March 2004. Prior to PHLP, Erin worked as a Program Analyst for the United States Department of Health and Human Services where she conducted evaluations of Federal health programs. Erin received an M.A. in Social Administration and a certificate in Health Administration and Policy from the University of Chicago. Since joining PHLP, Erin has been working on issues related to the Medicare Discount Drug Card program. She is interested in working on senior health care issues.

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