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Governor Proposes Severe Cuts to Human Services Funding in 2012-2013 Budget

County-delivered human services programs face significant changes and drastic funding cuts in fiscal year 2012-2013 under the Governor's proposed budget. For many years, counties have been categorically allocated funding for human services. Community or "base" funds are distributed by separate line items for targeted services including mental health, drug and alcohol, intellectual disability, child welfare special grants, homeless assistance programs, and the Human Services Development Fund. The Human Services Development Fund affords counties the flexibility to provide human services on a needs basis, unique to each community, while the other funding pots are allocated for the specific services identified. In the current fiscal year, the total funds distributed for the above line items are $842 million.

For FY 2012-13, Governor Corbett proposes changing how the money is allocated along with substantial reductions to counties' human services funding. The Administration seeks to consolidate the human service line items into a single "Human Services Development Fund Block Grant" and then decrease the total human services allocation to $673 million (a 20% reduction). Under a block grant, the $673 million isn't targeted to specific programs. Instead, the county has discretion to allocate the funding to address local needs; one of the main reasons cited by the Administration for advancing this proposal.

Consumer advocates and community providers have expressed serious concerns with this proposal. Advocates maintain that the severity of the funding cuts will drastically reduce the availability of base-funded services and be devastating to consumers of these services. Members of the behavioral health community (including consumers, providers, county administrators and advocates) are especially alarmed because currently, 73% of the funding that will be combined into the block grant is allocated to mental health and substance abuse services; under the block grant proposal, there is no guarantee at what level these services will continue to be funded. The funding cut, combined with the block grant proposal, has raised grave concerns about how the needs of behavioral health consumers will

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(Continued from Page 1) be met in any given county.

Mental health advocates note that measurable and meaningful progress has been made to improve the lives of people living with behavioral health issues. Three state psychiatric hospitals were closed, and a full range of services in the community offered so individuals with serious mental illness would not have to be institutionalized. Advocates supported hospital closures relying on the promise of increased funding for community supported services. A 20% reduction, combined with a block grant that does not guarantee funding for behavioral health services has created panic and serious concerns for all those impacted.

The Pennsylvania House and Senate Appropriations Committees have already held hearings on the Governor's spending proposal. Between now and the final passage of the budget, either chamber can propose substantial revisions to the DPW budget advanced by the Governor. Ultimately, the General Assembly must pass a General Appropriations Bill for spending across all programs which then goes to the Governor for signature to become the state's budget for FY 2012-13.

Lawsuit Challenges Administration's DPW Budget Proposal

The Disabilities Rights Network (DRN) and attorney Stephen Gold, on behalf of six mental health and intellectual disability organizations, filed a lawsuit against Governor Corbett, the Office of the Budget and the Department of Public Welfare (DPW). The lawsuit, filed in state court, claims that the 20% funding cut along with the proposal to transfer mental health and intellectual disability funds to a block grant violates the Mental Health and Intellectual Disability Act of 1966, which mandates that Pennsylvanians with mental illness and intellectual disabilities have access to adequate services and that the executive branch request sufficient appropriations from the legislature to fund those services. DRN petitions the court to require the Governor, the Budget Office and DPW to request sufficient funds from the legislature to fully fund the service needs of Pennsylvanians with mental health and intellectual disabilities.

An Overview of the Proposed Medicaid Budget

The Governor's proposed budget for fiscal year 2012-13 holds overall DPW funding steady but includes significant eligibility cuts to General Assistance-related Medicaid. The proposed budget also contains a number of other cost-containment initiatives that will affect Medicaid consumers. According to DPW officials, the department priorities guiding this budget are (1) providing services to the truly needy, (2) increasing self-sufficiency and independent living, (3) protecting the taxpayer, and (4) shaping a "lean but active government".

- **Eligibility Changes:** As part of a larger overhaul of the General Assistance (GA) program which includes the elimination of the General Assistance cash program, the Corbett administration proposes $170 million in savings through eligibility changes to GA-related Medicaid. DPW officials have explained the GA-related Medicaid changes as primarily affecting the "medically needy only" (MNO) category. The proposal is to collapse the current categories of GA-related MNO into one

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category for recipients aged 21-64 that has a 100 hours per month work requirement. This would eliminate the current MNO category based on age alone (being age 59-64). The estimated 5,000 consumers receiving coverage based on age would therefore have to work 100 hours per month to retain eligibility under this category. Because of the low income limits for MNO coverage, the 100 hour work requirement will likely mean GA-related MNO will be limited to those with either incurred or ongoing medical expenses they can use to "spend down" to the income limit.

DPW Secretary Gary Alexander has explained the cuts to GA medical benefits as one of the few options available to the state under the federal "maintenance of effort" (MOE) requirements. Part of federal health care reform, the MOE protections prevents states from changing Medicaid eligibility standards prior to the national Medicaid expansion in 2014. Because GA-related Medicaid is funded by state monies only, it is not subject to the federal MOE requirements.

DPW officials state that they are **not** changing the eligibility requirements for the GA-related "categorically needy" (NMP) coverage, which is primarily tied to temporary disability. The Department may decide, however, to more routinely ask for additional medical documentation to support a claimed disability or need for health-sustaining medications. This change is still under consideration.

- **Hospital Application Initiative:** The Administration projects $10 million savings through an initiative that would keep Pennsylvanians who become eligible for Medicaid through a hospital application in fee-for-service Medicaid instead of assigning them to Medicaid managed care (known as HealthChoices) until redetermination (typically 6 or 12 months later). DPW claims many consumers who enroll through a hospital application do not use any additional health services after they leave the hospital. By not enrolling this population in managed care for six to twelve months, DPW anticipates savings from the capitation rates normally paid to managed care entities.
- **MAWD Premium Increase:** DPW also projects $10 million in savings by increasing the monthly premium for consumers enrolled in the Medical Assistance for Workers with Disabilities (MAWD) program. Other than noting consumer premium payments will increase to account for inflation, DPW has not released further details of this change.
- **High Cost Case Reviews:** As one of many "program integrity" initiatives, DPW proposes to periodically review high cost cases to ensure appropriate care is being provided and to avoid duplication of services. DPW anticipates this will result in $45 million in savings. Various offices within DPW will coordinate to provide an unprecedented amount of review. As an example, DPW shared an anecdote of a consumer receiving services through multiple programs who as a result had been authorized more than 24 hours a day of home health care. This initiative would prevent such duplication of services.

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Proposed Medicaid Budget Overview (continued)

Highlights of the Office of Long Term Living's Proposed Budget

The Office of Long-Term Living (OLTL) is responsible for overseeing programs and services for older adults and people with disabilities. Here are highlights from the proposed 2012-2013 OLTL Budget:

- The proposed appropriation for the OBRA, Independence & CommCare Waivers represents a 6% cut in funding. Savings for these programs will be achieved by:
  - Fewer persons served in the OBRA and CommCare waivers (these programs have been closed to new enrollments and it does not appear likely that they'll open up before July 2013);
  - Cuts to Community Integration services which will limit how many units of this service waiver recipients can receive (these cuts are slated to begin in April 2012);
  - Reductions to provider rates (moving from provider-specific rates to uniform statewide per-service rates);
  - Cutting services through "intense management of high cost cases".

- Funds for the Attendant Care Program (which includes the Attendant Care Waiver & Act 150 programs) are being reduced 6.7% under the proposed budget. Savings in this program will be achieved by:
  - Fewer people serviced in the programs (there is currently a waiting list for the Act 150 program);
  - Cuts to some provider rates (moving from provider-specific rates to uniform statewide per-service rates);
  - Moving eligible individuals currently in Act 150 to the Attendant Care Waiver program to draw down federal funding;
  - Cutting services through "intense management of high cost cases".
- The line-item in the proposed budget which contains funding for the Aging Waiver received a 6% cut. Savings will be achieved through continuation of cost-containment measures that began during the current fiscal year (i.e., managing enrollments, changes to rates) and by cutting services through "intense management of high cost cases."
- The LIFE program (which is a managed care program for adults age 55 and older that combines medical care with community support) receives an 18.6% increase under the proposed budget which will allow them to serve additional people.

Highlights of the Office of Developmental Programs Budget

The Office of Developmental Programs (ODP) is responsible for funding and overseeing programs and services for individuals with Autism and those with intellectual disabilities. Highlights of ODP's proposed budget include:

- Funding for the Consolidated & PFDS Waivers under the proposed budget remains relatively steady and does not include any additional monies to provide additional

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(Continued from Page 4) waiver slots. The budget identifies savings of $34 million to be achieved through cuts to services as a result of "intensive review and case management of high-cost consumers."

- An $18.6 million increase to continue services for persons de-institutionalized from State Centers last year, converting private ICF beds to waiver funded beds and "other changes to continue current program."
- An allocation of approximately $116 million for Intellectual Disability base funding services which will be part of the Human Services Development Fund Block Grant discussed on page 1. This represents a 20% reduction in funding plus, under the block grant, there is no guarantee that these funds will be used for services to individuals with intellectual disabilities. Currently, base service funding is used to provide a variety of services including supports coordination, family aide, family education training, recreational therapy and recreation/leisure time activities, vocational therapy, dental hygienic, employment training, home modifications, and FSS/FDSS services. The proposal also includes $20.7 million for ID base funding services that will not be part of the block grant.
- A 14.6% reduction in funding for services administered by the Bureau of Autism Services mainly affecting funding for autism "mini-grants", contract staff, and the elimination of a special grant to Philhaven (a behavioral healthcare organization with locations in south central PA). The Adult Autism Waiver and the Adult Community Autism Program (ACAP) are expected to reach capacity (300 persons in the waiver; 100 in ACAP) and no new slots will be added.
- New funding of $1.7 million for adult protective services (for individuals age 18-59) as authorized under Act 70 of 2010. This is the first time funding has been allocated for these services and the funding in the proposed budget reflects the amount requested by advocates to begin implementing the law including the establishment of a hot line.

Health Reform Updates

As most readers are aware, the U.S. Supreme Court heard oral arguments March 26-March 28 regarding the constitutionality of the Affordable Care Act. A decision is expected by the end of June 2012 when the Court adjourns for its summer recess. More information about this is available on our website at www.phlp.org. While awaiting that decision, the federal government and the states (including Pennsylvania) continue to move forward on the implementation of various aspects of health care reform. Here are some updates:

PHLP Co-Authors Comments on Insurance Department's Proposed Plan for Health Insurance Exchange

The Affordable Care Act provides each state with an unprecedented opportunity to re-shape the health care system to fit its own unique needs and insurance marketplace. Last month, the Pennsylvania Department of Insurance released conceptual draft legislation for a state-operated exchange. The proposed bill would establish multiple, private exchanges; a model very different from other states which have proposed no more than two exchanges operated by either state government or a quasi-government authority. Any private entity meeting the exchange criteria (Continued on Page 6)

(Continued from Page 5) would be certified, and be permitted to sell qualified health insurance plans and other types of insurance including auto and home-owners.

PHLP is concerned about the multiple exchange approach and, with Community Legal Services, co-authored comments critical of the proposed model. We appreciated the Department's desire to create an Exchange unique for Pennsylvania, but discouraged the use of multiple Exchanges. A summary of the Department's proposal, our comments, and the Department's conceptual draft can be found on our website (www.phlp.org).

CMS Issues Final Rule on Medicaid Expansion

On March 16th, the Centers for Medicare and Medicaid Services (CMS) released final rules that spell out the terms for expanded Medicaid eligibility in 2014 under the Affordable Care Act and that require "real-time" enrollment that documents income, citizenship, and other data without the applicant having to bring in paperwork. Face-to-face interviews cannot be required. The rule also collapses the many eligibility categories now in Medicaid into just four: adults, children, parents of minor children, and pregnant women. "I'll guarantee you that Medicaid will look and feel like a very different program in 2014," announced federal Medicaid director Cindy Mann during a telephone briefing about the final rules.

The Affordable Care Act extends Medicaid coverage to all individuals between ages 19 and 64 with incomes up to 133 percent of the federal poverty level. That's $14,856 for an individual and $30,656 for a family of four based on the 2012 federal poverty level.

The proposed rules CMS issued in August initially called for the state exchanges to determine eligibility for federal premium subsidies or Medicaid. But in response to comments raised, the final rule provides two ways for Medicaid-eligibility evaluations: exchanges can determine whether an applicant qualifies for Medicaid or the exchange can make an *initial* determination and rely on the state's Medicaid agency for a final determination.

The final rule will require exchanges and state Medicaid agencies to use state and federal databases such as those kept by the Internal Revenue Service and Social Security Administration to help verify an applicant's income and other information needed to establish eligibility. Pennsylvania will have access to a federal data hub, which CMS expects will be available at no cost to the state. Attestation by an applicant will suffice for most requirements (except for proof of citizenship or immigration status), but where verification of eligibility information is necessary, it will be done in most instances from electronic databases. Information not needed for eligibility cannot be required, and written documentation cannot be required if electronic information is available. State residency will continue to be required for Medicaid eligibility, but a fixed address is not.

PHLP's publications will keep readers updated about Pennsylvania's implementation of Medicaid related changes. Earlier this month, PHLP co-authored a white paper on the revisions to state policy and practice necessary for effective implementation of federal health reform. The paper is posted on our website at http://www.phlp.org/wp-content/uploads/2012/03/PHLP-CLS-White-Paper-3-20.pdf.

MATP Crisis Averted — For Now

Consumers who received notice that their county's Medical Assistance Transportation Program (MATP) was shutting down totally or partially due to insufficient funds will be relieved to know that funding has been found to avert the crisis. As we noted in previous Newsletters, the MATP program statewide has faced severe fiscal problems this year as a result of a $26 million cut in funding enacted by the state legislature in June 2011. In response, DPW and the counties implemented cost-saving measures which included reducing the mileage reimbursement rate to 12 cents per mile and reducing the number of out-of-county trips made by MATP.

Despite those efforts, counties began to notify DPW early in 2012 that they were running out of money and would not be able to sustain their MATP program through the end of the fiscal year. Six counties actually sent notices out to their consumers telling them the MATP program was partially or totally shutting down due to lack of funding. These counties were Lackawanna, Luzerne, Union, Snyder, Wyoming and Butler. A number of other counties publicly announced the imminent shut-down of their MATP program. The Consumer Subcommittee of the state's Medical Assistance Advisory Committee, acting through their counsel PHLP, responded immediately- demanding that the state stop counties from sending any further notices and urging the state to make every effort to find the money needed to sustain the MATP program.

Thanks to the Consumers' strong advocacy, the state did issue a directive stopping the counties from sending out any additional shut-down notices. Even more importantly, DPW was ultimately able to identify additional monies that can be used to fund the county MATP programs so that they could resume normal operations. The state hopes the funds will be sufficient to shore up the MATP program until the end of the fiscal year which is June 30th. Counties that had already sent out shut-down notices are in the process of sending out new notices to their consumers informing them that the program is up and running again.

DPW's proposed MATP budget for FY 2012-13 reflects an 8% increase over current program funding. Even if that entire amount is included in the final state budget approved by the legislature, however, it will likely not be sufficient to maintain the MATP program as it currently operates for another year. That means the state will be continuing to look at ways to cut costs or increase efficiencies in the delivery of medical transportation services. PHLP will keep our readers apprised of any further developments or changes to the MATP program in future newsletters.

MATP copays are **not** starting April 1st as reported in our January newsletter. DPW is required to send written notice 30 days before co-pays begin and it has not yet sent such notice. Regulations were issued last month about these co-pays and other changes (see page 10) and DPW received a number of comments back from various stakeholders about the MATP co-pays. At this point, DPW is still considering if it will move forward with the MATP co-pays.

Update on Medicaid Pharmacy and Dental Benefit Limits

As part of the fiscal year 2011-12 budget passed last summer, the Corbett Administration reduced pharmacy and dental benefits for most adults on Medicaid.

A monthly cap of six prescriptions per month began in January 2012 for Medicaid consumers in fee-for-service (consumers who use the ACCESS card to get their prescriptions). As shown in the chart below, five of the eight Medicaid managed care plans announced their intent to adopt the "six drugs per month" limit. These plans have to mail their members notice of the benefit change at least 30 days before the limits start. As discussed in the November 2011 Health Law News, many drugs are automatically excepted from the "six drugs per month" limit. For any medications not automatically excepted, a consumer's prescriber can request a "benefit limit exception." The managed care member notice will discuss these processes and exceptions in more detail.

Dental benefit coverage for most adults in fee-for-service Medicaid was changed in September 2011. Coverage of dentures was reduced from "once per 7 years" to "once per lifetime" and coverage of root canals, crowns, and periodontal services was eliminated unless approved through a benefit limit exception. See the January 2012 Health Law News for more discussion of these limits and the benefit limit exception criteria and process. As shown below, seven of the eight Medicaid managed care plans have adopted the dental benefit reductions.

MCO / Delivery System	Prescription Limits	Dental Limits
Fee-for-service (ACCESS)	January 3, 2012	September 30, 2011
Aetna Better Health	Not Adopting	February 2012
AmeriHealth Mercy/Keystone Mercy	Adopting, Date TBD	January 2012
Coventry Cares	Not Adopting	Not Adopting
HealthPartners	Not Adopting	April 2012
Gateway Health Plan	May 2012	November 2011
United Healthcare Community Plan	March 2012	October 2011
UMPC For You	May 2012	May 2012

To see which managed care plans operate in a particular HealthChoices zone or county, consult PA Enrollment Services (www.enrollnow.net).

Reminder: Coventry Cares Starts in HealthChoices Southwest Zone April 1st

Medicaid recipients in the HealthChoices Southwest Zone (currently, Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties) now have a new physical health plan option available to them. Beginning April 1st, ***Coventry Cares is doing business in the Zone*** along with the current plans-Gateway Health Plan, United Healthcare Community Plan, and UPMC for You.

Individuals in the Southwest Zone who are new to Medicaid on or after April will be able to join Coventry Cares. Also, current Medicaid recipients who are in one of the other plans in the Southwest now have the option to change to Coventry Cares for their physical health coverage. Interested individuals can contact PA Enrollment Services (1-800-440-3989) for more information.

Certain Medicaid Co-pays To Increase Soon

The Department of Public Welfare (DPW) announced it will increase the sliding scale co-payment amounts for adults on Medicaid beginning **May 15th**. Only consumers who get their Medicaid through the fee-for-service system (those who obtain services using the PA ACCESS card) will be affected. Members of a Medicaid managed care plan will only be affected **IF** their plan adopts the increase and sends out its own notice. As required by law, DPW will mail notice of the change to affected Medicaid consumers at least thirty days in advance.

This change does not increase **fixed** co-payments, such as the $1 and $3 co-pays for generic and brand name prescriptions. It only increases **sliding scale** co-payments, which vary in amount depending on how much Medicaid pays a provider for a service. A doctor's office visit is an example of a service that has a sliding-scale co-pay. For consumers in General Assistance-related categories of Medicaid, the sliding scale co-pay amount is double that applied to other Medicaid consumers. The increased co-payment amounts are as follows (the current co-pays are in parentheses):

Medical Assistance (MA)	
Amount DPW Pays	**Consumer Copayment Amount**
$2-$10	$0.65 ($0.50)
$10.01-$25	$1.30 ($1.00)
$25.01-$50	$2.55 ($2.00)
$50.01 or more	$3.80 ($3.00)

General Assistance (GA)	
Amount DPW Pays	**Consumer Copayment Amount**
$2-$10	$1.30 ($1.00)
$10.01-$25	$2.60 ($2.00)
$25.01-$50	$5.10 ($4.00)
$50.01 or more	$7.60 ($6.00)

This change will **not** affect Medicaid consumers who are currently not required to pay any co-payments, such children under age 18, pregnant women, and residents of a long-term care facility. The change will also **not** apply to services to which no co-payment is applied, such as emergency, laboratory, and home health agency services.

Medicaid services cannot be denied to consumers unable to afford the co-payment. An individual who cannot afford to pay a co-payment at the time of service should tell their provider. A provider can bill a consumer afterwards, but cannot withhold services for the consumer's failure to make a copayment at the time of service.

DPW is implementing this change through an "expedited" regulation under the authority granted to it by Act 22 of 2011. Under this authority, DPW is able to promulgate regulations without going through the usual public notice and rulemaking processes (see the next page). The amounts of the co-payment increases are tied to an inflation index.

As an additional co-payment-related change in this regulation, DPW will no longer reimburse consumers who paid excessive co-payments. Currently, Medicaid consumers who pay more than $90 in co-pays, and GA-related Medicaid consumers who pay more than $180 in co-pays, over a six-month period are able to have the excess amount refunded to them. These refunds will stop effective May 15th.

DPW Expedited Rule Making Changes Under Act 22

Act 22 of 2011 gives Pennsylvania's Department of Public Welfare (DPW) the authority to issue new regulations without going through normally required administrative rule making procedures. While there is some question as to whether this delegation of power to an administrative agency is legal under the PA Constitution, DPW is now moving ahead to change various regulations under this new authority.

On February 23rd, DPW announced its intent to amend the Commonwealth's Medicaid State Plan and current Medicaid regulations to establish and increase co-payments for certain Medicaid services as described on the previous pages. The comment period was only two weeks and ended Friday, March 9, 2012. Here are highlights of PHLP's comments in regard to the proposed Medicaid copayment changes described in other sections of this newsletter.

Proposed Changes to Sliding Scale MA Co-Pays (see page 9): PHLP's comments were critical of this proposal because it will cause consumers to forego preventative services, worsen health outcomes, and prove counterproductive as a cost-containment initiative. Rather than increasing co-pays, PHLP urged DPW to follow the example of the managed care plans in its HealthChoices program, none of which charge a co-pay for any outpatient primary care services (FQHC, PCP, OB/Gyn, and certified nurse practitioner visits). Co-pays disproportionally harm low-income consumers with chronic health conditions. These individuals access services the most but are least able to afford any cost sharing. Insofar as even small increases in co-pays create barriers to care for this population, they will worsen health outcomes and prove counterproductive as a cost-containment measure.

Proposed MATP co-pays of $2 for a one-way trip (discussed in January's newsletter). PHLP believes this proposed co-payment is too high, particularly for GA-related Medicaid recipients, most of whom have income at or below $205 per month. Such a co-pay would impose a real financial burden on the sickest Medicaid recipients who require multiple doctors' visits per month – or even per week – to manage their conditions. For example, dialysis patients who must be treated two or three times a week will suddenly be asked to pay $50 or more in co-pays each month for transportation to treatment that is literally life saving. Cancer patients needing frequent chemotherapy infusions will face similar hardships if the MATP co-payment is imposed.

A listing of the draft "expedited regulatory changes" issued under Act 22 was posted by DPW on its website (www.dpw.state.pa.us). Other proposed changes relate to Office of Developmental Programs Home and Community-Based Services, Office of Long Term Living Home and Community-Based Services, and changes to Pharmaceutical Services Payment Methodology.

At the March 22nd meeting of the Medical Assistance Advisory Committee, DPW reported receiving hundreds of comments in the two weeks window for comments and is reviewing all of them. A decision on the final regulations and their date of implementation is expected soon.

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Open Enrollment for HealthChoices Expansion Begins in May

The Open Enrollment Period to choose a Medicaid managed care plan will begin in May for Medicaid consumers who live in seven rural Pennsylvania counties. As noted in our January Newsletter, DPW has decided to expand HealthChoices statewide over the next year and create two new HealthChoices zones where people can choose between managed care and ACCESS Plus. However, seven counties will join existing HealthChoices zones in July. In these seven counties, ACCESS Plus will **no longer** operate and instead ACCESS Plus consumers will be required to join a Medicaid managed care for their physical health care.

Bedford, Blair, Cambria and **Somerset** counties will become part of the ***HealthChoices Southwest Zone***. Medicaid consumers in those counties can enroll in any of the four managed care plans available in the Zone:

- Coventry Cares
- Gateway Health Plan
- United Healthcare Community Plan
- UPMC for You

Franklin, Fulton and **Huntingdon** counties will be incorporated into the ***HealthChoices Lehigh-Capital Zone***. The Medicaid consumers in those counties will have the following managed care plans to chose from:

- Aetna Better Health
- AmeriHealth Mercy Health Plan
- Gateway Health Plan
- United Healthcare Community Plan
- UPMC for You

Consumers in the seven counties will receive written information about the HealthChoices expansion and their plan choices prior to the start of the Open Enrollment Period in May. Consumers will be asked to enroll in a plan and choose a primary care practitioner (referred to as a PCP), who will provide most of the consumer's primary care and who will make a referral if the consumer needs to see a specialist.- ACCESS Plus members who do not choose a plan during open enrollment will be auto-assigned to a plan by DPW. The plan enrollments will take effect on July 1, 2012. Individuals who are currently enrolled in a voluntary managed care plan will remain in that plan unless they take action to join a new plan (see below).

Unlike ACCESS Plus, consumers in HealthChoices are restricted to health care providers (including dentists and vision care providers) that are in their health plan's network. Consumers can only go to a provider out of the network, and have it covered by the plan, if their health plan approves the out-of-network referral in advance.

Before enrolling in a plan, consumers should check with their providers (i.e., PCP, specialists, hospitals) to determine if they are in the network of any of the HealthChoices plans and then enroll in the plan that would allow them to keep most, if not all, of their important providers. Consumers should also check that the plan covers their medications as each plan had a different list of drugs (called a formulary) they will cover.

Correction to information we had in our January 2012 Newsletter:

Please note that individuals who live in one of the 7 counties that will join an existing HealthChoices zone in July **and** who are enrolled in a Voluntary Managed Care plan will remain enrolled in their plan unless the individual makes a different plan choice. These individuals will **not** be auto-assigned into a managed care plan. The information from our January 2012 newsletter indicated that all consumers in the 7 counties who failed to make a plan choice prior to July 1st would be auto-assigned into a plan.

Thank you to representatives from the Department of Public Welfare who read our January 2012 newsletter and brought this clarification to our attention.

Fran Chervenak Receives 2012 PLAN Excellence Award

Fran Chervenak, PHLP's Director of Client Services and Managing Attorney of the Pittsburgh office, was honored by the Pennsylvania Legal Aid Network (PLAN) at its annual awards banquet. Fran has dedicated her entire career to legal services. Prior to joining PHLP in 1998, she worked at the Legal Aid Society of Minneapolis. Fran has helped thousands of individual clients during her time at PHLP and has a reputation as a competent, caring advocate and a terrific mentor and teacher. Fran provides counsel to the DPW Consumer Subcommittee of the Medical Assistance Advisory Committee as well as the consumers appointed to the state's Medical Assistance Transportation Advisory Committee. She is an expert on the delivery of health care to Pennsylvania's dual eligible population. Fran's passion for the clients we serve and her work are remarkable. She thinks she's just doing her job but those of us who work with her and clients who have worked with her know that is a real understatement. Congratulations to Fran and the other 2012 PLAN Excellence Award Winners!

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