



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
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 manual, 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 as “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 so they can 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 Medicare and Medicaid eligibility for persons on Medicare. It will also explain how dual eligibles access their healthcare services. ***Please note that all amounts and figures quoted herein are for the year 2009 unless otherwise noted. Medicaid income limits and Medicare cost-sharing amounts can increase each year.***

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 who are age 65 and over, or under age 65, but permanently disabled and 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. Hospital Insurance (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 qualifying quarters¹;
- 2) She receives or is eligible to receive Railroad Retirement benefits;
- 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, a person 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 she does not have the 24-month wait before Medicare starts];
- 2) She has End-Stage Renal Disease;
- 3) She receives a disability pension from the Railroad Retirement board and meets certain conditions;
- 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 premium-free Part A, he can still enroll in and purchase Medicare Part A. The following people can purchase Medicare Part A.

- 1) A person age 65 or older who did not work and pay (or have a

¹ A qualifying quarter is a quarter in which a person worked and earned the minimum threshold amount. In 2009 the threshold amount is \$1090. This amount changes each year.

spouse or parent work and pay) into the Social Security system for 40 or more qualifying quarters can purchase Part A if she is a citizen, legal permanent resident, or legal alien who has been a resident for 5 or more years.

- 2) An adult with disabilities who is under age 65 may purchase Part A if he was previously entitled to premium-free Medicare Part A because he was receiving SSDI, but lost the SSDI benefit solely because his earnings exceeded a certain monthly amount (called the substantial gainful activity amount). The person must continue to have the disabling physical or mental impairment and must not be otherwise entitled to Medicare Part A. The monthly substantial gainful activity amount for 2009 is \$980.

A qualifying quarter of work means that the person worked and paid Medicare taxes during one of the four calendar quarters of the year. Calendar quarters are the calendar months ending March 31, June 30, September 30 and December 31 of any year. For persons who have earned 30-39 qualifying quarters of work, the premium for 2009 is \$244/month. For persons who have earned 29 or fewer qualifying quarters, the premium for 2009 is \$443/month.

If an individual must purchase coverage, she can only enroll during the *initial enrollment period* or *general enrollment period*. The initial enrollment period begins three months before the first month of eligibility and lasts until three months after the first month of eligibility (for a total of seven months). The general enrollment period runs from January 1 to March 31 of each year, with coverage beginning on July 1 of that year.

Beneficiaries who delay enrollment in Part A will be charged a delayed enrollment penalty. The penalty is a 10% premium surcharge (never any higher) on the Part A premium. This is payable for a period twice the number of years of the delay. For example, if a person delays enrollment in Part A for two years, she pays the extra 10% premium surcharge for four 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 benefits will be notified by the Social Security Administration (SSA) of his anticipated start date for Medicare Part A. A person who is not receiving Social Security benefits at the time he becomes eligible for Social Security must affirmatively make application to the Social Security Administration for his 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 Medicare Part A 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.

A person age 65 years or older, who is newly signing up for Social Security and qualifies for premium-free Medicare Part A, can enroll in Part A at any time upon taking Social Security benefits. Coverage for these individuals can be retroactive for up to six months (though not earlier than their 65th birthday).

General Enrollment Period. After the initial enrollment period (which occurs when an individual first becomes eligible for Part A), an individual who does not have Medicare Part A can only enroll during the general enrollment period of January to March of each year. Enrollment is effective on July 1 of that year. Those who qualify for a special enrollment period (as described below) can sign-up for Medicare Part A outside of the general enrollment period.

Special Enrollment Periods (SEPs). In certain situations, individuals may be eligible to enroll in premium Part A outside of the initial and general enrollment periods.

Persons age 65 and older, who delayed enrollment due to health insurance through employment-related group health insurance (coverage for 20 or more employees) of themselves or their spouses, are eligible for an SEP. They must enroll within eight months of the end of the employment or the end of the insurance, whichever is sooner.

A similar SEP is available to disabled adults who have coverage through a large group health plan (covering 100 or more employees). These individuals may enroll in premium Part A during an eight-month period which begins when the current employment ends; the plan is no longer classifiable as a large group health plan; or when the plan coverage is terminated, whichever comes first.

Delayed Enrollment Penalty Most people do not delay enrolling into Medicare Part A because it is “free.” People who have worked full-time for at least ten years and earned 40 qualifying quarters of work do not pay a premium for Part A.

As noted earlier, there is a 10% penalty imposed on individuals for delayed enrollment into Premium Part A. The penalty lasts twice the number of years that the person delayed enrollment in Part A. So, if a person delays enrolling in Part A for three years, she pays an extra 10% for six years. Remember that 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 when a person turns 65.*

2. Medical Insurance (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 benefits (Retirement, Survivors, and Disability Insurance, or RSDI, benefits) or Railroad Retirement benefits when they become entitled to Medicare. These individuals may decline Part B if they do not wish to be enrolled. Individuals who are not receiving Social Security or Railroad Retirement benefits, or who do not have Medicare Part A when they turn 65, 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 only during prescribed enrollment periods (described later). 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 may increase 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 2009 is \$96.40/month for individuals with annual income no more than \$85,000 and for married couples with annual income no more than \$170,000. Persons with higher incomes pay more as shown in this chart for 2009 income and premium amounts:

2009		
Income Tax Return Showing Income	Joint Income Tax Return Showing Income	Monthly Part B Premium Amount per Beneficiary
\$85,000 or less	\$170,000 or less	\$96.40
\$85,001-\$107,000	\$170,001-\$214,000	\$134.90
\$107,001-\$160,000	\$214,001-\$320,000	\$192.70
\$160,001-\$213,000	\$320,001-\$426,000	\$250.50
Above \$213,000	Above \$426,000	\$308.30

How Does One Enroll in Part B?

A person receiving Social Security benefits 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. If a person does not want Part B at that time, they must decline the coverage by notifying SSA; otherwise, Part B coverage will start on the anticipated start date. A person not receiving Social Security benefits but otherwise eligible for Medicare must affirmatively make application to the Social Security Administration 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 three months before they turn 65 years old.

When Can One Enroll in Part B?

Three enrollment periods are discussed below: the initial enrollment period, the general enrollment period and the special enrollment period.

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 they turn age 65. It ends three months after they turn age 65. If a person 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.

If a person enrolls during this period, there are no penalties and her coverage will be effective on either the date of eligibility or the first of the month of enrollment, whichever is later.

General Enrollment Period. If a person does not sign up for Medicare Part B when she first becomes eligible, she may enroll in Part B during the general enrollment period. This period runs from January 1 to March 31 of each year. (When March 31 falls on a non-business day, the general enrollment period is extended to the next business day.) People who enroll during this period normally pay a penalty. If a person signs up for Medicare Part B during the general enrollment period, her coverage will be effective on July 1 of that year unless she qualifies for an SEP at another time during the year.

Special Enrollment Periods. An SEP is available to a person who is eligible for Medicare but waited to enroll in Part B because she or her spouse was working and had group health plan coverage through an employer or union. It is also available if a person is disabled and has group health plan coverage based on her own or a family member's current employment. There is generally no penalty (discussed later) added to the premiums for enrolling in Part B during the special enrollment period.

If the SEP applies, a person has two options about when she can sign up for Medicare Part B. The person can enroll at any time while she is still covered by the employer or union group health plan through her or her spouse's *current or active* employment; alternatively, the person can enroll during the eight months following the month the employer or union group health plan coverage ends, or the employment ends (whichever is first). Coverage is effective the month of enrollment or any later month designated by the applicant.

Remember: If a person does not enroll in Medicare Part B during her special enrollment period, she will have to wait until the next general enrollment period, which is January 1 to March 31 of each year.

Delayed Enrollment Penalty. If enrollment is delayed (i.e., a person does not enroll during the initial enrollment period or an SEP), a penalty may be imposed. Whether a penalty is imposed depends on whether the individual had coverage through a current employer or a spouse's current employer.

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 did not take it, except in special cases (such as if an individual qualifies for an SEP). There is no cap on this penalty. The person will have to pay this extra amount as long as she has Medicare Part B. For example, if she delays enrolling in Part B for 30 months, she will be charged a 20% premium penalty (10% for two full years, or 24 months, of delay) for the rest of time she has Part B.

Note: If someone was eligible for Medicare Part B before age 65 and was subject to a delayed enrollment penalty because of delayed enrollment, that person will have another opportunity to enroll in Part B at age 65. If she then enrolls in Part B during her initial enrollment period, at age 65, any delayed enrollment penalty that was previously applicable will be eliminated. Also, individuals who qualify for the state to pay their Part B premium will not be subject to the Part B late enrollment penalty.

3. Medicare Advantage (Part C):

Part C is a misnomer in that it is not actually a benefit package. Instead, Part C refers to what are known as “Medicare Advantage Plans.” Part C is an option to obtain Medicare benefits covered under Medicare Part A, Part B and sometimes Part D through a private insurance company approved by Medicare. In contrast, original Medicare is a private fee-for-service (PFFS) plan, which means that beneficiaries can choose any doctor or specialist who accepts Medicare. Original Medicare is also available nationwide.

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 (with minor exceptions).

There are also some Medicare Advantage plans, called Medicare Special Needs Plans (SNPs), 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
- Medicare Private Fee-For-Service Plans (PFFS)
- Medicare Advantage Special Needs Plans (SNPs)
- Medicare Savings Accounts

Medicare Advantage Plans must, at a minimum, cover Medicare Parts A and B services. In most cases, there are extra benefits that are not covered under original Medicare. These extra benefits can include routine coverage of eyeglasses, dental benefits, hearing exams and hearing aids, and/or lower co-payments. Medicare Advantage Plans generally have special rules about how one can access care, such as only covering services when one goes to providers within the plan’s network, or requiring one to obtain a referral before she can see a specialist. In addition, most Medicare Advantage Plans offer prescription drug coverage (discussed later). In most Medicare Advantage Plans, if a person wants drug coverage, and her plan offers it, she must get it from her Medicare Advantage Plan and cannot enroll in a stand-alone prescription drug plan.

How Does One Enroll in Part C?

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

- Contact Medicare: Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Enrollment staff will review the person's healthcare needs and help them choose among the plan options. Medicare representatives will enroll the person into a Part C Plan based on the *individual's* choice.
- Contact the Plan: If the consumer has already chosen a Part C Plan, they can call the Plan directly (phone numbers are available at www.medicare.gov and also listed in the *Medicare & You 2009 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. After 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 own Website.

When Can One Enroll in Part C?

Initial Enrollment Period. Individuals can enroll in a 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 enrollment period (see page 9).

Annual Election Period (AEP). Once someone chooses a Part C plan, they are generally locked into their choice of Medicare Advantage Plan until the annual coordinated election period from November 15 to December 31 of each year. Individuals can change their Medicare Advantage Plan during this period and enrollment will be effective January 1. In addition, there are a number of SEPs that recipients are entitled to outside of the AEP and the open enrollment period (discussed below).

Open Enrollment Period. Every year, there is an open enrollment period (OEP) from January 1 to March 31. The OEP is for individuals who want to join a Medicare Advantage Plan, change their Medicare Advantage Plan or disenroll from their Medicare Advantage Plan and revert to original Medicare.

Individuals who make plan changes during the OEP can only make a

change to a “like plan.” This means, for example, 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. Or, if they are in a Medicare Advantage Plan with prescription drug coverage, they can only use the OEP to either: (1) change to a different Medicare Advantage Plan with prescription drug coverage, or (2) 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, as noted above, an individual who is enrolled in a Medicare Advantage Plan with no prescription drug coverage could not switch to a Medicare Advantage Plan with prescription drug coverage during this enrollment period. See pages 16-17 for more information about Part D (prescription drug plan) enrollment periods.

Special Enrollment Period. As noted earlier, an individual can only enroll, disenroll, discontinue, or change the election of an Medicare Advantage Plan offered during certain enrollment periods throughout the year. However, in certain circumstances a person will qualify for an SEP, which will allow her to make these changes outside of the specified enrollment period. Here are some examples:

- 1) The Center for Medicare & Medicaid Services (CMS) or the Medicare Advantage Plan has terminated the Plan’s contract with Medicare in the area in which the individual resides, or the Plan 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 the individual has experienced another change in circumstances as determined by CMS (not including terminations resulting from non-payment of premiums or from disruptive behavior).
- 3) The individual demonstrates to CMS, in accordance with guidelines issued by CMS, that the Plan violated a material provision of the contract or that the Medicare Advantage Plan misrepresented the Plan to the individual.
- 4) Dual eligibles, individuals with the low-income subsidy (LIS), and institutionalized individuals have an *ongoing* SEP to enroll in Part D and/or change their Medicare Advantage Plan with Prescription Drug Coverage. In addition, individuals who lose their dual eligible status or their LIS benefit have a certain amount of time after this happens to change plans.

These are just some of the situations that would qualify a person for a special

enrollment period to enroll in, disenroll from, or change their Medicare Advantage Plan. Individuals should call Medicare at 1-800-MEDICARE or 1-877-486-2048 (TTY) to find out whether they qualify for a special enrollment period.

4. Prescription Drug Insurance (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) if they have original Medicare or if they have a Medicare Advantage PFFS plan that does not include a prescription drug option. Individuals who are enrolled in a Medicare Advantage prescription drug plan (MA-PD) must receive their drug coverage through their Medicare Advantage Plan.

How Does One Enroll in 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 designated agent with power of attorney over the consumer). There are three ways to enroll into a Part D plan:

- Contact Medicare: Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. 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 selected a Part D plan, they can call the Plan directly. (Phone numbers are available at www.medicare.gov and are also listed in the *Medicare & You 2009 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 Medicare Website. After 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 own 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 SNP in January 2006). However, these auto-enrollments by Medicare for dual eligibles are into a randomly selected plan, without accounting for the individual's particular prescription drug needs. Therefore, even auto-enrolled dual eligible consumers have a great incentive to affirmatively choose a plan. This will ensure that they are in a Part D plan that covers their medications and is accepted at their pharmacy.

When Can One Enroll in Part D?

Initial Enrollment Period. Individuals who first become eligible for Medicare will have a Part D initial enrollment period that mirrors their Part B election period. Namely, it is a seven-month range that includes the three months prior to the month in which they become eligible, the month that the person became eligible, and the three months after the month in which they became eligible. Individuals who fail to enroll during their initial enrollment period will be barred from enrolling into a PDP until the next Annual Election Period (discussed below). Note, therefore, that most Medicare consumers are locked into 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 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 during their initial enrollment period. The AEP runs from November 15 to December 31 of every year, with plan changes becoming effective January 1.

Special Election Periods. Some consumers will qualify for a Special Election Period, which will allow them to switch Part D plans or enroll in Part D outside the initial enrollment period or AEP.

As noted earlier, all dual eligibles have a perpetual special election period. They can change plans at any time, effective the first day of the month following the enrollment change request. Individuals who lose their dual eligible status (i.e., they lose Medicaid coverage) have a short amount of time to change their plan after this happens.

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 into 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), the Part D Plan violates its contract or terminates the Plan, or the consumer becomes enrolled in a state pharmaceutical assistance program (such as Pennsylvania's Pharmaceutical Assistance Program for the Elderly (PACE) and PACE Needs Enhancement Tier plans).

In addition, there are a number of other situations where someone could qualify for a Part D special election period. Individuals can call Medicare at 1-800-MEDICARE or 1-877-486-2048 (TTY) to find out if they qualify for a special election period based on their particular situation.

Delayed Enrollment Penalty. There is a late enrollment penalty that accumulates any time a Part D eligible individual is without *creditable coverage* (discussed below) for a continuous period of 63 days or longer. The penalty is an extra surcharge to the Part D premium that the individual pays if they later enroll in Medicare Part D. The penalty amount will be a surcharge of 1% of the average national monthly premium for each month that the individual went without creditable prescription drug coverage. Note that this extra premium penalty continues every month for the duration of the individual's Part D enrollment.

Individuals who qualify for the low-income subsidy (LIS), and who enroll in a Part D plan by the end of the year, will have their late enrollment penalty waived. The penalty will be waived for the remainder of the time they have Part D, even if they lose their LIS at some point during the year.

Creditable drug coverage. *Creditable coverage* is prescription coverage that, 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 of whether 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 drug coverage, every year before the Annual Election Period starts on November 15.

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 election period and will not incur a late enrollment penalty if they enroll in Part D within a certain time period, as 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 election period that exists for such situations. This special election period

begins the month the individual is notified of the loss of creditable coverage and ends two months after either the loss (or reduction) occurs, or the individual received the notice, whichever is later. This special election period allows beneficiaries to avoid a gap in their drug coverage and avoid being charged the premium penalty.

Beneficiaries who lose their creditable drug coverage and do not exercise either of these two options, must wait until the next annual election period (November 15 to December 31 of each year) *and* will incur the late enrollment penalty. If someone in this situation is approved for the LIS, they can enroll in Part D at any time and will not be subject to the late enrollment penalty.

Critical Note for Dual Eligibles: The Medicare Improvements for Patients & Providers Act of 2008 eliminates the Part D premium penalty for LIS eligible individuals. Note the late enrollment penalty had already been eliminated for LIS eligible individuals by CMS in October 2007.

III. MEDICARE-COVERED SERVICES

1. Part A Coverage

Medicare Part A covers hospitalization, skilled nursing facility stays, home health care for beneficiaries without Part B, and hospice care. 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 consecutive 60-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 (1) how long the beneficiary is in the hospital during a given benefit period or hospitalization, and (2) 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 drugs, lab tests, x-rays, and all other necessary medical services and supplies. Care and services provided by residents and doctors of the hospital are covered under Part A. Care and services provided by the beneficiary's attending doctor's bill is not covered under Part A, but may be covered under Part B.

Table 1
2009 Medicare Part A Hospitalization Benefits at a Glance

Days of Each Hospitalization	Deductible	Co-Payment
1-60	\$1068	\$0
61-90	None additional (\$1068 already paid)	\$267 Per Day
91 → 150 (if the beneficiary has not yet used his/her lifetime reserve days)	None additional (\$1068 already paid)	\$534 Per Day
91 → 150 (if the beneficiary has already used)	None additional (\$1068 already paid)	Responsible for full daily rate for care at hospital, unless other supplemental insurance covers

his/her lifetime reserve days)		cost of hospitalization
151 and beyond	Participant pays all costs	Participant pays all costs

For blood transfusions while in the hospital, the 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 or has other secondary insurance). Medicare pays for all blood after the first three pints.

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,” and not every nursing home is considered a “skilled nursing facility.” Beneficiaries must note that Medicare provides short-term coverage; it is not a source of coverage for long-term care. The cost to the beneficiary rises each year.

Table 2
2009 Medicare Part A Skilled Nursing Facility Care Benefits at a Glance

Days of Each Stay	Deductible	Co-Payment
1-20	\$0	\$0
21-100	\$0	\$133.50 per day
101 and beyond	\$0	Beneficiary is 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 persons who are homebound, or normally unable to leave home unassisted,² who need

² This criterion is met if leaving the home requires a considerable and taxing effort, which may be shown by the patient needing personal assistance, or the help of a wheelchair or crutches, etc. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a walk around the block or a trip to the barber. Attendance at an adult day

intermittent coverage of skilled nursing or who need therapy care.

Medicare pays the entire cost of the home health care but only 80% of the Medicare-approved cost of any durable medical equipment the beneficiary needs (such as wheelchairs, hospital beds, oxygen and walkers). The beneficiary is responsible for the remaining 20% (unless s/he has supplemental coverage, such as Medicaid or a Medigap policy).

Hospice Care for Terminally Ill Patients

Medicare pays for virtually all hospice care with no deductibles or co-payments for two 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 care.

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 care in a hospital are the same as the costs for other hospitalizations; the beneficiary will pay a 20% co-payment for professional mental health services while in the hospital. See Table 1 for an explanation of the benefit limits and co-payments.

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 service, 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

care center or religious services is *not* an automatic bar to meeting the homebound requirement.

Medicare consumers can receive within the first six months of enrolling in Medicare.

Part B does not cover:

- Outpatient prescription drugs (except for certain drugs, such as immunosuppressants for individuals who had a Medicare-covered transplant)
- 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 earlier), a person is also responsible for an annual deductible (\$135 for 2009) and payment of 20% of the Medicare-approved amount for covered service visits. Note that the co-payment is 50% for covered mental health services. Persons with Medicaid will have all of 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 certain medication that has to be injected by medical professionals. 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 out-of-pocket 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 the Medicare-approved amount for

covered mental health services. (Compare this to the 20% coinsurance for covered physical health services under Part B.) Note, however, that mental health coverage under Medicare is extremely limited.

3. Part C Coverage

Typically the beneficiary must pay an extra monthly premium (in addition to their Part B premium) for coverage under a Medicare Advantage Plan. The Medicare Advantage Plans available to a Medicare beneficiary depend on which plans offer coverage in their county. Specific coverage details will vary by plan. Medicare Advantage Plans cannot offer less than the basic Medicare Part A and Part B coverage, but they may offer more coverage. Some Medicare Advantage Plans cover extra services that are not available under original Medicare, 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 that the consumer can only get care from providers who are in the Plan's network. Usually, individuals have lower out-of-pocket costs with Medicare Advantage Plans than they would if they had coverage through original Medicare. Consumers can join Medicare Advantage Plans rather than buy a "Medigap policy," which is a supplement to help consumers with the cost-sharing under original 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. A list of the Part D-approved stand-alone prescription drug and Medicare Advantage Plans is available at www.medicare.gov. Generally, the Part D plans can charge monthly premiums, annual deductibles, and varying co-payments. Consumers with Medicare and Medicaid, however, will not have to pay the monthly premium if they enroll in a plan that is zero-premium for individuals with the full low-income subsidy. Dual eligibles also pay no annual deductible and limited co-payments.

In 2009, persons with the full LIS pay \$1.10 per prescription for generics and other "preferred drugs" and \$3.20 per prescription for brand name drugs. Those with the partial LIS pay \$2.40 per prescription for generics and other "preferred drugs" and \$6.00 per prescription for brand name drugs. In 2009, LIS-recipients pay no co-pays once they have reached \$4350 in out-of-pocket drug expenses for the year. And, there are no co-pays for LIS-recipients who live in long-term care facilities (such as nursing homes and intermediate care facilities for the mentally retarded).

Generally, Part D Plans must cover Food and Drug Administration-approved drugs, biological products, vaccines, insulin and supplies associated with injecting insulin; in addition, Part D plans 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 Pennsylvania Medicaid has covered, and continues to cover, these drugs for dual eligibles.*), over-the-counter drugs, and drugs covered by Parts A and B of Medicare.

For 2009, Part D plans are required to cover all or substantially all available prescription drugs in the following six drug categories:

1. antidepressants;
2. antipsychotics;
3. anticonvulsants;
4. anticancer;
5. immunosuppressants; and
6. HIV/AIDS.

Note: Extended release versions do not have to be covered.

Consumers can access covered drugs through pharmacies and mail-order services that are in their Medicare prescription drug plan's network.

Choosing a Plan

Because beneficiaries can only access prescription drugs through a Part D plan, they will have to consider their plan choice carefully. Most beneficiaries will be locked into a plan for the year. Recall that dual eligibles can switch Part D plans at any time, as they have an ongoing special election period. 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? (Remember that dual eligibles will not pay the monthly premiums for the Part D plan as long as they pick a zero-premium plan for people with the full low-income subsidy. In addition, they will not have a deductible because the subsidy will cover it.)
- What co-payments will the plan charge me for my drugs? (Remember that dual eligibles' Part D co-pays are limited by the LIS and should not be more than \$2.40 for generic drugs and \$6.00 for brand name drugs on the plan formulary.)
- Is this a managed care plan? If so, how will that impact my access to services other than prescription drugs?

IV. MEDICAID FOR PERSONS ON MEDICARE

Medicaid is a mostly free state 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,³ they are a Pennsylvania resident and they are a U.S. citizen or qualified immigrant. Medicaid can be a person's only insurance (if he has no other coverage), or it can be a secondary insurance (if a person already has Medicare or is otherwise underinsured). Depending on her income and resources, a Medicare-recipient may be eligible for Medicaid to pay for all or some of her Medicare out-of-pocket expenses.

If a person is eligible for full Medicaid coverage, Medicare will still be her primary insurer and Medicaid will cover premiums, deductibles and other cost-sharing. Full Medicaid also affords coverage for particular services that are not available through Medicare (such as dental coverage and medical transportation costs).

In addition, it is critical to note that a person who has Medicare and qualifies for Medicaid under *any* category of eligibility is "deemed" eligible for the *full* LIS (discussed on page 23), which provides extra help in paying for Medicare Part D costs. That means they *automatically qualify* and *do not need to apply for an LIS*. Those who qualify for Medicaid under a spend-down (discussed later) qualify for the LIS for an entire year, even if they do not qualify for spend-down for the entire year. This results in a tremendous overall savings to the consumer because of the immense reduction in Part D costs.

If a Medicare-recipient's income is too high for full Medicaid programs, she may still be eligible for Medicaid assistance with payment of the Medicare Part B premium under a special Medicaid program.⁴ For information on Medicaid eligibility for persons who are not Medicare recipients, contact the Pennsylvania Health Law Project at 1-800-274-3258 or go to www.phlp.org.

1. Medicaid Programs for Medicare Recipients Over Age 60

There are several categories of Medicaid that cover persons on Medicare

³ See Appendix A for information on "countable" income and resources.

⁴ This special Medicaid program is known as the Medicare Savings Program. A Medicare recipient may qualify for one of these programs as a Qualified Medicare Beneficiary (QMB), a Specified Low-Income Medicare Beneficiary, or a Qualified Individual-1.

who are over age 60. Often, they have different requirements and different countable income and resource limits. Some of the categories discussed below are Medicaid for Persons on SSI, Healthy Horizons, spend-down, Home and Community-Based Waivers, Medicaid for Workers with Disabilities, Medicaid for Medically Improved Workers, and the Breast and Cervical Cancer Prevention and Treatment Program. Medicaid also covers long-term care in a nursing home, though this is not technically a separate category of eligibility.

Practice Note: If a person is found ineligible for one Medicaid 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 is eligible for Medicaid under a different category. See 55 Pa. Code §133.73 (relating to redetermining eligibility for the categorically needy) and 55 Pa. Code §133.83 (relating to redetermining eligibility provisions for the medically needy). If a person is terminated without a redetermination of eligibility, 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.

A. Medicaid for Persons on SSI

A person who receives Supplemental Security Income (SSI) is automatically eligible for Medicaid. As long as the person receives even as little as \$1.00 in SSI benefits, he/she will continue to receive Medicaid. In order to receive SSI, a person must meet the SSA's definition of "disabled" 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. As noted earlier, Pennsylvania pays for the Part B Medicare premium for certain individuals if they are eligible for both Medicare and Medicaid.

Also as noted earlier, Part A coverage is free to most SSA individuals (SSI recipients must pay for it because they don't have enough quarters of work history). However, if the individual did not work enough quarters to be eligible, or worked for an employer who was not covered by the Social Security system, the individual is required to pay a monthly premium for Part A coverage. Pennsylvania pays the Part A premium when the individuals are eligible for assistance as QMBs, or as Qualified Disabled and Working Individuals.

The countable income limit for SSI in 2008 is \$701.40 for a single person and \$1,065.80 for a married couple (where both are SSI eligible). 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. A portion of the non-applicant spouse's income may be deemed to be the applicant spouse's income. Whether the non-applicant spouse's income is deemed to the applicant's income 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 SSI and Social Security recipients who live in these residences, the state supplements their income to help pay the cost of the facility, up to \$439.30/month in a PCH and up to \$434.30 in a DCH. This supplement is considered to be SSI and thus entitles the person to Medicaid as an SSI recipient.

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 a married person whose spouse is under 65 and is not disabled, must be at or below \$867/month (in 2008). Countable income for a married couple where both spouses are eligible must be at or below \$1,167/month (in 2008).
- 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 Common 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.

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 program. If eligible, Medicaid will pay the Medicare Part B premium of \$96.40/month in 2009.

To be eligible, an applicant must have countable income less than 135% of the federal poverty level, which is \$1,170/month for an individual and \$1575/month for a couple in 2008. Countable resources must be below \$4,000 for an individual, or \$6,000 for a couple. Appendix A contains guidance on how to count income and resources.

Potential beneficiaries can apply by completing the PA 600M 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 the Web at www.compass.state.pa.us.

C. Spend-down

Spending-down to eligibility is an option for people, including Medicare recipients, whose income is too high to qualify automatically for a particular Medicaid program. Using spend-down, a beneficiary can *deduct* paid or incurred medical expenses from her countable income to meet Medicaid income eligibility requirements. There is no limit on how old an unpaid medical bill can be, so long as it is still owed by the client and has not previously been used to meet a spend-down. Note that Medicaid will not pay for the bills that were used to meet the spend-down.

There are two spend-down programs in Pennsylvania. One is a monthly spend-down (also known as *Non Money Payment*, or "NMP") and the other is a six-month spend-down (also known as *Medically Needy Only*, or "MNO"). The monthly spend-down is the more commonly utilized program by persons on Medicare. This program covers prescription drugs and durable medical equipment, making it generally of more use to persons with disabilities than the six-month spend-down.

For the monthly spend-down, once medical expense deductions reduce an individual's countable income below the spend-down limit (\$731.40/month for a single person or \$1,084.70/month for a married couple in 2009⁵), Medicaid will provide comprehensive Healthy Horizons medical coverage for the remainder of the month.

⁵ This amount includes a monthly state supplement of \$27.40/per individual (or \$43.70/couple), a personal needs allowance of \$10.00, and a standard deduction of \$20.00.

For the six-month spend-down, once a person's medical expenses reduce her six-month countable income to the \$2,550 limit, Medicaid will pay certain medical expenses for the remaining six-month period.⁶ Medicaid coverage for those on a six-month spend-down does not include coverage for prescriptions, medical supplies, or durable medical equipment.

See Appendix B for information on applying for spend-down.

D. Medicaid for Seniors Entering a Nursing Facility

Medicaid covers long-term care (LTC) in a nursing home for those who meet the income and asset eligibility requirements. In addition to the income and asset requirements, an applicant for Medicaid benefits must actually need long-term care in a skilled nursing facility. Individuals have the option to receive a similar level of care at home through the state's home and community-based waiver programs, which are discussed later.

Treatment of Income: Non Money Payment and Medically Needy Only are the main Medicaid eligibility categories that cover nursing facility care. For many residents, this means they first have to "spend down" their personal financial resources so that they can qualify for this form of government assistance. The income limit to qualify for Medicaid in the NMP category is 300% of the Federal benefit rate, or \$2022/month in 2009. As noted earlier, the MNO income limit for one person for six months is \$2,550 (or \$425 a month).

The basic Medicaid rule for nursing home residents is that they must pay all of their income, minus certain deductions, to the nursing home. Deductions in Pennsylvania include a \$45 personal needs allowance, any uncovered medical costs, and an allowance for a community spouse or dependent child living at home.

Resource (Asset) Rules: As a general rule, an MNO applicant is eligible for Medicaid in a nursing home if her assets (generally cash, stocks, bonds and real estate) are below \$2,400; however, there are a number of exemptions and excluded assets. The asset limit for NMP is \$2,000 plus a \$6,000 disregard.

Asset Exceptions (single or married): Assets that are not counted for purposes of the above calculation and which may be protected include, but are not limited to, the family residence (however, special rules apply as to possible estate recovery), one motor vehicle, property used in a trade or business, term insurance, life insurance with a face value maximum of \$1,500, an

⁶ Note that this limit remains the same and does not increase every year.

irrevocable burial reserve, household goods and personal effects.

Nursing facilities pay for long-term care. 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 assets.
- 2) There are rules to financially protect a spouse who is not in the nursing home (the "community spouse") to ensure that she can afford to live in the community.
- 3) There is estate recovery. Under the Medical Assistance Estate Recovery Program, the state seeks repayment for the cost of nursing and other long-term care from the estates of certain deceased Medicaid beneficiaries. Estate recovery only applies to services that a person received after age 55, but there may be exceptions.

E. Home and Community-Based Services Waiver Programs

There are numerous Home and Community-Based Services (HCBS) 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 that primarily serve persons who are age 60 and over.

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

An applicant must meet the financial and functional eligibility components of Home and Community-Based Services Waiver (HCBS) programs. Financial eligibility is the same for all HCBS Waiver programs. The income limit is \$2022/month (in 2009) for an individual, with a countable resource limit of \$8,000 per individual. Note that this is a higher income and resource limit than some other Medicaid programs. Functional eligibility differs by each Waiver program and refers to an applicant's abilities and need for care. To be functionally eligible, a person may be required to receive a particular level of care, have a specific diagnosis and/or satisfy an age requirement.

As with Medicaid for nursing home residents, the Medicaid rules for LTC

eligibility apply in the case of HCBS Waivers. This includes the rules surrounding asset protection, avoidance of the transfer penalty, and provisions for the community spouse.

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:	1-800-566-1901
Delaware County:	1-888-490-8499
Montgomery County:	1-800-591-8231
Philadelphia County:	1-888-482-9060

To access HCBS Waivers in Bucks county, applicants should contact the Bucks County Area Agency on Aging at 1-215-348-0510. The application form is available at: www.dpw.state.pa.us/omap/provinf/maforms/omappa600wp.pdf.

Common Waiver Programs

Aging Waiver. The new Office of Long Term Living (an office within the Department of Public Welfare as well as the Department of Aging) administers this Waiver. To be eligible the applicant must be 60 years of age or older and determined to be nursing facility eligible or disabled per an 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 care, 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.

The LIFE Program or Long-Term Care Capitated Assistance Program (LTCCAP). This program is the federal Program of All-Inclusive-Care for the Elderly. This program is currently only available to residents of Philadelphia, Allegheny and Beaver counties. LTCCAP is administered by OLTL. Persons age 60 years or older who are nursing facility eligible and on Medicare are eligible for this Waiver program.

Services under the LIFE or LTCCAP program include all Medicaid and Medicare healthcare services, home support, home health, personal care, respite care, 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 and services at one community site, such as an adult day care program.

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 the Department of Public Welfare's Office of Medical Assistance Programs at 1-717-772-2525.

F. Medicaid for Workers with Disabilities Program

For persons who are under age 65, Medical Assistance for Workers with Disabilities (MAWD) is another way to receive full Medicaid coverage. MAWD is available for disabled individuals 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.

A person is eligible for MAWD if he meets certain criteria. A MAWD recipient must:

- Be between the ages of 16 and 64;
- Have an illness or condition that meets Social Security's definition of "disability," which he can show by either being a recipient of Social Security disability benefits (SSDI), *or* submitting medical records to Medicaid so that they can find him disabled;
- Be working and earning wages;
- Have countable income less than 250% of the federal poverty guidelines. (For 2008 the limit is \$2,168/month for a single person and \$2,918/month for a married couple.); and
- Have 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 benefits (SSDI) or SSI benefits 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

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

Income & Resources

Less than half of an individual's earned income is considered in determining countable income. Appendix A explains how countable income is determined for the MAWD program. The MAWD program counts the resources of the applicant, and if they are married, the applicant's spouse. Appendix A lists resource exclusions.

Application

A person with a disability can apply for this program using the PA 600WD 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. (See Appendix A.)

This premium is payable monthly through payroll deduction or through direct payment by the participant. The premium is determined on a six-month prospective basis. An increase in income does not increase the premium amount until the end of the six-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 two-month suspension of premium payment for good cause (such as job loss, or temporary health problems).

G. Medical Assistance for Workers with Medically Improved Conditions

For persons who are under age 65, Medical Assistance for Workers with Medically Improved Conditions (MAWMIC) 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, 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 identical to the requirements for MAWD, except for the disability requirement. The application form is the same as for MAWD.

Disability

To be eligible for MAWMIC, an applicant must previously have been determined disabled by the Social Security Administration or the County's Medical Review Team, but subsequently no longer meet the Social Security disability criteria by virtue of being medically improved.

Work Requirement

The work requirements for MAWMIC are the same as for MAWD.

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

The Breast and Cervical Cancer Prevention and Treatment program provides free Medicaid 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 full Medicaid.

Eligibility

A woman is eligible for this program if she:

- 1) Has a household income under 250% of the Federal Poverty Level (For 2008, this amount is \$2,168/month for a single person and \$2,918/month for a household of two.);
- 2) Is under age 65;
- 3) Is a Pennsylvania resident;

- 4) Is a U.S. Citizen or other qualified immigrant;
- 5) Is uninsured or underinsured (i.e., she has no creditable coverage); and
- 6) Is screened or diagnosed through an approved Healthy Woman site. A list of the Healthy Woman sites is available at <http://www.health.state.pa.us/php/HW/hltwlist.htm>.

There is no resource limit for the BCCPT program. Call the Pennsylvania Health Law Project at 1-800-274-3258 or 1-866-236-6310 (TTY) for more information.

2. How to Apply for Medicaid

There are several ways to apply for Medicaid. A person can:

- 1) Go to the County Assistance Office to get a paper application and submit it in person or by mail.
- 2) Access the application online at <http://www.dpw.state.pa.us/omap/provinf/maforms/omapmaforms.asp>.
- 3) Complete and submit an electronic application via Commonwealth of Pennsylvania Access to Social Services at www.compass.state.pa.us.

Most Medicaid programs do not require an applicant to have a face-to-face interview. A face-to-face interview is required only for a Medicaid application or redetermination for long-term care (nursing home) and Waiver categories.

Applicants must provide documentation of their name, age, address, income, resources and other items on their application. If the CAO receives an application and the accompanying verification does not contain sufficient information to determine eligibility, and that information cannot be obtained by telephone or written contact, the caseworker may schedule an appointment interview for the client. 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 instructions on how to appeal. The same is true of any decision denying a Medicaid recipient a service or benefit that was requested by her provider. 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 instructions on how to appeal. A termination or reduction of ongoing Medicaid coverage or of ongoing benefits or services can also 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 loses the appeal and timely requests reconsideration, the CAO will reinstate and continue benefits, unchanged, upon notification by the Bureau of Hearings and Appeals. 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 Commonwealth Court within 30 days of the Final Order. If the beneficiary received continued benefits during the appeal process and loses the appeal, the CAO may establish an overpayment.

V. ACCESS TO SERVICES USING MEDICARE AND MEDICAID

1. Obtaining a Covered Service

Access to services differs by healthcare delivery system. For almost all Medicare-covered services under the original 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 Plan must follow the plan's rules for accessing services. This means that they may have to obtain 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. 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 five-county area are in what are called Medicare Advantage "Special Needs Plans." These plans are 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 Special Needs Plans are adequately tailoring their benefits, networks, or procedures to meet their enrollees' special needs. Before they were passively enrolled into SNPs, 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 from these SNPs and return to original Medicare.

For persons with both Medicare and Medicaid, the Medicaid 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 & You 2009 Handbook*, visit Medicare's Website at www.medicare.gov, or call 1-800-MEDICARE. To determine if a service is covered by fee-for-service Medicaid, a beneficiary can contact the recipient hotline at 1-800-509-0987 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 service that is not covered under Medicare or Medicaid, he can be required to pay only if the provider tells him ahead of time that he will be required to pay *and* Medicaid does not cover the service.

4. Providers

Dual eligibles in original Medicare can see any Medicare provider who is registered with Medicaid for a Medicare-covered service. If the provider does not participate in Medicaid, the dual eligible can still see the provider if the provider agrees to cancel the balance of the bill after Medicare pays. The Medicare provider will be able to bill Medicaid for the balance of the bill not covered by Medicare if he registers with Medicaid, even if he does not ordinarily participate in the program or accept other Medicaid patients. 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, but is covered by Medicaid (an example is dental care), the dual eligible must go to a Medicaid provider. Under fee-for-service Medicaid, a dual eligible can see any Medicaid provider who accepts the ACCESS Card. To find a Medicaid provider for physical health services, a dual eligible can call the 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.

5. Transportation

Medicaid consumers have the right to transportation to and from medical appointments with Medicaid and Medicare doctors. The Medical Assistance 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 such medical services 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. The contact numbers for the five-county Philadelphia area MATP providers are:

Bucks: 1-215-794-5554

Chester: 1-610-594-1079
Delaware: 1-610-490-3977
Montgomery: 1-215-542-7433
Philadelphia: 1-877-835-7412

6. Pre-approval in Medicaid

While Medicare-covered services cannot be prior authorized by Medicaid, services covered only by Medicaid 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 service or medication's medical necessity. This is usually done on a special form called the "MA-97" form. The Medicaid program will 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 than prescribed or proposes an alternative treatment.

To obtain a prior authorization for Medicaid-covered behavioral health services, a provider must submit a prior authorization request to her dual eligible patient'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. As stated earlier, 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, as long as they are registered as a Medicaid provider.

Medicaid must pay the Medicare 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 reimburse him/her to the Medicaid rate for the service.

For example, assume that a provider charges \$120 for a visit, and that Medicare's approved amount for this visit is \$100. In this case, Medicare will pay 80% of its approved amount, or \$80. The remaining co-payment, 20% of the Medicare-approved amount (\$20), should be billed to the Medicaid program through the person's ACCESS Card. However, if the Medicaid program pays \$83 for such a visit, the provider only gets \$3, not the remaining \$17 to make up the cost of the Medicare co-payment. If the Medicaid program usually only pays \$79 total for such a visit, the provider gets nothing towards the \$21 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 Medicare and 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.⁷ The beneficiary should also 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 and explain that he or she should not have been billed. The beneficiary should state that the provider must instead bill Medicaid. The dual eligible can also call or write a letter to the Department of Public Welfare's 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

⁷ This is called "balance billing," and it is not allowed.

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.⁸ 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 illegally charging dual eligible consumers.⁹

⁸ 42 U.S.C.A. 1396(a)(n)(3)(A).

⁹ 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 individuals and adults with disabilities. It can be overwhelming to navigate and coordinate care through the complex systems of Medicare and Medicaid. 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 can have differing countable income and resource limits. The kind and amount of income that is considered “countable” is relatively consistent across the programs. The same is true for countable resources. Below is an entire section on counting income and resources.

INCOME

All earned and unearned income, from whatever source derived, is initially *considered* when determining countable income. Income “from whatever source derived” includes employment income, SSA benefits, pension, retirement benefits, interest, dividends, rental properties, etc.¹⁰ However, state and federal laws exclude certain types and sources of income. In addition, the Medicaid eligibility rules require certain deductions and disregards to be taken before final the countable income is determined.¹¹

For an applicant whose spouse is also applying, the income limits are the same for married couples as with single individuals, except that a higher income is used to reflect the number of people in the household. However, where only the applicant is applying for Medicaid, the various Medicaid programs differ in whether and how much of the spouse’s income counts towards the applicant’s countable income. For example, in Medicaid for Persons on SSI, the spouse’s countable income (determined using the deductions outlined in the following section) may be deemed available to the applicant. The amount of the non-applicant spouse’s income that is deemed to be the applicant’s income depends on factors such as whether there are dependant children in the household. There are also certain earned income deductions available for the income of a blind, non-applicant spouse.

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

In determining Medicaid eligibility in Pennsylvania, the CAO first considers the applicant’s gross monthly income. Gross income is the amount of a person’s income before any deductions, expenses, or taxes are taken into account. However, not all income is countable for the purposes of Medicaid eligibility. In order to determine countable income, there are several deductions that are

¹⁰ See Medical Assistance Eligibility Handbook (MAEH) Chapter 350.

¹¹ See *id* for a comprehensive list of exclusions and inclusions. The MAEH is available on-line at: www.dpw.state.pa.us/oimpolicymanuals/manuals/oimpolman.asp.

taken from gross income. These include:

- **Standard deduction:** A standard deduction of \$20 is taken from all income. Usually it is first applied to unearned income. If there is no unearned income, it is taken entirely from earned income.
- **Unearned income deduction:** Expenses incurred to receive unearned income, such as bank fees and transportation costs, may be considered allowable deductions. Bank fees include, but are not limited to, cost of standard checks, annual ATM fees, minimum balance fees, ATM withdrawal fees, and per check fees. Transportation costs include the actual cost of public transportation or the automobile of another individual, or a deduction for the use of the applicant's personal vehicle to obtain the income.
- **Earned income deduction:** 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 expense deductions:** Additional deductions from countable earned income include 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. Examples include special transportation to and from work, attendant care services to help get to work and medical or prosthetic device(s) which are required to work.
- **Work expense deductions for people who are blind:** Individuals who are blind are entitled to additional work expense deductions. These include, but are not limited to, deductions for transportation expenses, such as a guide dog and its upkeep, cane travel instruction and transportation costs. There are also work-related expense deductions for translation of materials into Braille, a reader, lunches, optical aids, and licenses. There are many other work-related expense deductions for this category of Medicaid recipients.

RESOURCES

The CAO will initially consider each resource (or asset) a client has or can legally obtain. They will then determine if the resource should be counted or excluded for purposes of eligibility. The total countable resources of the applicant/recipient group are compared to the resource limit (if any) of each category to determine resource eligibility. See 55 Pa. Code §178.1. Resources considered include: personal property, life insurance, vehicles, burial spaces and burial funds, and real property. See *id.*

Determining Countable Resources

For Medicaid eligibility under Healthy Horizons (including spend-down)

and for SSI recipients, there is **no resource test** for an applicant/recipient with a natural or adoptive child under 21 years of age¹² 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.” Exercising care and control means 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 regarding the consideration of a non-applicant spouse’s resources. For SSI, a portion of the non-applicant spouse’s assets are deemed to the applicant. For Healthy Horizons, only those assets demonstrably belonging to the applicant are considered, and the one-person asset limit is used. For MAWD and MAWMIC, all assets of the non-applicant spouse and the applicant are considered, and there is only one asset limit of \$10,000. Also, for MAWD and MAWMIC resources are always considered, even if there is a child under age 21 in the home.

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-related Medicaid, Healthy Horizons, Waivers, MAWD, MAWMIC, and other special categories for SSI-related Medicaid. 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 policy-owner. See MAEH §340.4.
- **Vehicles:** One motor vehicle (the one with the highest equity value) is exempt as a resource. The amount owed on a second vehicle is deducted from its current value to determine its resource value. See MAEH §340.5.
- **Burial resources:** Burial spaces, burial reserves, burial plots, and irrevocable burial accounts are generally excluded. See MAEH §340.7.
- **Other Resource Exclusions:** For a further list of resource exclusions, see MAEH §340.8.

¹² This includes unborn children.

APPENDIX B

Applying for Spend-down

See pages 28-29 for a discussion of the spend-down categories of Medicaid eligibility. To apply for spend-down, an applicant should complete the PA 600 Application for Medicaid and indicate on it that she wants to apply for Medicaid under spend-down. The worker at the County Assistance Office will determine the monthly spend-down amount.

An applicant with the Monthly (NMP) Spend-down, should know that:

- Each month he or she will need to send in receipts, bills, or other documentation showing that he or she has incurred, or paid, the amount in medical expenses for which he or she is responsible.
- Expenses only count for the month in which they were incurred and/or paid.
- For the remainder of each month, the consumer will be eligible for Medicaid under NMP spend-down. Medicaid will cover the consumer's medical expenses, and 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.

An applicant with the Six-Month (MNO) Spend-down should know that:

- At the time the application is submitted, his 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 *old bills*.
- Unpaid expenses used to meet the spend-down can go back as far 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.