Health Law PA News

A Publication of the Pennsylvania Health Law Project

Volume 16, Number 1
January 2013

Statewide Helpline: 800-274-3258
Website: www.phlp.org

State Budget Process Begins in Earnest in February

On February 5th, Governor Corbett will deliver his budget address and unveil his spending plan for the 2013-14 fiscal year that begins July 1st. Following his address, Appropriations Committees in the state House and Senate then review the proposed budget and invite the heads of every state agency to appear before them at hearings to answer questions.

When the legislative hearings are concluded, each chamber introduces an appropriations bill that details spending. The bills ordinarily reflect the governor's original proposal but might include additions or cuts that reflect the priorities of that particular chamber.

State law requires that a budget be in place by the beginning of the state fiscal year on July 1st. As the deadline approaches, legislative leaders and the governor negotiate a budget that will secure enough votes to pass both chambers.

Below are other dates of interest regarding the state budget.

Senate Appropriations Budget Hearings

- Department of Insurance – February 21
- Department of Health – February 26
- Department of Aging – February 27
- Department of Public Welfare – March 5

House Appropriations Budget Hearings

- Department of Aging – February 22
- Department of Insurance – February 28
- Department of Health – March 5
- Department of Public Welfare – March 6

Future PHLP newsletters will provide analyses of the Governor's proposal as well as the spending bills of each chamber and what they mean for health coverage for vulnerable Pennsylvanians.

INSIDE THIS EDITION

Final Phase of Medicaid Managed Care Expansion Underway

The Department of Public Welfare (DPW) is now in the final phase of its statewide expansion of HealthChoices (what the state calls mandatory managed care for most Medicaid consumers). HealthChoices now exists in 45 counties and 4 zones: Southeast, Southwest, Lehigh/Capital and New West. The remaining 22 counties in the state will make up the HealthChoices-New East Zone that DPW is planning will go live on March 1st.

In January, DPW mailed out managed care plan enrollment information to over 205,000 Medicaid consumers in Bradford, Carbon, Centre, Clinton, Columbia, Juniata, Lackawanna, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northumberland, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming counties. **Consumers have until February 7th to enroll into one of three available plans.** Those who do not enroll in a plan by February 7th will be randomly auto-assigned to a plan effective March 1st. The three plans available to consumers in the New East Zone are:

- Amerihealth Northeast
- Coventry Cares
- Geisinger Health Plan (GHP Family)

Those currently enrolled in a Voluntary Plan with Amerihealth Mercy can either stay in the plan they are in (in which case they will move into HealthChoices with Amerihealth Northeast effective March 1) or they can switch to a new plan (by enrolling no later than February 7th) that will go into effect March 1st. **Those currently enrolled in a Voluntary Plan with United Healthcare Community Plan will not be able to stay in this plan because it is no longer doing business as a Medicaid plan in the Zone as of the end of February**. That means all those in United Healthcare will need to enroll into one of the three available plans by February 7th or else they will be randomly auto-assigned to a plan.

Individuals can contact PA Enrollment Services at 1-800-440-3989 or visit www.enrollnow.net for information about plan options and to enroll in a plan.

As a reminder, certain Medicaid consumers in the New East Zone **will not** be affected by the expansion of HealthChoices because they are exempt from Medicaid managed care. To be exempt, consumers must fit into one of these groups:

- **Full Dual Eligibles**: those on Medicare who also have full Medicaid through their ACCESS card
- **Aging (PDA) Waiver participants**
- **LIFE Program participants**
- **HIPP participants**: consumers who are also enrolled in employer-sponsored health insurance for which Medicaid is paying the premium

Anyone needing help with choosing a Medicaid plan, or with accessing care through their Medicaid plan once the HealthChoices New East zone is underway in March, should call PHLP's Helpline at 1-800-274-3258.

Want to Learn More?

PHLP will be conducting another webinar on HealthChoices Expansion for the New East Zone on **February 22nd** from **10 am-noon**. Please e-mail staff@phlp.org or click on this link to register: https://attendee.gotowebinar.com/register/4673329386489000960.

New PHLP Publications Detail the Benefits and Savings Of Expanding Medicaid

Pennsylvania lawmakers have an unprecedented opportunity to improve the lives and health of hundreds of thousands of uninsured Pennsylvanians, with the federal government initially covering the full cost of the program. Governor Corbett has not yet made a final decision about whether the state will expand its Medicaid program as allowed under the Affordable Care Act. Budget Secretary Charles Zogby recently said that the governor is not going to be rushed into a decision noting "It's something that he wants to look at the Pennsylvania way and not dictated by the federal government."

PHLP has released several analyses to inform the public and state policy makers about this option:

- "Medicaid Expansion: A Benefit for Rural Pennsylvania", co-authored by the Pennsylvania Office of Rural Health, describes the benefits for the nation's third largest rural population.
- "Expanding Medicaid in PA: Consider the Savings", highlights how expanding Medicaid in 2014 to cover an additional 600,000 uninsured adults will create $400 million per year in budget savings and new revenues.
- "Medicaid Expansion is Good for Families", is co-authored with Georgetown University's Center for Children and Families and details how 131,000 uninsured parents and families will benefit from expanding Medicaid.

Together, these analyses emphasize how expanding Medicaid is the right decision, both for Pennsylvania's budget and for Pennsylvania's families and communities. We encourage readers to review each of these reports at our website, www.phlp.org, and to share them widely.

State and Federal Officials Face a Shrinking Timeline to Open Health Insurance Exchange

In eight months (October 2013), Pennsylvania residents can begin to use new insurance markets, also called "exchanges", to enroll in health care coverage that will start January 2014. Exchanges offer individuals and their families a choice of health plans resembling what workers at major companies already receive. Through exchanges, the federal government will help many households pay their premiums by giving them a federal tax credit.

In December 2012, Governor Corbett announced that Pennsylvania will not operate its own health insurance exchange, citing unknown costs and a lack of certainty in federal rulemaking. Instead, Pennsylvanians will use an exchange operated by the federal government.

Much work remains to be done and many decisions need to be made by federal **and** Pennsylvania officials. For example, the state and the federal government must work together to construct an eligibility and enrollment process that ensures applicants are promptly screened for

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(Continued from Page 3) eligibility for all insurance programs including Medicaid and the Children's Health Insurance Program (CHIP) as well as be screened, in advance, for premium tax credits to purchase private insurance.

The state must build an information technology infrastructure that will interface with the federal exchange. Pennsylvania officials have requested further federal information and clarification to address a number of outstanding questions. Most states have made significantly more progress than Pennsylvania in finalizing their exchange systems and processes. According to a recent report released by the Kaiser Family Foundation, Pennsylvania lagged behind 46 other states in planning these infrastructure upgrades.

In the months ahead, PHLP will update readers about progress to make the exchange run well for the hundreds of thousands of uninsured Pennsylvanians who will use it to purchase quality affordable health insurance .

Women with Breast or Cervical Cancer Being Moved Into HealthChoices

Beginning March 1, 2013, women receiving Medical Assistance (MA) under the Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program will receive their coverage through a Medicaid managed care plan. Up until now, women in the BCCPT program were exempt from HealthChoices and received their coverage through the MA-Fee-for-Service system (ACCESS card). In December, however, DPW announced that it had decided to move these MA consumers into managed care as of March 1st.

On January 11, 2013, DPW sent out a notice to the 1,700 women in the BCCPT program across the state telling them about this change in how they access their healthcare benefits. The notice said that the women would soon receive information in the mail about HealthChoices and about the plans available in their county. Women living in the 22 counties making up the **HealthChoices New East Zone** (see article on page 2 for the list of these counties) have until **February 7th** to enroll into a HealthChoices plan. Women living anywhere else in the state are given until **February 14th** to enroll into a plan. If a woman does not enroll into a plan by the date specified, she will be randomly auto-assigned to a plan that will be effective March 1st.

When choosing among the plans available, women in the BCCPT program should pick a plan that has their oncologist, radiologist, hospital and other important providers in its network. All enrollments are done by calling PA Enrollment Services at 1-800-440-3989 or enrolling online at www.enrollnow.net.

Also starting March 1st, these women will be enrolled in a behavioral health managed care plan to get services for mental health or drug and alcohol problems. MA consumers do not get to choose their behavioral health managed care plan but instead must access services through the behavioral health plan chosen by their county. This plan will send the women a Member Handbook telling them how to obtain behavioral health services through the plan.

Enrollment Suspended for Keystone Mercy Health Plan

Beginning April 2nd, DPW is suspending new enrollments into Keystone Mercy Health Plan (KMHP) for the remainder of the 2013 calendar year. KMHP initiated the request to suspend enrollments and DPW stated it approved the suspension in order to balance membership distribution in the Southeast HealthChoices Zone.

Though it is one of five managed care plans available in the Southeast Zone, KMHP currently covers 55 percent of the Southeast HealthChoices population. This is the second time KMHP requested, and DPW approved, a suspension of enrollments into the plan-the first being in 2010.

The enrollment suspension will **not** affect existing KMHP members. Additionally, it will **not** apply to new births or to individuals added to the household of an existing KMHP member.

People who had KMHP and who then lose Medical Assistance/Medicaid eligibility will be enrolled back into KMHP as long as their break in coverage is less than six months. If the break in coverage exceeds six months, the individual will not be able to re-enroll into KMHP but instead must choose one of the other managed care plan available.

Existing KMHP members who switch to another plan will not be able to switch back to KMHP until the enrollment suspension is lifted at the end of the year. DPW will make exceptions to its suspension policy for "extraordinary circumstances" on a case-by-case basis.

MA consumers in the Southeast Zone enrolled in a managed care plan other than KMHP who wish to change to KMHP must make that selection by **March 14th** in order for the change to go into effect before the April 2nd enrollment "freeze."

Consumers and advocates have expressed concern to DPW over its intervention, yet again, in KMHP enrollments and in the resulting reduction of plan choices for consumers in the HealthChoices-Southeast zone.

If you have any questions about your health plan choices, contact PA Enrollment Services at 1-800-440-3989.

You can also contact PHLP's Helpline if you need additional assistance or have questions about plan choices.

Do you currently get the Health Law PA News through the mail? Would you like to get these newsletters by e-mail?

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Concerns Raised Over BHRS Changes

The Office of Mental Health and Substance Abuse Services (OMHSAS) has been redesigning Behavioral Health Rehabilitation Services (BHRS) over the last several months. The changes themselves, as well as the lack of stakeholder input to the changes, have raised significant concerns among families, providers, and advocates.

OMHSAS and the Medical Assistance Behavioral Health Managed Care Organizations (BH-MCOs) have long been concerned about the rising use and high cost of BHRS. BHRS, commonly referred to as "wraparound" services, are mental health treatment services provided to children and adolescents with significant behavioral health conditions such as Autism, Oppositional Defiant Disorder and Conduct Disorder.

These intensive services must be prescribed by a psychologist, psychiatrist or developmental pediatrician and are delivered in the child's home, school or other community setting. Wraparound services are delivered by provider staff referred to as Behavioral Specialist Consultants (BSC), Mobile Therapists (MT) and Therapeutic Staff Supports (TSS). BHRS also includes another service known as Summer Therapeutic Activities Program (STAP), commonly referred to as Therapeutic Summer Camp.

Changes to Wraparound Services

Some of the more concerning features of the redesign of Wraparound Services include:

- Limiting (and perhaps eliminating) BHRS for children with ADHD, based on the theory that medication is the most appropriate treatment for children with this diagnosis.
- Applying heightened scrutiny to requests for "high intensity" services (referring to either the number of hours of service or the length of time the service is prescribed). Details of what would be considered "high intensity" have not been provided by the state; however, more than 10 hours a week and longer than 6 months were mentioned as possible guidelines.
- Rewarding providers who reduce the amount of hours or the duration of services they prescribe.- Providers who consistently prescribe services within the parameters OMHSAS and the MCOs determine to be generally acceptable will gain "preferred provider" status-entitling them to approval of service requests with minimal review.

  Advocates fear that providers will feel pressured by these policies to prescribe less than the amount and duration of BHRS services needed to meet the clinical needs of their patients. If that happens, parents will not be able to appeal because the plan has approved, not denied, the level of service requested.

The redesign appears to have been developed by OMHSAS, the Mercer Consulting Group and the BH-MCOs and was done **without** the involvement of the OMHSAS Children's Advisory Committee (whose sole mission is to advise the state on these very issues) or affected families. Advocates and providers are keenly aware that BHRS are expensive and intensive services but are concerned that the changes as well as the redesign process are being driven by financial concerns and without sufficient consideration of the clinical impact on kids and families. Families are expressing concern that their children

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(Continued from Page 6) with significant behavioral issues will be left without BHRS services with few or no options for other forms of treatment.

OMHSAS is promoting new services called Multi-Systemic Therapy and Family Functional Therapy as evidence based practices appropriate for some kids who are now receiving wraparound services. However, there are a limited number of providers across the state trained to offer these services-especially in the rural parts of Pennsylvania. An equally important concern is that these new therapeutic modalities have not been tested on children with autism diagnoses and may not be appropriate for them.

Changes to Therapeutic Summer Camp

Families are also expressing concerns about significant changes to Therapeutic Summer Camp/STAP services. Last March, OMHSAS issued a 12-page bulletin outlining dramatic changes to STAP (see Bulletin number OMHSAS-12-01). STAP was added as an MA-covered service in 1996. Since then, providers offering STAP were required to submit a service description of their program for OMHSAS approval prior to providing billable services. Therapeutic Summer Camp programs varied in number of hours per day and number of days per week they operate. A typical program might offer camp for five to six hours per day, five days a week for six to eight weeks and the camp would be billable in its entirety, once approved by OMHSAS.

Under the new mandates, OMHSAS requires providers to bill in one-hour increments, stipulating that a 3-hour period is generally the maximum amount that will be approved per day. As stated in its Bulletin, OMHSAS determined that "STAP will be limited to the amount of treatment the youth population served can assimilate in one time period, which is generally no more than 3 hours per day for most ages and developmental needs". Even if that is correct, when OMHSAS makes such sweeping changes without input from affected families or from STAP providers it raises concerns and questions about the impetus for such changes. As with the BHRS changes, parents and other stakeholders are questioning if these changes are really about quality improvements to services or primarily an effort to rein in spending.

In addition to the concerns set out above, there are also questions about whether some of these changes deprive children with autism spectrum diagnoses of services mandated under the Autism Insurance Law-Act 62. As noted in the following article on BSC licensure, Act 62's mandates apply to Medical Assistance as well as commercial health insurance plans.

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For the Capital Region, go to www.uwcr.org and pledge a donation to PHLP.
For the Pittsburgh Region, go to www.unitedwaypittsburgh.org and select agency code number 11089521.

Provider Licensure Changes Could Affect Services to Children with Autism

Upcoming changes regarding Behavioral Specialist Consultant provider licensure are a cause for concern for families whose children have an autism diagnosis and who receive services through Medical Assistance/Medicaid. As discussed in the previous article, Behavioral Specialist Consultants (BSCs) provide Behavioral Health Rehabilitation Services ("BHRS"- commonly known as "wraparound") along with Therapeutic Staff Support (TSS) and Mobile Therapists (MT). BSCs have the highest level of education and their role is to advise the treatment team in the development and revision of the child's treatment plan. The requirements for BSCs were established by DPW's Office of Mental Health and Substance Abuse Services (OHMSAS).

Act 62 (commonly known as the Autism Insurance Law), passed in 2008, is largely known for its mandated coverage of autism services by certain commercial health insurance plans. However, Act 62 also applies to Medical Assistance. One provision of Act 62 creates a category of licensed provider called a "behavior specialist". The Act defines behavior specialist as: "an individual who designs, implements or evaluates a behavior modification intervention component of a treatment plan, including those based on applied behavioral analysis, to produce socially significant improvements in human behavior or to prevent loss of attained skill or function, through skill acquisition and the reduction of problematic behavior." Act 62 also sets out certain qualifications for behavior specialists and gives the state Board of Medicine responsibility to issue regulations regarding licensure and to handle applications from people seeking behavior specialist licensure. The Act allows one year from the date those licensure regulations are issued for behavior specialists to become licensed in order to continuing being an "autism service provider". The Board of Medicine issued the behavior specialist regulations on May 26, 2012.

OMHSAS issued a notice to providers in August 2012 that persons providing wraparound services as a BSC to children with an autism spectrum diagnosis would have to be licensed, per Act 62, as a Behavior Specialist by May 26, 2013 in order to bill Medical Assistance for their services unless they had another license recognized by Act 62 (i.e., licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner).

An estimated 30 percent of those currently serving as a BSC do not meet the educational and experience requirements to be licensed as a behavior specialist under Act 62. Families whose children have an autism spectrum diagnosis and who are receiving services from a BSC should ask their wraparound agency whether their child's BSC meets the requirements for licensure under Act 62 and, if not, what plans the agency has to ensure continuity of BSC services beyond the May 26th deadline.

Unfortunately, because the licensure regulations are only eight months old and the state Board of Medicine has had no prior experience licensing behavior specialists, there is likely to be confusion over required documentation and backlogs in processing licensure applications. In addition, other BSCs will need to get additional training or education to meet the Act 62 licensure requirements.

This presents a real risk that many BSCs will not obtain Act 62 licensure by the May 26th deadline and that DPW will stop paying for their services. Families whose BSCs don't yet meet the training and education requirements, or whose licensure applications haven't yet be approved, may wish to contact OMHSAS to urge that it revise the May 26th deadline and continue to pay BSCs while they obtain the required training or complete the licensure application process.

Payment Problems Continue for Waiver Recipients and Caregivers Under New Vendor

Individuals receiving services through the Aging, Attendant Care, COMMCARE, Independence, and OBRA Waivers and their caregivers continue to struggle with payment problems even after a new vendor, Public Partnerships, Ltd (PPL) took over responsibilities late last year. Consumers in these waiver programs who hire their own workers under the consumer model receive Financial Management Services (FMS) for the administrative tasks associated with the consumer model. The FMS provider is responsible for writing paychecks, paying required taxes, and handling paperwork related to workers compensation and other employment-related issues.

As discussed in previous newsletters, the Office of Long-Term Living (OLTL) decided to contract with only one company, PPL, to provide FMS services across the state. As of January 1st, anyone receiving FMS services in the waivers listed above must receive those services through PPL. Cases were transitioned to the new vendor in mid-December, so PPL could start issuing paychecks as of January 1st. Since the transition to PPL began, thousands of caregivers have experienced delays in receiving their paychecks, leaving individual waiver consumers at risk for losing their workers who they rely on for their daily care and placing great burden on caregivers who are struggling to pay their bills. Adding to the frustration of these individuals is the fact that they have been unable to reach PPL by phone to report problems or find out the status of their pay. These problems have been occurring across the state and across the five OLTL Waiver programs.

OLTL is aware of the problems and they are working with PPL to get these problems resolved. However, neither party has provided detailed information about what steps they were taking to correct the problems nor did they give a sense of when the problems would be ultimately fixed. Both OLTL and PPL blame many of the problems with the delayed payments on problematic data received from previous FMS providers.

Important Information for Consumers using PPL

The packet does not need to be completed to submit timesheets; however, PPL timesheets must be used (available at www.publicpartnerships.com). Consumers who don't already have a PPL timesheet with their attendant's name on it can download a blank copy from PPL's website, fill it out completely, and use that.

- Only one time sheet should be faxed at a time. If a consumer hires more than one worker, wait until the first timesheet goes through before faxing the next. Consumers are advised **not** to fax a cover sheet- just the time sheet. In addition, timesheets may **not** be faxed before the due date, even if the worker will not be working any more days during that pay period.
- Consumers with access to the internet can get a user name and password to track the processing of their workers' timesheets online.

Consumers who are trying to hire a new attendant are currently experiencing a delay of about a month before they are put on payroll by PPL. Individuals whose health might suffer, or who are at risk of going into a nursing home or other institution because of this delay, should call the Disability Rights Network at 1-800-692-7443.

Waiver consumers who experience problems with their caregivers being paid by PPL can contact PHLP's Helpline at 1-800-274-3258.

Update: Managed Care Plans and the MA Benefit Limits

Additional managed care plans are adopting benefit limits that began in 2011 after the Corbett Administration reduced pharmacy and dental benefits for most adults on Medical Assistance (MA). An updated chart on which MA managed care plans have adopted the pharmacy and dental reductions is presented below.

A monthly cap of six prescriptions per month was put in place in January 2012 for MA consumers in "fee-for-service" (consumers who use the ACCESS card to get their prescriptions). Many drugs are automatically excepted from the "six drug limit," meaning that consumers can get these medications filled after they have reached their six prescription limit. However, drugs that are automatically exempt from the limit still count toward the six prescription limit. For any medication not automatically excepted, a consumer's prescriber can request a "benefit limit exception." As shown below, six of the nine MA managed care plans have adopted the prescription limit. **Aetna Better Health** is the latest plan to start these limits beginning **February 1, 2013**. Aetna members should have received written notice about this change.

Dental benefit coverage for most adults in "fee-for-service" MA was changed in September 2011. Coverage of dentures was reduced from "once per seven years" to "once per lifetime". Coverage of root canals, crowns, and periodontal services will only be provided if a benefit limit exception is requested and approved. As shown below, eight of the nine MA managed care plans have adopted the dental benefit reductions.

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

MCO	Prescription Limits	Dental Limits
Aetna Better Health	**February 2013**	Adopted
AmeriHealth Mercy/Keystone Mercy	Adopted	Adopted
Coventry Cares	**Not Adopting**	**Not Adopting**
HealthPartners	**Not Adopting**	Adopted
Gateway Health Plan	Adopted	Adopted
United	Adopted	Adopted
UMPC for You	Adopted	Adopted
Geisinger Family Plan	**Not Adopting**	**March 2013**

Settlement Brings Changes to the Waiver Application Process

At the end of November 2012, the Federal District Court for the Eastern District of Pennsylvania approved a settlement agreement between the Disability Rights Network (DRN) and the Department of Public Welfare (DPW) in the class action lawsuit, Mosley v. Alexander.

The settlement should improve the application and enrollment process for individuals who are trying to access the AIDS, Attendant Care, CommCare, Independence and OBRA Waivers.

The lawsuit was filed by DRN because of problems their clients were experiencing, including significant delays in the waiver eligibility determination process, inappropriate denials without written notice, and the failure to notify individuals of their right to a timely determination and to appeal delayed determinations.

Under the settlement agreement, DPW will be required to determine waiver eligibility within 90 days and must allow all individuals interested in applying for a waiver the opportunity to do so.

The agreement specifies timeframes for various steps of the waiver application process and written notice requirements. It also holds DPW responsible for notifying individuals who were inappropriately told they could not apply of their right to reapply for a waiver program.

DRN will receive regular reports from DPW in order to monitor compliance with the settlement agreement.

The previous waiver application process involved several steps:

- Maximus (the Independent Enrollment Broker for the Waiver programs listed above) conducting an in-person assessment,
- Doctor completing a Physician Certification form,
- Level of Care Assessment completed (generally by the local Area Agency on Aging),
- Financial eligibility determination by the County Assistance Office (CAO), and
- Office of Long-Term Living giving final decision on eligibility.

While these same steps remain under the new process, the order in which they occur is different. Maximus will still be responsible for the initial assessment and for making sure the Physician Certifications are completed.

After the Level of Care Assessment is done, however, OLTL will now review the case and approve it **before** it is sent to the County Assistance Office for a financial eligibility determination. The CAO will send the notice of eligibility to the applicant. All of this is to be done within 90 days.

Advocates are hopeful that these changes will improve the process for individuals trying to access the waiver programs. Individuals having problems applying are encouraged to call PHLP's Helpline.

ODP Changes Policy, Allowing Consolidated Waiver Recipients to Rent Housing

Persons receiving services under the intellectual disability waivers (both Consolidated & PFDS) have been able to own their own home without getting it licensed as a "group home". However the Office of Developmental Programs (ODP) had insisted that people getting more than 30 hours of services a week could not **rent** their own home or apartment without getting it licensed as a "group home" or getting an exception to the licensure requirement from ODP. This was the so-called "30 hour rule".

ODP recently dropped the licensure requirement for persons renting their own home or apartment, as long as they are not renting it from a service provider. The new policy was announced in Developmental Programs Bulletin, 6400-13-01, effective January 12, 2013. This policy change should give persons on the Consolidated waiver more independent living options.

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