



Dual Eligibles' Access to Care:

An Advocate's Guide to Assisting the Dual Eligible Consumer in the Philadelphia Area

Age 60 and Older

Prepared by the
Pennsylvania Health Law Project

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I. OVERVIEW

This manual is for advocates and consumers who have Medicare and are also eligible for or enrolled in a Medicaid program. Medicaid in Pennsylvania is called “Medical Assistance” or “MA.” In this Guide, we use the generic term, Medicaid. However, the eligibility limits referenced here do not necessarily apply outside Pennsylvania. Persons with Medicare and Medicaid are frequently referred to a “dual eligibles” due to their being dually eligible for both Medicare and Medicaid.

It is critical that seniors and persons with disabilities have the healthcare coverage and supportive services they need to maintain the highest possible level of health and functioning. While Medicare is frequently the primary source of healthcare coverage for people age 65 and over and those adults who have permanent disabilities, Medicare provides incomplete healthcare coverage. Under Medicare, not all healthcare services are covered. For those that are covered, there is significant cost-sharing. Persons on Medicare face cost-sharing obligations including premiums, co-payments, and deductibles. The amounts of these premiums, co-payments, and deductibles increase each year. Because Medicare does not cover all healthcare services (for example, Medicare covers minimal home or community based services and only limited durable medical equipment) and because there is significant cost sharing for the services that are covered, most participants must supplement their Medicare with other insurance. People on Medicare may fill the gaps with Medicaid, a Medicare Supplement policy, or other patchwork of supplementary coverage. Lower-income persons on Medicare can obtain additional coverage and lower their costs by enrolling in Medicaid.

This manual will explain eligibility for Medicare and Medicaid for persons on Medicare. It will also explain how persons with both Medicare and Medicaid access their healthcare services. *Please note that all amounts and figures quoted herein are for the year 2007 unless otherwise noted. Medicaid income limits and Medicare cost-sharing amounts rise each year.*

Note that there are many Medicaid programs available to lower-income persons on Medicare. This Manual, prepared with the generous support of The Pew Charitable Trusts, will focus primarily on programs available to persons age 60 and older who are on Medicare and reside in the five-county Philadelphia area. Additionally, the manual will focus on the healthcare access issues related to this particular group of consumers. Most of the information contained herein is applicable in other parts of the state as well; however, please call the

Pennsylvania Health Law Project Helpline at 1-800-274-3258 or 1-866-236-6310
TTY to confirm the rules for other parts of the state.

II. MEDICARE ELIGIBILITY AND ENROLLMENT

Medicare is a federal program of Hospital, Medical and Prescription Drug Insurance that is available to eligible individuals over 65 or with permanent disabilities who are receiving Social Security Disability Insurance (SSDI) benefits.

There are three benefit parts to Medicare: Part A (Hospital Insurance), Part B (Medical Insurance), and Part D (Prescription Drug Insurance). Part C ("Medicare Advantage") does not create a separate benefit. Instead, Part C establishes an alternative delivery mode, by allowing beneficiaries to elect to get their care through private managed care organizations that contract with Medicare.

1. Medicare Eligibility and Enrollment – PART A:

Premium-Free Part A:

A person age 65 or older who is a citizen or permanent resident of the United States is eligible for premium-free Medicare Part A hospital insurance if:

- 1) She receives or is eligible to receive Social Security benefits because she worked or had a spouse that worked or, in the case of an adult child with a disability, had a parent that worked and paid into the social security system for 40 or more quarters (earning \$1000 per quarter in 2007; or
- 2) She receives or is eligible to receive railroad retirement benefits; or
- 3) She or her spouse (living or deceased, including divorced spouses) worked long enough in a government job where Medicare taxes were paid; or
- 4) She is the dependent child of someone who worked long enough in a government job where Medicare taxes were paid.

Before age 65, she is eligible for premium-free Medicare Part A hospital insurance if:

- 1) She has been entitled to Social Security disability benefits for 24 months (unless the person has Lou Gehrig's disease [amyotrophic lateral sclerosis] in which case they do not have the 24 month wait before Medicare starts); or
- 2) She has End Stage Renal Disease; or
- 3) She receives a disability pension from the railroad retirement board and meets certain conditions; or

- 4) She or her spouse has worked long enough in a government job where Medicare taxes were paid and she meets the requirements of the Social Security disability program; or
- 5) She is the child or widow(er) age 50 or older, including a divorced widow(er) of someone who has worked long enough in a government job where Medicare taxes were paid and she meets the requirements of the Social Security disability program.

Premium Part A: If A person does not meet the requirements for free Part A, he can still enroll in and purchase Medicare Part A.

The following people may be able to purchase Medicare Part A:

- 1) A person who is a citizen or legal permanent resident or who is a legal alien that has been a resident for 5 or more years who is age 65 or older but who did not work and pay (or have a spouse or parent work and pay) into the Social Security system for 40 or more quarters (earning \$1000 or more for 2007)
- 2) An adult with disabilities under age 65 may only purchase Part A if the person has been entitled to Medicare Part A, continues to have a disabling physical or mental impairment, loses entitlement to disability benefits solely because his or her earnings exceed the amount allowed (this amount is \$900 for 2007, and is not otherwise entitled to Medicare Part A.

For persons who have earned 30-39 qualifying quarters of work, the premium for 2007 is \$226/month. For persons who have earned 29 or fewer qualifying quarters, the premium for 2007 is \$410/month. A qualifying quarter of work means that the person worked and paid Medicare taxes during one of the four (three-month) quarters of the calendar year. If an individual must purchase coverage, enrollment in Part A can only occur during the initial enrollment period (the three months before and after the first month of eligibility) or general enrollment period (January to March of each year) and coverage will begin on July 1 of that year. A delayed enrollment penalty of 10% is charged for twice the number of years of the delay. So, if a person delays enrolling in Part A for 2 years, she pays an extra 10% for 4 years.

If a person does not qualify for free Medicare Part A and he has limited income and resources, he may be eligible for the Medicaid program to pay for his Part A premium.

How Does One Enroll in Part A?

A person receiving Social Security retirement or disability checks will be notified by the social security administration of their anticipated start date for Medicare Part A. A person who is not receiving Social Security payments at the time they become eligible for Social Security must affirmatively make application to Social Security for their Medicare coverage. This can be done by visiting or calling the local Social Security Office. Individuals can contact SSA starting three months before they turn 65 to start the application process.

When can one enroll in Part A?

Initial Enrollment Period. The Initial Enrollment Period is a seven-month window that includes the three months prior to the month of eligibility, the month of eligibility, and the three months after the month of eligibility.

General Enrollment Periods. After the Initial Enrollment Period (when first eligible for Part A), a consumer who is not in Medicare Part A can only enroll during the General Enrollment Period of January to March of each year (with enrollment being effective on July 1 of that year) unless they qualify for a Special Enrollment period at another time during the year.

Special Enrollment Periods. For an individual over 65 years of age newly signing up for Social Security who qualifies for free Medicare Part A, enrollment in Part A can take place at any time upon taking Social Security benefits and coverage for these individuals can be retroactive up to six months back to when turned 65 unless the individual must purchase Part A coverage. If an individual must purchase coverage, enrollment in Part A can only occur during the Initial or General Enrollment Periods and coverage will begin on July 1 of that year. Similarly, for beneficiaries enrolling in the general enrollment period Part A coverage will not begin until July 1 of that year.

There is also a special enrollment period for persons 65 and older who delayed enrollment due to health insurance through employment-related Group Health Insurance (coverage for 20 or more individuals) of themselves or their spouse. They must enroll within 8 months of the end of the employment or the end of the insurance, whichever is sooner. A similar SEP is available to persons who are disabled adults with coverage through a LARGE Group Health Insurance (covering 100 or more lives of employer's employees). Same timeframes apply.

Delayed Enrollment Penalty. There is a 10% delayed enrollment penalty imposed for delayed enrollment into Premium-Part A that lasts twice the number of years that the person delayed. So, if a person delays enrolling in Part

A for 2 years, she pays an extra 10% for 4 years. There is no delayed enrollment penalty if a person is allowed an SEP.

NOTE: Even though the full retirement age is no longer 65 for Social Security Retirement benefits, Medicare entitlement still begins to be available when she turns 65.

2. Medicare Eligibility and Enrollment – PART B:

Anyone eligible for Medicare Part A is eligible for Medicare Part B. However, a beneficiary does not have to take Part B. And, in some circumstances, a person can be enrolled in Part B, even if he or she does not have Part A.

Enrollment in Part B is automatic for persons who are receiving Social Security Retirement or Disability or Railroad Retirement checks when they become entitled to Medicare. These individuals do have the opportunity to decline Part B if they do not wish to be enrolled. Individuals who are not receiving Social Security or Railroad Retirement checks, or who do not have Medicare Part A at the time they turn 65 years old must apply for Part B through the Social Security Office. A person who would have to pay a monthly premium for Part A may elect to only take Part B when they become eligible for Medicare. Individuals can sign up for Medicare Part B starting three months before they turn 65 years old.

All persons who choose to enroll into Part B must pay a monthly premium for the coverage, unless the person is lower-income and has her premium paid for her by the Medicaid program. The monthly premium amounts rise each year. While the premium used to be a set amount per beneficiary per month, the Medicare Modernization Act of 2003 called for adjusting the premium amounts, beginning in 2007, based on the beneficiary's income.

The standard premium amount in 2007 is \$93.50/month for individuals with annual income no more than \$80,000 and for married couples with annual income no more than \$160,000. Persons with higher incomes pay more as shown in this chart for 2007 income and premium amounts:

2007		
Income Tax Return Showing Income	Joint Income Tax Return Showing Income	Monthly Part B Premium Amount per Beneficiary
≤ \$80,000	≤ \$160,000	\$93.50
\$80,001-\$100,000	\$160,001-\$200,000	\$105.80
\$100,001-\$150,000	\$200,001-\$300,000	\$124.40
\$150,001 - \$200,000	\$300,001- \$400,000	\$142.90
> \$200,000	>\$400,000	\$161.40

How Does One Enroll in Part B?

A person receiving Social Security retirement or disability checks will be notified by the Social Security Administration of their anticipated start date for

Medicare Part B and can then choose whether to participate in Part B or not. A person not receiving Social Security payment but otherwise eligible for Medicare must affirmatively make application to Social Security for their Medicare coverage. This can be done in person or over the phone with the local Social Security office. An individual can apply for Part B starting 3 months before they turn 65 years old.

When can one enroll in Part B?

Initial Enrollment Period. The Initial Enrollment Period is a seven-month period that begins three months before the month a person is first eligible for Medicare Part B. For most people, the Initial Enrollment Period begins three months before the month she turns age 65. It ends three months after she turns age 65. If she is disabled and getting benefits from Social Security or the Railroad Retirement Board, the Initial Enrollment Period generally begins three months before her 25th month of entitlement.

General Enrollment Period. After the initial seven-month enrollment period (the three months prior to the month of eligibility, the month of eligibility, and the three months after the month of eligibility), a consumer can only enroll in Part B during the General Enrollment Period of January to March of each year (with enrollment being effective on July 1 of that year) unless she qualifies for a Special Enrollment Period at another time during the year.

Special Enrollment Periods. This enrollment period is available if a person is eligible for Medicare based on age 65 or disability but waited to enroll in Medicare Part B because she or her spouse was working and had group health plan coverage through their *current* employer or union based on this work.

If a person is disabled and has group health plan coverage based on her own or a family member's (specific family members like spouse or parent's?) current employment, the Medicare Part B Special Enrollment Period rules may also apply. If this applies, the person can sign up for Medicare Part B anytime while covered by the group health plan based on current employment status or during the eight-month period following the month the group health plan coverage ends or the employment ends, whichever is first.

Delayed Enrollment Penalty. If enrollment is delayed, a penalty may be imposed. Whether a penalty is imposed depends on the reason for the delay; the amount of the penalty, which is added to the monthly premium, is based on the length of delay. The cost of Medicare Part B will go up 10% for each **full** 12-month period that the person could have had Medicare Part B but didn't take it, except in special cases (such as if an individual qualifies for an SEP). The person will have to pay this extra amount (called a premium surcharge) as long as she

has Medicare Part B*. If she delays enrolling in Part B for 30 months, she will be charged a 20% premium penalty (10% for 2 full years of delay) for the rest of time she has Part B. *Please note that if someone was eligible for Medicare Part B before they turned 65 years old and they delayed enrollment and were subject to a delayed enrollment penalty, they will have another opportunity to enroll in Part B when they turn 65 years old. If they enroll in Part B during their Initial Enrollment Period when they turn 65, any delayed enrollment penalty they were subject to before that point will be eliminated.

3. Medicare Eligibility and Enrollment – Part C

Part C is a misnomer in that it is not actually a benefit package. Instead, Part C is what Congress called the creation of the option to obtain Medicare benefits covered under Medicare Parts A, B, and D through a private insurance company approved by Medicare (or that contracts with Medicare) – usually a managed care model.

A person with Medicare can join a Medicare Part C or “Medicare Advantage” plan if he

- 1) has both Part A and Part B,
- 2) lives in the Plan’s service area, and
- 3) does not have End Stage Renal Disease

Additionally, there are some Medicare Advantage plans, called Special Needs Plans, which serve only a subset of Medicare beneficiaries. Special Needs Plans can choose to exclusively or disproportionately serve persons who are dually eligible, persons with select chronic conditions, or “institutionalized” individuals.

Medicare Advantage Plans include:

- Medicare Health Maintenance Organizations (HMOs) (the most common Medicare Advantage plans)
- Medicare Preferred Provider Organizations (PPOs)
- Medicare Private Fee-For-Service Plans (PFFS)
- Medicare Advantage Special Needs Plans (SNPs)
- Medicare Savings Accounts (MSAs)

[Medicare Advantage Plans must cover all the services that Medicare Parts A and B cover. These types of plans can cover some extra benefits that are not covered under the Original Medicare Program (like routine coverage of eyeglasses, routine dental benefits, and coverage of hearing exams and hearing aids). Medicare Advantage Plans generally have special rules about how you

can access care such as only covering services when you go to providers within the plan's network or requiring you to obtain a referral before you can see a specialist.

How Does One Enroll into Part C:

There are three ways to enroll into a Medicare Advantage or Part C Plan:

- Contact Medicare: 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048 TTY). Enrollment staff will review the person's healthcare needs and help them choose among the Plan options. Medicare representatives should enroll the person into a Part C Plan based on the individual's choice.
- Contact the Plan: If the consumer has already decided which Part C Plan they want, they can call the Plan directly (phone numbers available at www.medicare.gov and also listed in the Medicare & You 2007 Handbook). Most plans will accept an application over the phone; however, some Plans require the consumer to complete a paper application in order to enroll.
- Enroll online: The consumer or their authorized representative can go to www.medicare.gov and compare the Part C Plans available. Once the consumer chooses a plan, she can enroll directly through the website. When enrolling online, the individual will get a confirmation number. The enrollment information is sent directly from Medicare to the Plan for processing. Some Part C plans also allow individuals to enroll through the Plan's website.

When Can One Enroll in Part C?

Individuals can enroll in a Part C or Medicare Advantage Plan during their Initial Enrollment Period for Medicare Parts A and B. So, if a person is newly eligible for Medicare, she can join a Part C Plan at any time during her seven month Medicare Part B Initial Election Period (see page 8).

Annual Election Period. Once someone chooses a Part C plan, they are generally locked-in to their choice of Medicare Advantage plan until the Annual Enrollment Period of November 15 to December 31 of each year, unless they qualify for one of the limited special election periods. Individuals can change their Medicare Advantage Plan during this period and coverage with the new plan should start January 1st of the following year.

Open Enrollment Period. Every year, there is an Open Enrollment Period from January 1st through March 31st for individuals who want to join a Medicare Advantage Plan, change their Medicare Advantage Plan or disenroll from their Medicare Advantage Plan and go back to Original Medicare. Individuals who make plan changes during this enrollment period can only make change to a “like plan” which means that if they have Original Medicare and a stand-alone Part D prescription drug plan, they can only join a Medicare Advantage Plan that includes prescription coverage. Also, if they are in a Medicare Advantage Plan with prescription drug coverage, during this period, they can only change to a different Medicare Advantage Plan with drug coverage or go back to Original Medicare and join a stand-alone Part D prescription drug plan. Likewise, individuals who do not have Part D coverage can only join a Medicare Advantage Plan with no drug coverage during this enrollment period. Individuals cannot enroll in Part D or disenroll from a Part D plan during this enrollment period. So, an individual who is enrolled in a Medicare Advantage Plan with no prescription drug coverage could not switch to a Medicare Advantage Plan without prescription drug coverage during this enrollment period. See page 14 for more information about Part D enrollment periods.

Special Enrollment Period. An individual may at any time discontinue the election of an Medicare Advantage plan offered and change his or her election when

- 1) CMS or the organization has terminated the organization's contract for the plan, discontinued the plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan, or the impending discontinuation of the plan in the area in which the individual resides.
- 2) The individual is not eligible to remain enrolled in the plan because of a change in his or her place of residence to a location out of the service area or continuation area or other change in circumstances as determined by CMS but not including terminations resulting from a failure to make timely payment of an MA monthly or supplemental beneficiary premium, or from disruptive behavior.
- 3) The individual demonstrates to CMS, in accordance with guidelines issued by CMS, that the organization violated a material provision of the contract or that the organization misrepresented the plan to the individual.
- 4) , Duals, LIS individuals, and Institutionalized individuals have perpetual special enrollment rights to change their Medicare Advantage Plan with Prescription Coverage (MA-PD) any month.

4. Medicare Eligibility and Enrollment - Part D

All persons eligible for or enrolled in Parts A and/or B are eligible for the voluntary Medicare prescription drug program, known as Part D. Generally, enrollment is not automatic and must be elected. Individuals can get their Part D coverage through a stand-alone Prescription Drug Plan (PDP) that works with Original Medicare or through a Medicare Advantage Plan that includes prescription drug coverage (MA-PD).

How Can One Enroll into Part D:

Any Medicare consumer can enroll into a Part D plan. A consumer can also have an “authorized representative” enroll him into a Part D plan. An authorized representative includes someone appointed by the consumer to act on his behalf (such as a family member, social worker, or friend) and persons authorized by State law to act for a consumer (such as a Power of Attorney). There are three ways to enroll into a Part D Plan:

- **Contact Medicare:** 1-800-MEDICARE (1-800-633-4227 or 1-877-486-2048 TTY). Enrollment staff will review the person’s other insurance (if any), their medications, and their pharmacy, and help them choose among the Plan options. Medicare representatives will enroll the person into a Part D Plan based on the individual’s choice.
- **Contact the Plan:** If the consumer has already decided which Part D Plan they want, they can call the Plan directly (phone numbers available at www.medicare.gov and also listed in the Medicare & You 2007 Handbook). Most plans will accept an application over the phone; however, some Plans require the consumer to complete a paper application in order to enroll.
- **Enroll online:** The consumer or their authorized representative can go to www.medicare.gov and compare the Part D Plans available. Once the consumer chooses a plan, she can enroll directly through the website. When enrolling online, the individual will get a confirmation number. The enrollment information is sent directly from Medicare to the Plan for processing. Some Part D plans also allow individuals to enroll through the Plan’s website.

Medicare consumers should apply directly to the PDP or MA-PD they wish to enroll in. Note that the general rule for most consumers is that they must affirmatively apply to be enrolled in Medicare Part D. However, dual eligible

consumers in Pennsylvania who do not join a plan on their own are auto-enrolled into a PDP by Medicare (although many dual eligibles were passively enrolled on a one-time only basis into a Medicare Advantage Special Needs Plan in January 2006). However, these auto-enrollments by Medicare for dual eligibles are done to a randomly selected plan without calculating the individual's particular prescription drug needs. Therefore, even auto-enrolled consumers have a great incentive to affirmatively choose a plan.

When Can One Enroll in Part D?

Initial Enrollment Period. Individuals who first become eligible for Medicare will have a Part D Initial Election Period that mirrors their Part B election period, namely a range that includes the three months prior to the month in which they become eligible through the three months after the month in which they become eligible. Individuals who fail to enroll in their Initial Enrollment Period will be barred from enrolling until the next Annual Election Period of November 15 to December 31 of each year. Note, therefore, that most Medicare consumers are locked-in to their Part D plan choice for the duration of the calendar year. For this reason, it behooves them to select their Part D plan with great care.

Annual Annual Election Period. The Annual Election Period occurs every year and allows individuals to either switch Part D plans or enroll in Part D for the first time if they did not enroll in their Initial Enrollment Period. The Annual Election Period runs from November 15th until December 31st of every year with plan changes becoming effective January 1st

Special Enrollment Periods. Some consumers qualify for a Special Election Period, which allows them to switch Part D plans or enroll in Part D outside the Initial Enrollment Period or Annual Election Period. All dual eligibles have a perpetual Special Enrollment Period. They can change plans at any time, effective the first day of the month following the enrollment change request. Institutionalized individuals and all LIS participants also have perpetual SEPs. Special Election Periods will also be granted for other limited reasons - such as when the consumer involuntarily loses their creditable coverage, the consumer moves in or out of the Part D Plan's region, the consumer moves into, or moves out of, an institution such as a Skilled Nursing Facility or a long-term care hospital, or the Part D Plan violates its contract or terminates the Plan.

Delayed Enrollment Penalty. There is a late enrollment penalty that accumulates any time a Part D eligible individual is without creditable coverage*for a period of 63 continuous days or longer. The penalty is an extra

surcharge to the Part D premium the individual pays if they later enroll in Medicare Part D. The penalty amount will be a surcharge of 1% of the premium for each month the individual went without creditable prescription drug coverage. Note this extra premium penalty continues every month for the duration of the individual's Part D enrollment.

*Creditable Coverage is prescription coverage which, according to a CMS actuary, offers a benefit as good as or better than Medicare Part D. Regulations require all insurers to provide notice to Part D eligible individuals whether or not their current insurance is considered "creditable coverage". This notice must be provided to individuals who are newly eligible for Medicare before their Part D Initial Enrollment Period begins and to all Medicare beneficiaries who have other prescription coverage every year before the Annual Election Period starts on November 15th.

Beneficiaries who lose their creditable drug coverage after the Initial Enrollment Period will be able to enroll in a Part D plan during a Special Enrollment Period (SEP) and will not incur a late enrollment penalty if they enroll in Part D within a certain time period specified below. If prescription drug coverage is terminated or reduced after the Initial Enrollment Period and, as a result, the coverage is no longer creditable, beneficiaries have two options: 1) They can find new creditable coverage if they are eligible for any coverage that is available to them or 2) They can enroll in a Medicare Part D plan during the special enrollment period (SEP) which is a 63-day enrollment period, beginning on their first day without prescription drug coverage. The SEP allows beneficiaries to avoid a gap in their drug coverage and avoid being charged a premium penalty.

Beneficiaries who do not enroll in a Part D plan during this 63-day period and who do not obtain other creditable coverage must wait until the next annual open enrollment period (November 15-December 31) and will incur a late enrollment penalty.

Critical Note:

Persons with both Medicare and Medicaid can change Part D plans at any time with a plan change effective the first of the month following the request to change plans. Unlike the Part B premium penalty, which is waived for dual eligibles who are enrolled in a Medicare Savings Program or other Medicaid program that covers Part B premiums, dual eligibles are subject to applicable delayed enrollment penalties for five years if they delay enrollment into Part D.

III. MEDICARE COVERAGE - What Health Care Services are Covered Under Medicare?

1. Part A Coverage

Medicare Part A covers Hospitalization, Skilled Nursing Facility, Home Health Care for beneficiaries without Part B, and Hospice. Unlike Medicaid, there are deductibles and co-payments that a Medicare participant who lacks other coverage must pay. Medicare Part A operates on an unusual benefit period, which begins when a beneficiary starts a three day stay in the hospital and ends when there is a 60 consecutive day break of neither hospitalization nor skilled nursing facility inpatient stay.

Hospitalization

Generally, the amount that Medicare pays and the amount that a beneficiary pays depends on how long the beneficiary is in the hospital during a given benefit period or hospitalization and whether the beneficiary has any other health insurance.

Specifically, Medicare covers a semi-private room and meals, general nursing services, operating and recovery room costs, intensive care, prescriptions, lab tests, x-rays, and all other necessary medical services and supplies. Residents and doctors of the hospital are covered under Part A. The beneficiary's attending doctor's bill is not covered under Part A, but may be covered under Part B.

2007 - Medicare Part A Hospitalization		
Days of Each Hospitalization	Deductible	Co-Payment
1-60	\$992	\$0
61-90	None additional (\$992 already paid)	\$248 Per Day
91 → 150 (if the beneficiary has not yet used his/her lifetime reserve days)	None additional (\$992 already paid)	\$496 Per Day
91 → (if the beneficiary has already used his/her lifetime	None additional (\$992 already paid)	Responsible for full daily rate for care at hospital - unless other supplemental insurance covers cost of hospitalization

reserve days)		
151 and beyond	Participant pays all costs	Participant pays all costs

For Blood Transfusions while in Hospital

- 1) Medicare pays for all blood after the first three pints
- 2) Beneficiary pays for the first three pints of blood that he or she requires during each benefit period (unless the beneficiary is eligible for full Medicaid from the state)

Skilled Nursing Care in a Skilled Nursing Facility (SNF)

Medicare covers semi-private rooms and meals, skilled nursing services, rehabilitation, drugs, and medical supplies. Medicare will only cover the SNF stay if there has been a hospitalization of at least three days prior to the transfer to the SNF and if the beneficiary has skilled care needs that must be tended by a skilled nursing professional. There is a strict legal definition of “skilled care patient” - not everyone in a nursing home is considered “skilled.” Medicare provides short-term coverage and is not a source of coverage for long-term care. The cost to the beneficiary rises each year. These are the 2007 figures:

2007 - Medicare Part A Skilled Nursing Facility Care		
Days of Each Stay	Deductible	Co-Payment
1-20	\$0	\$0
21-100	\$0	\$124 Per Day
101 → ???	\$0	Responsible for full daily rate for care at SNF - unless other supplemental insurance covers cost of SNF care

Home Health Care

Medicare does not cover full-time home health care. Medicare does cover part-time or intermittent home health care for homebound persons (the person can leave the home -the test is whether it is taxing and challenging for them to leave or whether they require assistance to leave for a walk around the block or a visit to church, etc.) who need intermittent coverage of skilled nursing or therapy care.

Medicare pays the entire cost of the home health care but only 80% of the cost of any wheelchair, walker or other medical equipment the beneficiary needs. The beneficiary is responsible for the remaining 20%, unless eligible for full Medicaid from the state or some other supplemental coverage.

Hospice Care for Terminally Ill Patients

Medicare pays for virtually all Hospice care with no deductibles or co-payments for 2 periods of 90 days and an unlimited number of 60 day periods when a doctor certifies that a person is terminally ill. Medicare does require the beneficiary to pay a co-payment of up to \$5 for prescription drugs provided by the Hospice company and a co-payment of up to 5% of the Medicare payment for inpatient respite.

Mental Health Coverage

Medicare covers mental health treatment that requires an inpatient hospital stay in either a general hospital or a psychiatric hospital. Medicare will only cover 190 days in a psychiatric hospital over a beneficiary's lifetime but does not impose a limit on general hospitalization coverage. The costs for mental health costs in a hospital are the same as the costs for other hospitalizations, except that the beneficiary will pay a 20% copayment for health professional services while in the hospital. See above for an explanation of the limits and copayments.

2. Part B Coverage

Part B has traditionally covered physician services (for treatment, not for routine check-ups), outpatient hospital services, durable medical equipment/supplies, ambulance, dialysis costs, home health, x-rays, lab tests, outpatient physical therapy, vaccines and drugs administered in a physician's office. Part B also covers the following preventive health items: a) Annual mammography for women age 40 and over, b) Pap smear and pelvic exam every two years except in some special high risk situations or if the consumer is of child-bearing age, c) annual prostate screening for men age 50 and over, d) colorectal cancer screening, e) bone mass screening, f) Diabetes glucose monitoring g) cardiovascular screening every five years, h) glaucoma testing, and I) a one-time "Welcome to Medicare physical exam" which new consumers can receive within the first 6 months of enrolling in Medicare.

Part B does not cover:

- Outpatient prescription drugs (except for certain drugs)
- Routine office visits and wellness visits (except the "Welcome to Medicare physical exam)
- Eye exams and eyeglasses (except following cataract surgery)
- Hearing exams and hearing aids
- Long Term Care
- Transportation
- Dental care

In addition to the monthly premiums for participating in Part B (as described above), a person is also responsible for an annual deductible (\$131 for 2007) and payment of 20% of the fee for covered service visits (although the co-payment is 50% for covered mental health services). Although persons with Medicaid will have these costs covered (along with the Part B premium amount) by the Medicaid program.

Mental Health treatment

Medicare Part B covers outpatient mental health services with the following providers:

- Physician
- Clinical psychologist
- Clinical social worker
- Clinical nurse specialist
- Nurse practitioner
- Physician's assistant

The services that are covered include individual and group therapy, family counseling, diagnostic tests, occupational therapy related to mental health treatment, individual patient training and education for the treatment of a mental health issue, and prescription medication that is not usually self-administered. Medicare does not cover support groups in non-medical centers.

Medicare also covers partial hospitalization services for beneficiaries who would otherwise need to be hospitalized.

The costs for mental health services covered by Medicare Part B are different than the costs for other services covered under Medicare Part B. Beneficiaries will pay 50% of doctor and professional charges as well as a 20% copayment for facility charges. Note, however, that Medicare does not cover many mental health services that are regularly provided.

3. Part C Coverage

Typically the beneficiary must pay an extra monthly premium (on top of their Part B premium) for coverage under a Medicare Advantage Plan. The plans available to a Medicare beneficiary depend on which plans offer coverage in their county. What is covered depends on the plan. Plans cannot offer less than the basic Medicare Part A and B coverage but may offer more coverage. Some Medicare Advantage plans cover extra services like dental care, eye exams and eyeglasses, and/or hearing exams and aids.

Many of the Medicare Advantage Plans have a closed provider network which means the consumer can only get care from providers who are in the network. Usually, individuals have lower out-of-pocket costs with Medicare Advantage Plans than they would if they just had coverage through Traditional Medicare. Consumers can join these types of plans rather than buy a Medigap policy (a supplement to help them pay for their cost-sharing through Traditional Medicare).

4. Part D Coverage

Medicare Part D makes prescription drug insurance available through private insurance companies to anyone who is enrolled in or eligible for Medicare Part A and/or Part B. Part D approved stand-alone prescription and HMO plans may be found at www.medicare.gov. Generally, the plans can charge monthly premiums, annual deductibles, and varying co-payments. For consumers with Medicare and Medicaid, however, there should be no monthly premium (unless the person picked a “high cost” or “above average cost” plan), no annual deductible, and co-payments that are limited for 2007 as follows:

- Co-Pays on prescriptions depending on income:
 - o Persons with 2007 income less than \$851/mo (single) or \$1,141/month (married):
 - § \$1 per prescription for generics and other ‘preferred drugs’
 - § \$3.10 per prescription for all other drugs (brand name)
 - o Persons with higher incomes:
 - § \$2.15 per prescription for generics and other ‘preferred drugs’
 - § \$5.35 per prescription for all other drugs (brand name)
- No co-pays once person has reached \$3850 in out-of-pocket expenses for the year
- No co-pays for persons who live in long-term care facilities

Generally, Part D Plans must cover FDA approved drugs, biological products, vaccines, insulin and supplies and must cover at least two drugs from each therapeutic class. They *do not* have to cover drugs historically excluded from Medicaid coverage (including benzodiazepines and barbiturates [*although note that PA Medicaid has covered these and continues to cover these for dual eligibles*]), over-the-counter drugs, and drugs covered by Parts A and B of Medicare.

For 2007, Part D plans are required to cover all or substantially all available prescription drugs in 6 drug categories:

- Antidepressants

- Antipsychotics
- Anticonvulsants
- Anticancer
- Immunosuppressants
- HIV/AIDS

Extended release versions do NOT have to be covered.

Consumers will be able to access covered drugs through pharmacies and mail-order services that are in their Medicare Prescription Drug Plan's network.

Choosing a plan

Because beneficiaries will only be able to access prescription drugs through a Part D plan, beneficiaries will have to consider their plan choice carefully. Most beneficiaries will be locked into a plan for the year. Beneficiaries with Medicare and Medicaid will be able to switch Part D plans at any time. In choosing a plan, beneficiaries should consider the following questions:

- Does the Plan cover all of the drugs I take?
- Will I be able to use the pharmacies that I go to now?
- How much will the Plan cost me? (Dual eligibles generally will not pay the premiums/deductibles, unless they choose a more expensive plan.)
- What copayments will the Plan charge me for my drugs?
- Is this a managed care plan – and, if so, how will that impact how I get services other than prescription drugs?

IV. MEDICAID FOR PERSONS ON MEDICARE

Medicaid is a mostly free public health insurance program. It is not welfare. In fact, most people on Medicaid do not receive welfare in the form of cash benefits.

Anyone on Medicare can also get Medicaid if their countable income and resources (i.e., assets) are within the income and resource limits for the Medicaid programs. Depending on her income and resources, she may be eligible for Medicaid to pay for all or some of her Medicare out-of-pocket expenses. Full Medicaid also affords coverage for particular services not available through Medicare (such as dental coverage or transportation costs).

If her income is too high for full Medicaid programs, she might still be eligible for Medicaid assistance with payment of the Medicare Part B premium under a special Medicaid program.¹ If she is eligible for full Medicaid coverage, Medicare would still be the primary insurer and Medicaid would cover premiums, deductibles and other cost-sharing. Full Medicaid would pay for services covered by Medicaid but not by Medicare. For more information on eligibility for persons not on or not yet on Medicare, go to www.phlp.org or contact the Pennsylvania Health Law Project at 1-800-274-3258.

See Appendix A for information on “Countable” Income and Resources/Assets.

1. Medicaid Programs for Persons on Medicare Age 60+

- There are several **categories** of Medicaid that cover persons on Medicare who are age 60+. Often, they have different requirements and different countable income and resource limits. Some of the categories are Persons with SSI, Healthy Horizons, Spend-down, Home and Community Based Waiver Programs, Medicaid for Workers with Disabilities and Breast and Cervical Cancer Prevention and Treatment Program.

Practice Note: If a person is found ineligible for one category, he/she may be eligible under another category. If a person has been receiving Medicaid under one category and is subsequently found no longer eligible for that category, he/she may not be terminated from Medicaid without a complete redetermination to evaluate whether he/she may be eligible for Medicaid under

¹ This special Medicaid program is known as the Medicare Savings Program (MSP). She may qualify for one of these programs as Qualified Medicare Beneficiary (QMB), a Specified Low-Income Medicare Beneficiary (SLMB), or a Qualified Individual (QI).

a different category. (See 55 Pa. Code §133.73 NMP; §133.83 MNO) If a person is terminated without a redetermination, call the Pennsylvania Health Law Project at 1-800-274-3258 for information or assistance on appealing the termination and the requirement of a redetermination.

For information on Medicaid programs for persons on Medicare under 60, go to www.phlp.org or contact the Pennsylvania Health Law Project at 1-800-274-3258.

A. Medicaid for Persons on SSI

A person who receives Supplemental Security Income (SSI) automatically gets Medicaid. As long as the person is eligible for as little as \$1.00 of SSI payment, he/she will continue to receive Medicaid. In order to receive SSI, a person must meet the Social Security Administration's definition of "disability" and have countable income and resources at or below the SSI limits.

Persons who are on SSI and Medicaid when they turn 65 become eligible for Medicare in addition to their SSI and Medicaid.

Currently, the countable income limit for SSI for 2007 is \$650.40 for a single person (or a married person whose spouse is neither over 65 nor has a disability) and \$1007.70 for a married couple (where both are eligible as either being over 65 or having a disability). Resources must not exceed \$2,000 for a single applicant or \$3,000 for a married couple.

A married SSI applicant whose spouse is under 65 and not disabled is subject to the countable income limit for a single person and a portion of the non-applicant spouse's income may be deemed to be the applicant spouse's income. This will depend on the amount of the non-applicant spouse's income, the number of dependent children in the family, and other factors.

Personal Care Home or Domiciliary Care Home Residents - Exceptions

There is one exception to the countable SSI income limit, which applies to a person with a disability who lives in a personal care home (PCH) or a domiciliary care home (DCH). For persons with disabilities who do not receive SSI and SSI recipients who live in these residences, the state pays a monthly supplement to the SSI amount, up to \$439.30 in a PCH and up to \$434.30 in a DCH. As a consequence, a person whose income is above the SSI limit of \$647.40 but below the PCH or DCH SSI limit of \$1057.30 (DCH) or \$1062.300 (PCH) can get the SSI state supplement (in the amount necessary to raise their countable income to \$1,057.30 or \$1,062.30) and gets the automatic Medicaid that comes

with being on SSI.

Critical Note:

It is essential to note that a person enrolled in full Medicaid due to receipt of SSI payments automatically qualifies for the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs. This results in a tremendous overall savings to the consumer between the \$93.50 back each month and the immense reduction in Part D costs due to the subsidy in addition to coverage of all Medicare Part A and B cost-sharing and additional health services available through having Medicaid coverage.

B. Healthy Horizons

Eligibility for Full Medicaid Coverage

Persons on Medicare can obtain full Medicaid coverage, including partial prescription drug coverage, durable medical equipment coverage, and Medicare cost-sharing and premium payment, through the Healthy Horizons category of coverage if they meet the eligibility requirements. The income and resource requirements are below:

- 1) Countable income for a single person or married person whose spouse is under 65 and is not disabled is at or below \$851/month (for 2007). Countable income for a married couple where both spouses are eligible must be at or below \$1,141/month (for 2007).
- 2) Resources must not exceed \$2,000 for a single applicant or \$3,000 for a married couple.

Potential beneficiaries can apply for Healthy Horizons using the PA 600 Application Form. This form is available at the County Assistance Office (CAO) or online at

<http://www.dpw.state.pa.us/omap/provinf/maforms/omappa600p.pdf>. The application can also be completed and submitted electronically at www.compass.state.pa.us.

Critical Note:

It is essential to note that a person enrolled in full Medicaid through the healthy horizons program automatically qualifies for the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs. This results in a tremendous overall savings to the consumer between the \$93.50 back each month and the immense reduction in Part D costs due to the subsidy in addition to coverage of all Medicare Part A and B cost-sharing and additional health services available through having Medicaid coverage.

Eligibility for Medicaid Payment of Part B premium

A person on Medicare whose income is too high for full Medicaid may still be eligible to have her Medicare Part B Premium paid for by the Healthy Horizons Medicaid program. If eligible, she will receive the Medicare Part B Premium of \$93.50/month for 2007 added back into her monthly check from the Social Security Administration.

To be eligible, she must have countable income less than 135% of the Federal Poverty Level, which is \$1,149/month for 2007 and countable resources below \$4,000 for an individual or \$6,000 for a couple. Again, remember to use Appendix A for guidance on how to count income and resources.

Potential beneficiaries can apply by completing the PA 600 M form and mailing it to the nearest County Assistance Office. This form can be obtained from the CAO or online at <http://www.dpw.state.pa.us/omap/provinf/maforms/omappa600m.pdf>. It can also be completed and submitted electronically via www.compass.state.pa.us

Critical Note:

It is essential to note that a person enrolled in the Medicare Savings Program automatically qualifies for the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs. This results in a tremendous overall savings to the consumer between the \$93.50 back each month and the immense reduction in Part D costs due to the subsidy.

Spend Down

Spend-down allows a person needing Medicaid coverage whose income is too high for full Medicaid to become eligible under another category. People with Medicare can also become eligible for Medicaid under a spend-down. Under spend-down, paid or incurred medical expenses can be deducted from a beneficiary's countable income for Medicaid eligibility purposes.

There are two spend-down programs in Pennsylvania. One is a monthly spend-down and the other is a six-month spend-down. The monthly spend-down is the more commonly utilized program by persons on Medicare. This program covers prescription drugs and durable medical equipment (DME), making it generally of more use to persons with disabilities.

For the monthly spend-down once the medical expense deductions reduce the countable income below the spend-down limit (\$680/month for single person or \$1007 for a married couple in 2007), Medicaid will provide comprehensive Healthy Horizons medical coverage for the remainder of the month.

For the six-month spend-down, if she is an adult between the ages of 59-64, once her medical expenses reduce her 6-month countable income to the \$2,550 limit (Note that this limit remains the same and does not increase every year.), Medicaid will pay certain medical expenses for the remaining six-month period. This coverage does not reimburse prescriptions, medical supplies, or durable medical equipment.

NOTE: Under spend-down, Medicaid will not pay for the bills that were used to meet the spend-down. Also NOTE: Under 6 month (MNO) spend-down, Medicaid does NOT cover prescription drugs, dental care, or DME. See Appendix B for information on Applying for Spend-Down.

Critical Note:

It is essential to note that a person who has Medicare and qualifies for Medicaid under a spend-down automatically qualifies for the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs for an entire year, even if they do not qualify for spend-down for the entire year. This results in an immense reduction in Part D costs due to the subsidy over the year.

Home and Community Based Services Waiver Programs

There are numerous Home and Community Based Service Waiver programs in Pennsylvania that provide full Medicaid healthcare and supportive services for persons with an array of disabilities at varying ages. For persons on Medicare, the Medicaid Home and Community Based Services Waiver Programs provide an excellent opportunity for beneficiaries to remain in their own homes even when their care or service needs advance to the point at which the person would be considered eligible for care in or from a nursing home. There are two waiver programs primarily serve persons who are age 60 and over.

For information on all Home and Community Based Services Waiver Programs that serve persons who are under 60, go to www.phlp.org and look under the Home and Community Based Services in the drop down menu or contact the Pennsylvania Health Law Project at 1-800-274-3258.

She must meet the two eligibility components of Home and Community Based Services Waiver (HCBS) programs: financial and functional. Financial eligibility is the same for all HCBS Waiver programs. She must satisfy the income limit of \$1,869/month (for 2007) for an individual and a countable resource limit of \$8,000 per individual. Note that this is a higher income and resource limit than some other Medicaid programs. See Appendix G for more information on income and assets. Functional eligibility differs by each waiver program and refers to her ability and need for care. Functional eligibility requirements may require that she receive a particular level of care, have a specific diagnosis and/or satisfy an age requirement.

The HCBS Waiver programs are long term care (LTC) programs. As a result, special Medicaid rules for LTC eligibility apply. These rules are different from other Medicaid programs in that:

- 1) There are rules regarding disposing of or transferring of assets.
- 2) There are rules to financially protect a spouse who is not on the Waiver program to insure that she can afford to live in the community.
- 3) There is estate recovery (where the state seeks repayment for the cost of services provided after the recipient has died from the recipient's estate). Recovery is sought only for services received after the person turns age 55, but exceptions may apply.

How one applies for a waiver depends on the county of residence. In four of the five Philadelphia-area counties, Community Choice expedites admission to HCBS programs. To apply for a HCBS waiver program in those

four counties, applicants can contact Community Choice or the agency that administers the waiver. The Community Choice numbers in the Philadelphia area are:

Chester County: 800-566-1901
Delaware County: 888-490-8499
Montgomery County: 800-591-8231
Philadelphia County: 888-482-9060

To access HCBS Waivers in Bucks county, applicants should contact the Bucks County Area Agency on Aging at 215-348-0510 The application form is available at :

www.dpw.state.pa.us/omap/provinf/maforms/omappa600wp.pdf.

The following is a brief overview of the two most common waiver programs serving persons age 60 and older:

(1) Aging Waiver. The new Office of Long Term Living (out of the Department of Public Welfare and the Pennsylvania Department of Aging) administers this waiver. The factors triggering eligibility are: the applicant is 60 years of age or older and the applicant is determined to be nursing facility eligible or disabled per assessment by the local Area Agency on Aging.

The following services are included in the aging waiver: home support, home health care, personal care, respite, adult day care, transportation, attendant care, and meals. Waiver services cannot, in the aggregate, cost more than 80% of the cost of care in a Nursing Home. Settings in which the Aging Waiver is currently allowed include the applicant's private home and domiciliary care homes. HCBS services are prohibited in personal care homes.

(2) Long Term Care Capitated Waiver Program. This program is the federal program of All-Inclusive-Care for the Elderly being implemented as a pilot program in Pennsylvania The new Office of Long Term Living (out of the Department of Public Welfare and the Pennsylvania Department of Aging) administers this program. Persons age 60 years or older who are nursing facility eligible and on Medicare are eligible for this waiver program.

Services include all Medicaid and Medicare health care services, home support, home health, personal care, respite, adult day care, transportation, attendant care, meals, medical and nursing care, podiatry care, dental care, and other services. The participant receives all of his or her care through one center, in order to better manage care.

Services can be delivered in domiciliary care homes or in a participant's private home but only in Philadelphia, Beaver and Allegheny Counties. For more information contact DPW - OMAP 717-772-2525.

Critical Note:

It is essential to note that a person enrolled in full Medicaid through a HCBS Waiver program automatically qualifies for and gets enrolled into the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs. This results in a tremendous overall savings to the consumer between the \$93.50 back each month and the immense reduction in Part D costs due to the subsidy in addition to coverage of all Medicare Part A and B cost-sharing and additional health services available through having Medicaid coverage.

E. Medicaid for Workers with Disabilities Program

For persons who are under 65, Medical Assistance for Workers with Disabilities (MAWD) is another way to receive full Medicaid coverage. MAWD is available for persons with disabilities who work and receive compensation for their work but whose income and resources do not exceed the established limits. This Medicaid program is not free; it costs 5% of the participant's **countable** income. Below is a description of the eligibility requirements. MAWD can be a person's only insurance (if he has no coverage now), or it can be a secondary insurance (if he is already on Medicare or have some coverage through his job but it does not cover all his health care needs).

A person is eligible for MAWD if he:

- is between the ages of 16 through 64 *and*
- has an illness or condition that meets Social Security's definition of "disability" which she can show by either being a recipient of Social Security disability benefits (SSDI), *or* submitting medical records to Medicaid so that they can find her disabled
and
- is working and earning wages *and*
- has countable income less than 250% of the federal poverty guidelines, for 2007 the limit is \$2127/month for a single person and \$2852/month for a married couple *and*
- has countable assets valued at less than \$10,000

Disability

To be eligible for this program, the applicant must be considered disabled. An applicant who receives Social Security Disability Insurance payments (SSDI) or receiving SSI payments will automatically be considered disabled. If the applicant does not receive SSDI or SSI, he or she must submit documentation about his or her disability to the County Assistance Office, to be reviewed by a Medical Review Team for the state. The Medical Review Team will make a determination of disability based on the medical documentation. Pennsylvania's MAWD program uses the same definition of disability for its Medicaid programs as the Social Security Administration, though Pennsylvania does not apply the assumption that a person is not disabled if he or she works a certain number of hours.

Practice Note: A MAWD recipient is not required to apply for SSDI or SSI. This is different from the requirement for Healthy Horizons recipients.

Work Requirement

In order to qualify for this program, one must work and must receive compensation for that work. The applicant must be able to provide proof of employment and compensation. There is no minimum amount of work required, so as little as 1 hour/month can satisfy the requirement. Self-employment qualifies as work so long as it generates income.

Income

A person is allowed to work and still get SSDI as long as she continues to be disabled. If her earnings are less than \$640/month (for 2007), there is **no impact** on her SSDI. Most MAWD participants earn significantly less than \$640/month. If her total earnings are more than \$640/month, then Social Security provides a "trial work period" of 9 months (not necessarily consecutive) during which she can receive full SSDI benefits regardless of earning over \$640/month. Each month that she earns more than \$640 will be considered as one trial work month. At the end of the trial work period, she can receive SSDI for another 36 months as long as she earn less than \$900/month. In 2007, earning above \$900/month is considered to be "substantial gainful activity" by Social Security.

Resources

The applicant's countable resources must not exceed \$10,000. Countable resources of a spouse are considered in full, without any deductions for the spouse's own use. Additionally, the applicant and spouse's resources are counted even if there is a child under 21 in the house. Countable resources are determined in accordance with the SSI rules.

Application

A person with a disability can apply for this program using the PA 600 WD form, which can be mailed to the applicant's local county assistance office. This form can be obtained from the CAO or downloaded from <http://www.dpw.state.pa.us/Resources/Documents/Pdf/FillInForms/PA%20600WD-single%20sheets.pdf>. An application can also be completed and submitted electronically at www.compass.pa.us.

Premium

Even though the non-applying spouse's income is considered in determining eligibility for MAWD, it is not considered in determining the amount of the monthly premium that the applicant must pay in order to participate in the program.

To determine the premium amount, the county assistance office will calculate 5% of the applicant's countable income. Countable income is determined in the same way it is calculated for an SSI applicant.

This premium is payable monthly through payroll deduction or through direct payment by the participant. The premium is determined on a 6-month prospective basis. An increase in income does not increase the premium amount until the end of the 6-month period. If the premium amount would be less than \$10, it is waived. Additionally, if the participant is unable to pay and contacts the CAO, he/she may be granted a 2-month suspension of premium payment for good cause (such as loss of job, or temporary health problems).

Critical Note:

It is essential to note that a person enrolled in full Medicaid through the MAWD program automatically qualifies for the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs. This results in a tremendous overall savings to the consumer between the immense reduction in Part D costs due to the subsidy in addition to coverage of all Medicare Part A and B cost-sharing and additional health services available through having Medicaid coverage.

F. Medicaid for Workers with Medically Improved Conditions

For persons who are under 65, Medicaid for Workers with Medically Improved Conditions is the complement program to MAWD. It is available to persons with disabilities who were eligible for or were receiving Medicaid for Workers with Disabilities (MAWD), who work at least 40 hours a month and receive compensation for their work . Like MAWD, this Medicaid program is not free; it costs 5% of the participant's countable income.

The requirements for Medicaid for Workers with Medically Improved Conditions are virtually identical to the requirements for MAWD except for the disability and work requirements. The application form is the same as for MAWD.

Disability

To be eligible for this program, an applicant must previously have been found disabled by the Social Security Administration or the county's Medical Review Team but now no longer meets the Social Security disability criteria by virtue of being medically improved.

Work Requirement

In order to qualify for this program, an applicant must work and must receive compensation for that work. He/she must be able to provide proof of employment and compensation. He/she must work at least 40 hours/month earning at least minimum wage. An applicant can be self-employed.

Critical Note:

It is essential to note that a person enrolled in full Medicaid through the MAWD program automatically qualifies for the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs. This results in a tremendous overall savings to the consumer between the \$93.50 back each month and the immense reduction in Part D costs due to the subsidy in addition to coverage of all Medicare Part A and B cost-sharing and additional health services available through having Medicaid coverage.

G. Breast and Cervical Cancer Prevention and Treatment Program (BCCPT)

What is BCCPTP?

This program provides free Medical Assistance coverage to women who have breast or cervical cancer (or pre-cancerous conditions) and who meet the other eligibility requirements. Women who are eligible receive Medicaid program.

Who is eligible for BCCPTP?

A person is eligible for this program if she is a woman who:

- has a household income under 250% FPL (for 2007, \$2127/month for a single person and \$2852/month for a household of 2). ;
- is under age 65;
- is a Pennsylvania resident;
- is a US Citizen or other qualified immigrant;
- is uninsured or underinsured (No creditable coverage);
- is screened/diagnosed through an approved **HEALTHY WOMAN** site (a list of which can be found at <http://www.health.state.pa.us/php/HW/hltwlist.htm>)

Call the Pennsylvania Health Law Project at 1(800)274-3258 or 1(866)236-6310 (TTY) for more information on this program.

Critical Note:

Generally, a person with Medicare Part A and B is not considered eligible for BCCPT and thus is not automatically enrolled into the FULL low-income subsidy or extra help in paying for their Medicare Part D plan costs.

2. How to Apply for Medicaid

There are several ways to apply for Medicaid.

- 1) Go to the County Assistance Office to get an application
- 2) Access the application online at <http://www.dpw.state.pa.us/General/FormsPub/003670865.htm>

- 3) Complete and submit an electronic application via COMPASS at www.compass.state.pa.us

Most Medicaid programs require an applicant have a face to face interview. If a face to face interview is required and the applicant is unable to go to the County Assistance Office in person due to the person's medical condition, the applicant can request that a worker come to his or her home.

Applicants will have to provide documentation of their name, age, address, income, resources and other items on their application. If the applicant is unable to provide documentation but has made an effort to find it, the County Assistance Office cannot deny Medicaid for lack of documentation

3. Appeal Rights

Any decision denying an applicant Medicaid coverage must be provided to the applicant in writing with a reason and with instructions on how to appeal. The same is true of any decision denying a Medicaid recipient a service or benefit that was requested by the Medicaid recipient's provider on behalf of the Medicaid recipient. An appeal of a denial of a new application or new request for services must be made within 30 days of the date of a written denial.

Any decision terminating or reducing Medicaid coverage must also be provided to a recipient in writing with a reason and with instructions on how to appeal. Any decision terminating or reducing benefits or services that a Medicaid recipient has been receiving must also be provided to the applicant in writing with the reason and instructions on how to appeal. A termination or reduction of ongoing Medicaid coverage or of ongoing benefits or services can be appealed. **While the recipient has 30 days to file an appeal, if the appeal is filed within 10 days of the date of the termination or reduction notice, the benefits must continue pending the outcome of the appeal.** If the beneficiary receives continued benefits and loses the appeal, the CAO may establish an overpayment. If the beneficiary loses the appeal and timely requests reconsideration, the CAO will reinstate and continue benefits unchanged upon notification by OHA and such benefits shall continue until the Final Order of Reconsideration is issued. If the beneficiary is dissatisfied with the final order issued by the Secretary, she may appeal to the Commonwealth Court within 30 days of the final order.

V. ACCESS TO SERVICES USING MEDICARE AND MEDICAID

1. **Obtaining a covered service**

Access to services differs by healthcare delivery system. Before they were passively enrolled into Medicare Advantage Special Needs Plans, most dual eligibles in the five-county area obtained their Medicare through the traditional Fee-for-Service Medicare system (also called “Original Medicare”). Many dual eligibles disenrolled or continue to disenroll and return to Original Medicare.

For almost all Medicare covered services under the traditional Medicare program, there is no pre-approval process. This means that dual eligibles can go to their providers for a service and the service should be billed to Medicare first. Any balance should be billed to Medicaid.

Dual eligibles who obtain Medicare through a Medicare Advantage (managed care) plan will have to follow the plan’s rules for accessing services. This means that they may have to get a referral or prior approval before receiving services. When seeing a Medicare Advantage plan provider, a dual eligible should present their Medicare Advantage card (along with any necessary referral forms) and their Medicaid Access Card. In theory, the provider should bill the Medicare Advantage plan first and bill any remaining balance to the Medicaid Access Card.

Most dual eligibles who are in Medicare Advantage plans in the area are in what is called Medicare Advantage “Special Needs Plans”. These are plans permitted to limit enrollment exclusively or disproportionately to dual eligibles, persons with chronic conditions, or institutionalized individuals. Some consumers have had problems with their Medicare Advantage Special Needs Plan. Not all plans are tailoring their benefits, networks, or procedures to meet their enrollees Special Needs.

For persons with both Medicare and Medicaid, the Medicaid Access Card Program is not allowed to require pre-approval for Medicare covered services. However, they can require pre-approval for services that will only be covered by Medicaid, and not by Medicare.

2. **Covered Services**

To determine if a service is covered by Medicare, a beneficiary can refer to the Medicare benefits guide, visit Medicare’s website at www.medicare.gov, or

call 1-800-MEDICARE. To determine if a service is covered by Medicaid Fee for Service, contact the recipient hotline at 1-800-433-4324 or go online to www.dpw.state.pa.us to view the fee schedule of covered services. For help obtaining coverage information, call PHLP at 1-800-274-3258.

3. Paying for services

If a dual eligible needs a services that is not a Medicare or Medicaid covered service, the dual eligible can be required to pay only if the provider tells the dual eligible ahead of time that he or she will be required to pay **and** Medicaid does not cover the service.

4. Providers

Dual Eligibles in traditional Medicare can see any Medicare provider for a Medicare covered service, even if the provider does not participate in Medicaid. The Medicare provider will be able to bill Medicaid for the balance of the bill not covered by Medicare, regardless of whether he or she participates in MA. If the dual eligible is in a Medicare HMO, however, he or she is limited to providers who are in the Medicare HMO's network.

If the service needed is not covered by Medicare, such as dental care, but is covered by Medicaid, the dual eligible must go to a Medicaid provider. Under Medicaid Fee for Service, a dual eligible can see any Medicaid provider who accepts the Access Card. To access Medicaid covered behavioral health services in the five county Philadelphia area, the dual eligibles must go to providers who participate in the behavioral health Managed Care Organization's network.

To find a Medicaid provider for physical health services, dual eligibles can call their local County Assistance Office. To find a Medicaid provider for behavioral health services, a dual eligible should call his or her behavioral health Managed Care Organization, if he or she is enrolled in a Behavioral Health Managed Care Organization. Most dual eligibles in the five county Philadelphia area are enrolled in a behavioral health Managed Care Organization. Dual eligibles who are not enrolled in a behavioral health managed care organization should call their local MH/MR office for the names of providers in the area. A list of these offices can be found in the blue government pages of the phone book under "County Government."

5. Transportation

Medicaid consumers have the right to transportation to and from medical appointments with Medicaid and Medicare doctors. The Medicaid

Transportation Program (MATP) will either take dual eligibles to their appointments or reimburse them for travel expenses. MATP is available to provide transportation to and from services such as physician visits, pharmacies, and mental health appointments. Dual eligibles are entitled to bring an escort along if it is medically necessary or if they do not speak English.

In order to use this service, dual eligibles must complete a separate application to the MATP provider in their county. Also, they must contact the MATP provider in advance to arrange pick-up times and any special accommodations. See contact numbers below for the five-county Philadelphia area's MATP provider:

Bucks:	215-794-5554
Chester:	610-594-1079
Delaware:	610-490-3977
Montgomery:	215-542-7433
Philadelphia:	800-240-6588

6. Pre-approval in Medicaid

While Medicare covered services cannot be prior authorized by Medicaid, services covered by Medicaid only may have prior authorization requirements. To obtain a prior authorization for services under Fee-for-Service Medicaid (using the Access card), the provider must prescribe the service or medication, and then submit the prescription to Medicaid. The provider must also submit documentation of the medical necessity of the service or medication. This is usually done on a special form called the "MA-97" form. The Medicaid program must then review the request and decide whether to deny or approve it. The program must issue a written decision including reasons stated for its decision.

Under Medicaid, if a dual eligible is denied a request for prior authorization, he or she has a right to appeal that denial. He or she can also appeal if Medicaid approves a lower level of services or proposes an alternative treatment, which may be a denial in disguise.

To obtain a prior authorization for Medicaid covered behavioral health services, providers must submit a prior authorization request to the dual eligible's behavioral health Managed Care Organization, along with any documentation that supports the medical necessity of the service. If the behavioral health MCO denies the services or approves a lower level of service, the dual eligible can appeal the decision.

VI. BILLING ISSUES FOR DUAL ELIGIBLES

1. **Provider payment**

Dual eligibles are generally not required to pay Medicare deductibles and copayments for Medicaid covered services. Providers should first bill Medicare for their services. Medicaid is the payer of last resort and providers should not bill Medicaid until they have billed all other insurers. After billing Medicare, the provider can bill Medicaid for any remaining co-payment or deductible. However, the provider may not receive the entire billed amount.

Medicaid must pay the deductibles and coinsurances up to the amount that Medicaid usually pays for the service. This means that Medicaid is only required to pay a Medicare provider enough to get him/her to the Medicaid rate for the service.

So, for example, if the provider charges \$100 for the visit and Medicare pays its 80% share or \$80, the remaining 20% or \$20 should be billed to the Medicaid program through the person's Access Card. If the Medicaid program usually only pays \$83 total for such a visit, the provider only gets \$3 (not the remaining \$20). If the Medicaid program usually only pays \$79 total for such a visit, the provider gets nothing towards the \$20 remaining. As a result, sometimes, Medicare providers will not be compensated the full amount from the Medicaid program that they expect or are used to getting paid for the services they provide.

Providers must accept the payment they get from Medicaid as payment in full, no matter how little they get from Medicaid or even if they get nothing from Medicaid. They cannot bill a beneficiary for any remaining balance (this is called "balance billing," and it is not allowed). The beneficiary should not be billed for any deductibles or coinsurances related to the medical services he or she is receiving.

If a dual eligible receives a bill from a provider, he or she should call or write a letter to the provider who sent the bill explaining that he or she should not have been billed and that the provider should instead bill Medicaid. The dual eligible can also call or write a letter to Department of Public Welfare- Office of Medical Assistance Programs, informing them that he or she has received a bill from a provider. If the dual eligible is having trouble explaining to the provider that he or she is not responsible for the bill, he or she can call the Pennsylvania Health Law Project's helpline at 1-800-274-3258.

2. Legal authority against balance billing

The federal Medicaid statute, with which states must comply in order to receive funding for their Medicaid programs, requires that when a provider submits a claim to Medicaid for the balance left unpaid by Medicare, the amount paid by Medicaid must be accepted as payment in full. [42 U.S.C.A. 1396(a)(n)(3)(A)]. It also makes clear that dual eligible consumers have no legal liability to pay a provider or an HMO for that service and that a provider or HMO can be sanctioned for charging dual eligible consumers. [42 U.S.C.A. 1396(a)(n)(3)(B) and (C)].

VII. CONCLUSION

Accessing healthcare coverage and services is extremely challenging for lower-income elderly and adults with disabilities. Navigating the complex systems of Medicare and Medicaid can be overwhelming. For additional information or assistance in accessing healthcare coverage or services, please contact the Pennsylvania Health Law Project at 1-800-274-3258 or visit us online at www.phlp.org.

APPENDIX A

Countable Income and Resource Limits

Different Medicaid programs for Seniors have differing countable income and resource limits. These are included below in the description of the Medicaid Programs available. What income is considered and how much of it is counted is relatively consistent across the programs, as is what resources are considered and counted. Below is an entire section on counting income and resources.

INCOME

All earned and unearned income (from whatever source derived) - e.g. employment income, SSA, pension, retirement benefits, interest, dividends, rental properties, etc. are initially considered when determining countable income. (See Medical Assistance Eligibility Handbook Chapter 350. (MAEH)) However, State and Federal laws exclude certain types and sources of income and the Medicaid eligibility rules require certain deductions and disregards before the countable income is determined. (See MAEH Chapter 350 for a more comprehensive list of exclusions or inclusions than what is listed here. The MAEH is available on-line at:

www.dpw.state.pa.us/oimpolicymanuals/manuals/oimpolman.asp

For an applicant whose spouse is also applying, the rules are the same across all programs and are the same for all married couples as they are with single individuals except that higher income limits are used. However, the various Medicaid programs differ in how much of the applicant's spouse's income is to be counted towards the applicant's countable income when the spouse is not also applying for Medicaid.

In the SSI program, Social Security Administration rules call for only a portion of the non-applicant spouse's income to be counted as the applicant's income. The amount deemed to be the applicant's income depends on factors such as how many children there are in the household.

In other Medicaid categories ALL of the non-applicant spouse's income is considered when determining the applicant's countable income. However, the income limit applied is that of a two-person household.

Determining Countable Income for SSI, Healthy Horizons, Waivers, MAWD, MAWMIC, and Special SSI categories

In order to determine countable income, there are several deductions that

are taken from gross income (before taxes and expenses). These include:

- **Standard deduction:** A standard deduction of \$20 is taken on all income. Usually it is first applied to unearned income. If there is no unearned income, it is taken entirely from earned income. Expenses incurred to receive unearned income (e.g., transportation costs to obtain the income, bank or attorney fees,) may also be deducted.
- **Earned income disregard:** Earned income is entitled to a \$65 deduction. Once that deduction is taken, another deduction of half of the remaining income is taken.
- **Impairment-related work expenses:** Additional deductions from countable earned income included expenses paid for items or services that enable the applicant to work provided he or she needs the item or service because of his or her disability (e.g., special transportation to and from work, attendant care services to help get to work)
- **Special rules for people who are blind:** Individuals who are blind are entitled to additional work expense deductions. These include deductions for transportation expenses, including a guide dog and upkeep of the dog, cane travel instruction, public transportation including taxi fare and actual costs (up to 15 cents a mile) for transportation by a private vehicle. Additionally, individuals who are blind can deduct other work related expenses such as translation of materials into Braille, a reader, lunches, optical aids, and licenses. There are many other work-related expenses that individuals who are blind can deduct from earned income.

RESOURCES

The CAO will evaluate each resource or asset a client has or can legally obtain and then determine if it should be counted or excluded. The total countable resources of the applicant/recipient group are compared to the resource limit (if any) of each category to determine resource eligibility. (55 Pa. Code 178.1) Resources considered (but not necessarily counted) include: personal property, life insurance, vehicles, burial spaces and burial funds, and real property. (*See id.*)

1) Determining Countable Resources

There is **no resource test** for any applicant/recipient with a natural or adoptive child under 21 years of age (including unborn children) living in the household. This exclusion also applies to an applicant/recipient with a child under 21 years of age living in the household over whom the applicant/recipient

is exercising care and control, meaning that the applicant is caring for the child in a parental/ guardian capacity. (See MAEH 340.1)

Like income, each program has slightly different rules for how a non-applicant spouse's resources are considered. For SSI, a portion of the non-applicant spouse's assets are considered the applicant's countable resources. For Healthy Horizons, only those assets demonstrably belonging to the applicant are considered and the one person asset limit is used. For MAWD, all assets of the non-applicant spouse and the applicant are considered and there is only one asset limit of \$10,000. Resources are considered, even if there is a child under 21 in the house.

For the remaining Medicaid categories that impose a resource test, all assets of the non-applicant spouse and the applicant are considered and the appropriate limit for the number in the household is used.

Other resource provisions:

- **Life Insurance:** The face and cash surrender value of life insurance is only counted as a resource when determining eligibility for SSI, Healthy Horizons, Waivers, MAWD, MAWMIC, and Special SSI categories. If the total face value for an insured person is more than \$1,500, and the total cash surrender value is determined to be more than \$1,000 for each insured person, the CAO will count the amount over \$1,000 as a resource to the person who owns the policy. (See MAEH 340. 4)
- **Vehicles:** One motor vehicle (with the highest equity value) is exempt as a resource and the amount owed on a second vehicle is deducted from the current value to determine the resource value of the second vehicle. (See MAEH 340.5)
- **Burial resources:** Burial spaces, burial reserves, burial plots, and irrevocable burial accounts are generally excluded. (See MAEH 340.7 for further discussion.)
- **Other Resource Exclusions:** For a further list of resource exclusions see MAEH 340.8.

APPENDIX B

Applying for Spend-Down

To apply, complete the PA 600 Application for Medicaid and indicate on it that the applicant wants to apply for Medicaid under spend-down.

For the Monthly (NMP) Spend-down,

- Submit the application for Medicaid. The worker at the County Assistance Office will determine the monthly spend-down amount.
- Each month the consumer will need to send in receipts, bills, or other documentation showing that he or she has been billed for or paid the amount in medical expenses for which he or she is responsible.
- Expenses only count for the month in which they were paid or incurred (if not yet paid).
- For the remainder of each month, Medicaid will cover the consumer's medical expenses. The consumer will have an Access Card that he or she will be able to use when the spend-down is met. (Please note: Medicaid will not pay for the expenses that were used to meet the spend-down.)
- NMP Medicaid covers prescription drugs, dental care, and most durable medical equipment.

For the Six-Month (MNO) Spend-down,

- At the time the application is submitted, the applicant's eligibility is determined for a six month period.
- This period can be *retroactive* for up to three months prior to application, so this option may be beneficial if the applicant owes *back bills*.
- Unpaid expenses used to meet the spend-down can go as far back as three months prior to the application date.
- The income limits are lower under the six-month spend-down than under the monthly spend-down for a person with a disability.
- The six-month spend-down does not cover prescriptions, dental care, or most durable medical equipment.