

Getting Healthcare Coverage and Services for Adults Who are Age 18-59: A Guide for Consumers and Advocates

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I. OVERVIEW

This manual was created with the generous support of the Pew Charitable Trusts' Vulnerable Adults Fund. It is designed to help adults age 18-59 and advocates who work with this population navigate the publicly funded healthcare programs available to these adults in Pennsylvania. Section II focuses on Medical Assistance and the eligibility criteria for entry into Medical Assistance programs. Section III focuses on other available programs and the eligibility criteria for entry into these other available publicly funded programs. Section IV explains how one gets services through Medical Assistance. Section V provides a brief conclusion.

We are hopeful that you will find this manual helpful. If you have any questions, need an application or would like more information about the programs discussed in this manual, please call the Pennsylvania Health Law Project at (800) 274-3258.

II. MEDICAL ASSISTANCE (MA)

A. Medical Assistance Basics

What Is Medical Assistance?

Medical Assistance (MA) (also known as Medicaid) is a free¹ public health insurance program funded by the Federal and State government. In Pennsylvania, Medical Assistance is administered through the Department of Public Welfare. However, it is not welfare. In fact, most people on MA do not receive welfare in the form of cash benefits.

Who Is Eligible?

Anyone can apply for MA, but not everyone is eligible. In order to be eligible, the applicant must be a PA resident who is a US Citizen or covered Immigrant (see below), who qualifies for coverage under one of the covered categories of eligibility, and who meets the related countable income and resources test associated with the category of eligibility. The MA eligibility criteria are discussed in detail below.

¹ With the exception of the new Medical Assistance for Workers With Disabilities Program, Medical Assistance is free to persons with disabilities.

1. Citizenship/Immigration Status

What if the Applicant Is Not a U.S. Citizen?

Even if the applicant is not a US Citizen, he/she may be eligible for full benefits under MA, as long as all other MA requirements are met, if he/she fits into one of the following categories:

- Lawful permanent residents
- Refugees, Asylees
- Cuban and Haitian Entrants
- Persons Paroled in the US for one year or more
- Persons permanently residing in the US under "color of law" (PRUCOL) (an immigrant whose presence is known to the government and who is allowed to remain in the US with the knowledge and permission of the INS)²
- Persons granted Withholding of Deportation or Withholding of Removal
- Certain battered spouses and children (Spouses or children of US Citizens or permanent residents who have filed a "self-petition" under the Violence Against Women Act)

NOTE: Even if the applicant does not fit into one of these categories, he/she may be eligible for Emergency Medical Care as explained below.

Emergency Medical Care for Aliens Who Are Otherwise Ineligible for Full MA

If the applicant does not fit into one of the categories of immigrants (listed above) that are eligible for full MA benefits, he/she may still be eligible for Emergency Medical Care under MA to treat an Emergency Medical Condition.

An Emergency Medical Condition (EMC) is a medical condition with acute symptoms of such severity, including severe pain, that without immediate medical attention, the result may be: 1) that the patient's health is in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any body organ or part.

² Note: Anyone unsure of PRUCOL status should check with an immigration attorney before applying for MA, since the Department of Public Welfare (DPW) does contact INS to verify PRUCOL status. Also, it's a good idea to verify with an attorney whether MA will affect ability to get a "green card" in the future.

Examples of aliens eligible for Emergency Medical Care are: 1) ineligible aliens (lawfully admitted but only for a temporary or specified time); 2) illegal aliens; and 3) undocumented aliens.

An alien must prove the existence of the Emergency Medical Condition with a doctor's note which: 1) identifies the Emergency Medical Condition; 2) specifies the need for medical treatment resulting from the Emergency Medical Condition; and 3) provides a date on which the emergency is expected to end.

Persons in receipt of EMC are not required to sign a citizenship/alienage declaration form, verify alien status, or verify a social security number. In order to qualify for EMC, the applicant must meet all other requirements for MA, as explained in the manual. Undocumented aliens have been able to obtain Emergency Medical Care with no INS problems.

To apply for Emergency Medical Assistance, complete the PA 600 form. Write MA Only on the application. Submit the doctor's letter certifying the emergency medical condition along with any supporting documents to the CAO. Call the Pennsylvania Health Law Project at (800) 274-3258 for assistance.

2. Residency Requirement

An applicant for Pennsylvania Medical Assistance must reside in Pennsylvania and intend to remain here. There is no minimum amount of time that they must have lived in the state prior to applying. Simply living here with the intent to remain is adequate for satisfying the Medical Assistance residency requirement.

3. Categorical Eligibility

There are several categories of Medical Assistance that cover adults age 18-59. Most are described below. Often, they have different requirements and different countable income and resource limits.

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

If a person is terminated without a redetermination, call the Pennsylvania Health Law Project at (800) 274-3258 for information or assistance on appealing the termination and requesting a redetermination.

4. Financial Eligibility

Financial eligibility requirements differ across the categories of eligibility. Thus, the income and resource limit an applicant must meet depends on the category under which they are applying. The income limits are subject to change every year. The income limits included in this manual are for the year 2004. For more information on the income and resource limits for the categories available to adults age 18-59, see below.

B. Medical Assistance (MA) Programs for Vulnerable Adults

There are several Medical Assistance programs available to adults age 18-59. These are described below. Please note: The income limits are subject to change every year. The income limits included in this guide are for the year 2004.

1. Supplemental Security Income (SSI)

Eligibility

A person who receives SSI automatically gets Medical Assistance (MA) and does not need to apply for it separately. As long as the person is eligible for even just \$1.00 of SSI payment, he/she will continue to receive Medical Assistance. In order to receive SSI, a person must meet the Social Security Administration's definition of "disability" (See <http://www.socialsecurity.gov/dibplan/dqualify4.htm> for the Social Security Administration's definition of Disability) and have countable income and resources at or below the SSI limits.

Currently, the countable income limit for SSI is \$591.40 for a single person (or a married person whose spouse is neither age 65 or older nor has a disability) and \$889.70 for a married couple who both are either age 65 or older or has a disability.

Determining Countable Income:

In order to determine countable income, there are several deductions that are taken from gross income (before taxes and expenses). These include:

- a standard deduction of \$20
- for earned income, a deduction of another \$65, half the remaining income, and additional disregards for impairment related work expenses, child care costs, and transportation to work.
- other items listed in the SSI regulations

A married person whose spouse is neither age 65 or older nor has a disability is subject to the countable income limit for a single person. However, a portion of the non-applicant spouse's income may be deemed to be the applicant spouse's income. This will depend on the amount of the non-applicant spouse's income as well as on the number of dependent children in the family. The countable income limit will change accordingly.

There is one exception to the countable SSI income limit, which is made for a person with a disability who lives in a personal care home (PCH) or a domiciliary care home (DCH). For persons with disabilities and SSI recipients who live in these residences, the state pays a monthly supplement to the SSI amount, up to \$394.30. As a consequence, a person whose income is above the SSI limit of \$591.40 but below the PCH or DCH SSI limit of up to \$958.30 can get SSI (in the amount necessary to raise their countable income to \$958.30) and gets the automatic MA that comes with being on SSI.

Determining Countable Resources

Currently, the countable resource limit for a single person (or a married person whose spouse is neither age 65 or older nor has a disability) is \$2,000 and for a married couple (where both are eligible as either being age 65 or older or having a disability) is \$3,000.

Countable Resources do not include:

- House the applicant lives in
- One car
- Second car with an equity value no greater than \$4,500
- Irrevocable burial account
- Cash surrender value of a whole life insurance policy under \$1,500
- Any other items listed in the SSI regulations

NOTE: These rules regarding calculation of countable income and resources apply to several categories that appear on the next several pages including: Healthy Horizons, Home and Community Based Services (Waivers), and MAWD/MAWMID (although for MAWD/MAWMID both the applicant and his/her spouse's total income and resources are subject to the calculation even if only one person is applying).

2. Healthy Horizons

a. Full Medical Assistance (MA) Coverage

Persons with disabilities can obtain full MA coverage, including prescription

drug, durable medical equipment, dental, vision coverage and Medicare cost-sharing and premium payment, through the Healthy Horizons category of coverage if they meet the following requirements:

- 1) have a disability that meets the Social Security disability criteria;
- 2) have countable income under \$776/month for a single person (or a married person whose spouse is neither age 65 or older nor has a disability) and \$1041/month for a married couple who both are either age 65 or older or has a disability;
- 3) have countable resources for a single person (or a married person whose spouse is neither age 65 or older nor has a disability) of \$2,000 or for a married couple (where both are eligible as either being age 65 or older or having a disability) is \$3,000.
- 4) In addition, the applicant must be a U.S. citizen or one of the covered immigrant groups and reside in Pennsylvania.

This category is for persons with permanent disabilities regardless of whether they receive Social Security Disability Insurance (SSDI). For an applicant already receiving SSDI, the County Assistance Office will only review the applicant's income and assets in determining eligibility for MA. To apply, complete the PA 600 form and mail the application along with supporting documents to the local County Assistance Office. This form is available at the County Assistance Office (CAO) or online at <http://www.dpw.state.pa.us/oim/pdf/appl-for-benefits.pdf> . If the applicant has unpaid medical expenses incurred within the last 3 months, indicate this on the application and submit the bills to the CAO.

An applicant who is not receiving SSDI must submit an Employability Assessment form along with the PA 600 form in which the doctor (who must be a MA provider) certifies that the applicant is unable to work due to an illness or condition that is expected to last 12 months or more. The Employability Assessment form is available from the CAO, the doctor's office, or online at: <http://www.dpw.state.pa.us/omap/provinf/maforms/omappa1663.pdf>.

At the applicant's request, the CAO must provide an applicant with a Noncontinuous Eligibility card. This card allows the applicant to see a doctor to complete the Employability Assessment form at no charge to the applicant. The CAO will also be able to provide the names of doctors who accept MA.

b. MA Payment of Part B Premium

Some persons with disabilities who are on Medicare and whose incomes are too high for full MA may be eligible to have all or part of their Medicare Part B Premium paid for them by the MA program. If approved, the recipient will

receive all or part of the \$66.60 Part B Premium added in to their monthly checks from the Social Security Administration.

To be eligible, persons must have countable income less than 135% of the FPL (\$1048/month single and \$1406/year married) and countable resources below \$4,000 for an individual or \$6,000 for a couple.

To apply, complete the PA 600M form and mail it to the local County Assistance Office. This form can be obtained from the CAO or online at <http://www.dpw.state.pa.us/oim/pdf/mail-in-medicare.pdf>.

c. Unique or Changed Circumstances for Persons with Disabilities

The County Assistance Office must complete a redetermination prior to terminating any person from MA. If a SSI recipient does not begin to work but has a change in circumstances in his/her life that makes the recipient ineligible under other MA categories, he/she might qualify for continuing MA through one of the special SSI-related categories. The former SSI recipient may qualify for continued MA as an Adult Disabled Child or a Disabled Widow if his/her income increases are due to receipt of survivor's benefits from SSDI. If the SSI recipient's income increases are due to cost of living increases associated with receipt of SSDI, he/she may also qualify for continued MA.

3. Persons Undergoing Drug or Alcohol Treatment

Persons who are undergoing active treatment for drug or alcohol addiction may be eligible for full Medical Assistance if participation in the treatment program precludes employment, and the program is licensed and approved by the Department of Health or is administered by an agency of the federal government. The applicant must also meet the citizenship, residency, income (\$205/month for an individual), and resource (\$250 for an individual; \$1,000 for 2 or more in the household) guidelines to be eligible for MA.

To apply, complete the PA 600 Form and mail the application along with supporting documents to the local County Assistance Office.

NOTE: There is a nine-month lifetime limit for eligibility under this category. Try to qualify for MA under another category first.

4. Victims of Domestic Violence

A victim of domestic violence who receives protective services may be eligible for full MA. The following are examples of protective services: living in an emergency shelter or emergency housing for abuse victims; supportive

counseling from an abuse program; services to prevent further potential abuse; services necessary to remain at home; filing assault or battery charges against the abuser or other services from the police department; obtaining a restraining order or a peace bond against the abuser; or any service by any branch of government (including the courts or the police) or agency meant to counsel or protect the individual from abuse. The CAO will need to verify these services. Forms of verification may include: phone contact with a domestic violence center; written verification from a domestic violence center, law enforcement records; and restraining order. The applicant must also meet the citizenship, residency, income (\$205/month in Philadelphia County – amount differs by county), and resource (\$250 for an individual; \$1,000 for 2 or more in the household) guidelines to be eligible for MA.

To apply, complete the PA 600 Form and mail the application along with supporting documents to the local County Assistance Office. This form is available at the County Assistance Office (CAO) or online at <http://www.dpw.state.pa.us/oim/pdf/appl-for-benefits.pdf> .

NOTE: There is a nine-month lifetime limit for eligibility under this category even if protective services continue after the nine months. Try to qualify for MA under another category first.

5. Pregnant Women

Women of any age who are pregnant may be eligible for full MA if the applicant meets the citizenship, residency and income requirements (\$1,926/month for household of 2. The mother and unborn child are each counted toward the total number of household.) Resources are not counted for this category.

The applicant will be IMMEDIATELY eligible for free health care coverage under MA for up to two months if pregnancy is verified and the above requirements are met. The doctor's visit to verify the pregnancy will also be covered if the applicant is found to be eligible.

To apply, complete PA 600CH or PA 600 Form while at the doctor's office. The doctor will forward the completed MA application along with two copies of the Presumptive Eligibility Form to the County Assistance Office in the applicant's county or district. Within 45 days, the applicant should go to the local CAO to submit proof of one month's income to remain eligible for the rest of the pregnancy and for follow up visits during the post-partum period (60 days after delivery). Any increase to the household income during this period will not affect MA eligibility during this period (For example, if the mother returns to work during this time). The baby will be covered for up to a year after its birth

regardless of any changes to household income.

To find a MA certified presumptive eligibility provider, call the Pennsylvania Department of Health at (800) 986-2229. A list of providers can also be found at: <http://www.dpw.state.pa.us/omap/provinf/hbpmapi.asp>

6. Working Adults

a. *With Disabilities – MAWD and MAWMIC*

Medical Assistance for Workers with Disabilities (MAWD)

The Medical Assistance for Workers with Disabilities Program (MAWD) is available to persons with disabilities who are ages 16 to 64 and who work and receive compensation for their work but whose income and resources do not exceed the established limits. Applicants must also meet the citizenship and residency requirements. This MA program is not free. It costs 5% of the applicant's countable income.

Persons with Disabilities

In order to qualify for this program, the applicant must have a disability that would satisfy the Social Security Administration definition of disability. The applicant is not required to be receiving SSI or SSDI to be eligible. The applicant is also not required to apply for SSI or SSDI in order to remain eligible for MAWD. The applicant must provide documentation of disability to the Department of Public Welfare along with the application if he/she is not receiving SSI or SSDI. After the applicant submits the application, DPW's Medical Review Team will make a determination as to whether the applicant's disability meets the Social Security disability definition. A person who has not been found disabled by SSA cannot qualify for MAWD until the Medical Review Team has made its disability determination.

Work Requirement

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

Income

To be eligible for MA for Workers with Disabilities, the applicant's

countable income must not exceed 250% of the federal poverty level. In 2004, the income guidelines are \$1,940 for a single person and \$2,603 for a married person (regardless of whether the spouse is applying for benefits). There are significant deductions of earned income. Income of the applicant's spouse is also counted if they are living together, and the income eligibility limit for 2 applies even if only 1 spouse meets the non-financial eligibility criteria.

Resources

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

Application

A person with a disability applies for this program using the PA 600WD form. This form can be obtained from the CAO or downloaded from <http://www.dpw.state.pa.us/oim/pdf/PA%20600WD-single%20sheets.pdf>. For self-employed applicants, tax returns, business records, receipts, copies of payment by checks, and letters of employment are some of the documents that can be submitted to verify income. If the applicant has unpaid medical expenses incurred within the last 3 months, indicate this on the application and submit the bills to the CAO. The CAO will request proof of income for those months in which retroactive coverage is sought. If eligible, the applicant will be billed the monthly premium for those months by the CAO.

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 will have to 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 by deducting \$20 for unearned income, deducting \$65 and half the remaining income from the earned income, and deducting impairment related work expenses, child care costs, and transportation to work, and other items listed in the SSI regulations.

This premium will be payable monthly through payroll deduction or through direct payment by the participant. The premium will be determined on a

6 month prospective basis. An increase in income would not increase the premium amount until the end of the 6 month period. If the premium amount would be less than \$10, it will be waived. Additionally, if the participant is unable to pay the premium or to work in any given month, contact the CAO and let the caseworker know. The participant may be granted good cause for non-payment and premiums will be suspended for up to two months. Examples of good cause are loss of a job or temporary illness that prevents the recipient from working.

If participant chooses direct payment, send premium payments to:
Commonwealth of Pennsylvania
Department of Public Welfare
Medical Assistance for Workers with Disabilities-Premiums
P.O. Box 8052
Harrisburg, PA 17105-8052

NOTE: Be sure to include social security number on check/money order. Do not mail premiums to the County Assistance Office.

MA for Workers With a Medically Improved Condition (MAWMIC)

The requirements for Medical Assistance for Workers with a Medically Improved Condition are virtually identical to the requirements for Medical Assistance for Workers with Disabilities except for the disability and work requirements. The application is the same as for MAWD.

Medical Assistance for Workers with a Medically Improved Condition is available to persons with disabilities who were eligible for or were receiving Medical Assistance for Workers with Disabilities. An applicant must previously have been found disabled by the Social Security Administration or Medical Review Team but now no longer meets the Social Security disability criteria by virtue of having a medically improved condition.

He/she must be able to provide proof of employment and compensation. He/she must work at least 40 hours/month earning at least minimum wage (currently \$5.15/hour). An applicant can be self-employed.

b. Without Disabilities

Adults who are 21-58 and working a minimum of 100 hours per month, earning at least minimum wage (For 2004, \$5.15/hour) are eligible for Medically Needy Only (MNO) MA. This type of coverage does not include prescription drugs, dental care, or most durable medical equipment. Eligibility is determined for a 6 month period. The applicant must also meet the citizenship, residency,

income (\$425/month for an individual), and resource (\$2,400 for individual or \$3,200 for 2 or more in household) guidelines to be eligible for MA.

To apply, complete the PA 600 Form and mail the application along with supporting documents to the local County Assistance Office. This form is available at the County Assistance Office (CAO) or online at <http://www.dpw.state.pa.us/oim/pdf/appl-for-benefits.pdf> .

7. Adults caring for child or other person with disability

Persons caring for someone in the household who is ill or disabled (child or adult) or under 13 years old and who is not a relative may be eligible for MA. The applicant must also meet the citizenship, residency, income (\$205/month for an individual), and resource (\$250 for an individual; \$1,000 for 2 or more in the household) guidelines to be eligible for MA.

For this category of MA, it is necessary to submit a note from the physician indicating that the person being cared for is "ill or disabled". Submitting SSI/SSDI receipts or award letter of the person being cared for is also sufficient to prove disability/illness. The applicant will still need to submit a doctor's note describing the care the individual needs (for example feeding, bathing or safety). The applicant must also show that there is no one else in the household who is able to perform the care-taking task (for example, pay stubs from others in the household who are working).

To apply, complete the PA 600 Form and mail the application along with supporting documents to the local County Assistance Office. This form is available at the County Assistance Office (CAO) or online at <http://www.dpw.state.pa.us/oim/pdf/appl-for-benefits.pdf> .

8. Temporary Disability

A person with a temporary disability that does not otherwise qualify for MA may be eligible for MA if his/her doctor certifies that he/she has an illness or condition that keeps him/her from working. The applicant must also meet the citizenship, residency, income (\$205/month for an individual), and resource (\$250 for an individual; \$1,000 for 2 or more in the household) guidelines to be eligible for MA.

NOTE: If the doctor certifies illness or condition is expected to last 12 months or more, higher income limits will be used to determine eligibility.

It is not necessary for the applicant to be receiving SSDI or SSI. An applicant who is not receiving SSDI must submit an Employability Assessment

form along with the PA 600 form in which the doctor (who must be a MA provider) certifies that the applicant is unable to work due to an illness or condition that is expected to last less than 12 months and indicates how long the illness or condition is expected to last. MA will be authorized for the period that the doctor certified that the applicant is temporarily disabled.

To apply, complete the PA 600 Form and mail the application along with the Employability Assessment form and other supporting documents to the local County Assistance Office. This form is available at the County Assistance Office (CAO) or online at <http://www.dpw.state.pa.us/oim/pdf/appl-for-benefits.pdf> . The Employability Assessment form is available from the CAO, the doctor's office or online at: <http://www.dpw.state.pa.us/omap/provinf/maforms/omappa1663.pdf>.

At the applicant's request, the CAO must provide an applicant with a Noncontinuous Eligibility card. This card allows the applicant to see a doctor to complete the Employability Assessment form at no charge to the applicant. The CAO will also be able to provide the names of doctors who accept MA.

9. Health Sustaining Medications Category of Eligibility

A person with a disability that does not otherwise qualify for MA may be eligible for MA if he/she requires health-sustaining medications in order to maintain employment. The applicant must also meet the citizenship, residency, income (\$205/month for an individual), and resource (\$250 for an individual; \$1,000 for 2 or more in the household) guidelines to be eligible for MA.

To apply, complete the PA 600 Form and mail the application along with the Health Sustaining Medication Assessment form and other supporting documents to the local County Assistance Office. This form is available at the County Assistance Office (CAO) or online at <http://www.dpw.state.pa.us/oim/pdf/appl-for-benefits.pdf> .

In order to qualify, a person must have his/her prescribing doctor (who must be a MA provider) fill out a Health Sustaining Medications form (PA 1671), on which the doctor certifies that the person is able to work, but only with the assistance of Health Sustaining Medications. The form is available at the CAO, doctor's office, or online: <http://www.dpw.state.pa.us/omap/provinf/maforms/omapmaforms.asp>

At the applicant's request, the CAO must provide an applicant with a Noncontinuous Eligibility card. This card allows the applicant to see a doctor to complete the Health Sustaining Medications form at no charge to the applicant.

The CAO will also be able to provide the names of doctors who accept MA.

NOTE: The applicant does not have to be currently working or have secured a job in order to be eligible.

10. Spend Down

What is Spend-down and how does it work?

Spend-down allows individuals, who but for excess income, would be eligible for MA. Applicants must fit within one of the MA categories in addition to meeting the citizenship, residency, and resource limits. Under spend-down, paid or incurred medical expenses are deducted from the applicant's countable income for MA eligibility purposes. There are two spend-down programs in Pennsylvania. One is a monthly spend-down and the other is a 6-month spend-down.

The monthly spend-down (called NMP Spend-down) provides health coverage including prescription drugs, dental care, and durable medical equipment. Once the medical expense deductions reduce the applicant's countable income under the SSI limit, MA will pay any of the applicant's remaining medical bills incurred during the rest of the month. Currently, the countable income limit for SSI is \$591.40 for a single person (or a married person whose spouse is neither age 65 or older nor has a disability) and \$889.70 for a married couple who both are either age 65 or older or has a disability. Examples of medical expenses: prescriptions, doctor's visits, and health insurance premiums (including Medicare Part B payments). There is no retroactive coverage for this category of MA.

To apply for monthly or "NMP" Spend-down, complete the PA 600 application for MA and write Spend-down on the application. This form is available at the County Assistance Office (CAO) or online at <http://www.dpw.state.pa.us/oim/pdf/appl-for-benefits.pdf>. The CAO will calculate the monthly spend-down amount. Each month, send the CAO medical bills and receipts that the MA recipient has been billed for or paid the amount in medical expenses. If possible, try to satisfy the spend-down amount during the beginning of the month, so that MA will be in effective earlier in the month.

The 6 month spend-down (called "MNO" Spend-down) provides hospital coverage and routine care. This category DOES NOT include prescription drugs, dental care, and durable medical equipment. Typically, applicants for this category were hospitalized for emergency care. Once the medical expense deductions reduce the applicant's 6 month countable income under \$2,550 (the MNO Spend-down limit), MA will pay any remaining medical expenses for the 6

month period. Retroactive MA coverage is available for up to three months prior to application, so this option may be beneficial for applicants who owe back bills.

NOTE:

- Under spend-down, MA will not pay for the bills that were used to meet the spend-down.
- There is no time limit for unpaid medical expenses used to meet the spend-down amount.

11. Home and Community Based Services Waiver Programs

a. *Waivers*

Through Home and Community-Based Services (HCBS) Waiver Programs, Pennsylvania gets the Federal Government to waive, or not apply, existing service limits to individuals with disabilities who require healthcare and supportive services in order to remain in their home or community based setting.

There are 12 Waiver Programs currently operating in Pennsylvania plus several pilot programs. Nine of these programs are available to vulnerable adults age 18-59. They each provide different supportive services, in varying amounts, to different populations. Participation in a Waiver Program includes receipt of supportive services and full MA coverage.

The Waiver Programs available to Vulnerable Adults age 18-59 are:

- 1) Department of Public Welfare – Office of Medical Assistance
 - * AIDS Waiver
 - * Elwyn Waiver
 - * Michael Dallas Waiver
- 2) Department of Public Welfare – Office of Social Programs
 - * Attendant Care Waiver
 - * COMMCARE Waiver
 - * CSPPPD/OBRA Waiver
 - * Independence Waiver
- 3) Department of Public Welfare – Office of Mental Retardation
 - * Consolidated MR Waiver
 - * Person/Family Directed Support MR Waiver

Waiver Programs may include any of the following services:

- Adult Day Programs
- Assistive devices such as adaptive eating utensils or communication devices

- Attendant care/Personal Care Services
- Case management/Coordination of delivery of services
- Physical changes to the home such as widening a doorway for wheelchair accessibility/Home Modifications
- Employment support services
- Home health care (Shift nursing or Home Health Aides)
- Homemaker Services (Cooking, housekeeping, buying groceries)
- Hospice care
- In-home medical care such as physical therapy and skilled nursing
- Respite care
- Transportation to and from services and/or medical care

Waiver services are not an entitlement. All programs have a limited enrollment. There is no guaranteed entrance into a waiver program, even if an applicant meets all of the program eligibility requirements. There may even be waiting lists. Also, the amount of services a participant may receive may be limited by the total cost of providing the services. Federal law requires that the cost of providing services through a waiver must be less than the cost of institutional care.

Eligibility:

To be eligible to receive supportive services in the home or community based setting, a person with a disability must satisfy a functional test in addition to the countable income and resource tests for the Waiver programs.

Depending on the program, a person whose care needs meet the functional requirements for a Waiver Program, which usually are equivalent to requiring the individual to need the services of a nursing facility, intermediate care facility for mental retardation, or intermediate care facility for other related conditions, would be functionally eligible for a Waiver.

To be financially eligible to participate in a Waiver program, an applicant may have countable income up to 300% of the federal benefit rate for SSI (\$1,692/month for an individual applicant or \$2,538/month for married applicants who are both applying) and countable resources up to \$8,000 per applicant. Resources are not considered where the applicant is under 21 or where the applicant has a child under 21 residing in the home.

NOTE: A non-applying spouse's income and resources are not considered in determining Waiver eligibility.

AIDS Waiver

Administered by the Department of Public Welfare, Office of Medical Assistance (OMAP), this Waiver Program provides services that are not paid for under MA program to eligible persons with AIDS or Symptomatic HIV Disease.

Functional Eligibility:

- Age 21 and older
- Persons with AIDS/HIV
- Nursing Facility Level of Care
- Can not be enrolled in a Health Choices Managed Care Organization (If enrolled in a MCO, contact the Special Needs Unit to access the following services)

Services:

- Home health care services
- Homemaker
- Nutritional consultation
- Specialized medical equipment and supplies

For more information about this program, call OMAP at (717) 772-2525.

Elwyn Waiver

Administered by the Department of Public Welfare, Office of Medical Assistance Programs (OMAP), this Waiver Program provides community-based services to eligible persons who are deaf or deaf and blind and reside in the Valley View Facility, Delaware County.

Functional Eligibility:

- Age 40 and older
- Deaf or deaf and blind

Services:

- Assisted living

Location of Person:

- Valley View Facility Media, Pennsylvania

Geographic Availability:

- Delaware County

For more information about this program, call OMAP at (717) 772-2525

Michael Dallas Waiver

Administered by the Department of Public Welfare, Office of Medical Assistance Programs (OMAP), this Waiver Program provides services to eligible persons who are technology-dependent (i.e. requiring technology to sustain life or replace a vital bodily function).

Functional Eligibility:

- Technology-dependent
- Doctor statement of need for mechanical device
- Nursing Facility Level of Care
- All ages

Services:

- Attendant Care
- Case Management
- Durable Medical Equipment
- Nutritional supplements
- Private duty nursing
- Respite Care

For more information about this program, call OMAP at (717) 772-2525

Attendant Care Waiver

Administered by the Department of Public Welfare, Office of Social Programs (OSP), this Waiver Program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

Functional Eligibility:

- Ages 18 - 59
- Physically disabled
- Mentally alert
- Nursing Facility Level of Care

Services:

- Attendant care
- Either received through Consumer Directed Model, where consumer hires, trains, and fires their own attendants, or through Agency Directed Model, where agency hires, trains, and fires attendants for consumer.

For more information about this program, call OSP at (800) 757-5042

COMMCARE Waiver

Administered by the Department of Public Welfare, Office of Social Programs (OSP), the COMMCARE Waiver Program provides services in the community to eligible persons with traumatic brain injury in order to prevent institutionalization and allows them to remain as independent as possible.

Functional Eligibility:

- Ages 18 - 59
- Traumatic Brain Injury
- Specialized rehab hospital facility or nursing facility level of care

Services provided through this program:

- Service Coordination
- Educational Services
- Environmental Adaptations
- Personal emergency response system
- Coaching and Cueing
- Habilitation and Support
- Respite
- Supported Employment
- Transportation
- Skilled Nursing
- Prevocational Services
- Community Integration
- Cognitive Therapy
- Structured Day Program
- Assistive Technology
- Chore Services
- Night Supervision
- Counseling
- Behavioral Specialist Consultant

The COMMCARE Waiver is locally administered by contractors of the DPW OSP. In most areas, the local Center for Independent Living is the local contractor. For more information about this program or to locate a local contractor, call OSP at (800) 757-5042.

CSPPPD/OBRA Waiver

Administered the Department of Public Welfare, Office of Social Programs (OSP), this Waiver Program provides services to persons with developmental disabilities so that they can live in the community and remain as independent as possible (this includes relocating or diverting individuals from a nursing home to a community setting).

Functional Eligibility:

- Developmentally disabled
- Disability manifests itself before age 22
- Disability is likely to continue indefinitely; results in substantial functional limitations in three or more major life activities: (Mobility, Communication, Self-care, Learning directions, or Capacity for Independent Living)
- Primary diagnosis not mental health or mental retardation
- Intermediate Care Facility/Other Related Condition level of care

Services:

- Adult Day Services
- Community Integration
- Daily Living
- Education Services
- Home Support
- Minor Accessibility Adaptations/Assistive Technology
- Prevocational Services
- Service Coordination/Resource Management
- Respite Services
- Routine Wellness
- Supported Employment
- Nursing- Visiting Nurses
- Specialized Therapy Services (PT, OT, speech, visual and behavioral)
- Transportation

The CSPPPD/OBRA Waiver is locally administered by contractors of the DPW, OSP. In most areas, the local Center for Independent Living is the local contractor. For more information about this program or to locate a local contractor, call OSP at (800) 757-5042.

Independence Waiver

Administered by the Department of Public Welfare, Office of Social Programs (OSP), this Waiver Program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to

remain as independent as possible.

Functional Eligibility:

- Age 18 and older
- Severe physical disability which is likely to continue indefinitely; results in substantial functional limitations in three or more major life activities (Mobility, Communication, Self-care, Learning directions, or Capacity for Independent Living)
- Nursing facility level of care
- Primary diagnosis not mental health or mental retardation
- Cannot be ventilator dependent

Services:

- Community Integration
- Daily Living
- Environmental accessibility adaptations
- Personal Emergency Response System
- Respite Care
- Service Coordination
- Specialized Medical Equipment/supplies
- Specialized Therapy Services (PT, OT, Speech, Visual and Behavioral)
- Visiting nurse

The Independence Waiver is locally administered by contractors of the DPW, OSP. In most areas, the local Center for Independent Living is the local contractor. For more information about this program or to locate a local contractor, call OSP at (800) 757-5042.

Consolidated Waiver for Individuals with Mental Retardation

Administered by the Department of Public Welfare, Office of Mental Retardation (OMR), this Waiver Program provides services to eligible persons with mental retardation so that they can remain in the community.

Functional Eligibility:

- Age 3 and older
- Mental retardation
- ICF/MR Facility level of care

Services:

- Environmental accessibility adaptations
- Habilitation services (residential, day, prevocational, supported employment services, homemaker/chore services, adaptive equipment)

- Permanency planning
- Respite care
- Specialized therapy
- Transportation
- Visiting nurse

For more information about this program, call OMR at (717) 783-5764.

Person/Family Directed Support Waiver

Administered by the Department of Public Welfare, Office of Mental Retardation (OMR), this Waiver Program provides services to eligible persons with mental retardation so that they can remain in the community.

Functional Eligibility:

- Age 3 and older
- Mental retardation
- Does not require Office of Mental Retardation licensed community residential services

Services:

- Adaptive Appliances and Equipment
- Environmental accessibility adaptations
- Transportation
- Homemaker/Chore Services
- Personal Support
- Respite
- Specialized Therapy Services (PT, OT, speech, language, visual, mobility, and behavioral)
- Habilitation Services (Residential day, prevocational and support employment)
- Visiting Nurse
- NOTE: Services are currently capped at \$21,125/year

To contact DPW-Office of Mental Retardation about this program, call (717) 783-5764.

For assistance in applying for any of these Waiver programs, contact the Pennsylvania Health Law Project at (800) 274-3258.

b. HCBS Waiver Pilots and State-funded Homes and Community Based Services Programs

Autism Pilot Program

Technically, this is a special component of the OBRA/CSPPD waiver and is operated by the Office of Social Programs. It funds services to a small number (currently less than 20) of young adults with autism who are living outside their parents' homes. The most common service is one-on-one assistance with community integration, job coaching and other tasks necessary for independent living.

Act 150

PA operates a program, called Act 150, which provides the same type and amount of services as the attendant care waiver but is not funded through Medical Assistance. Because Medical Assistance does not fund attendant care under Act 150, some of the eligibility provisions required by Medical Assistance do not apply. This program does not provide MA.

For example, there are no limits on the amount of assets (resources) an individual may have to qualify for attendant care under Act 150. There is a limit of \$8000 in countable assets under the waiver. Furthermore, unlike the waiver, there is no income limit under the Act 150 program, although individuals with incomes above 125% of the federal poverty level are required to pay a portion of the costs, on a sliding fee basis. Also unlike the attendant care waiver, an individual does not need an "Options" assessment by the County Area Agency on Aging nor a medical assessment for nursing home level of care to qualify for attendant care under Act 150. This makes the application process for Act 150 much quicker than for the waiver. There is also no estate recovery under Act 150.

12. Special Pharmaceutical Benefits Program

There are two Special Pharmaceutical Benefits Programs. One is for persons with HIV/AIDS. The other is for persons with a DSM IV diagnosis for Schizophrenia. These programs help low and moderate income individuals and families pay for specific drug therapies used for the treatment of HIV/AIDS or Schizophrenia.

The SPBP covers the costs for drugs on the SPBP's HIV/AIDS or mental health drugs formulary. The formulary can be found online at http://www.dpw.state.pa.us/omap/hiv_aids/omapsbpform.asp or http://www.dpw.state.pa.us/omap/hiv_aids/omapsbpform2.asp. The SPBP program also covers aerosolized pentamidine treatments, a 12 piece IV administration package used with glanciclovir therapy, and clozaril support services if applicable.

To be eligible for the Special Pharmaceutical Benefits Program, the applicant must have a diagnosis of HIV or Schizophrenia and meet the income limit of \$30,000 a year for individuals with an allowance of \$2,480 for each additional applicable family member. Applicants must prove medical need for SPBP covered drugs by submitting copies of prescriptions written by their physician(s).

To apply for either program, call 1-800-922-9384. Applications for the program for persons with HIV are made on form MA 366 which can be obtained by calling the number above or by downloading at http://www.dpw.state.pa.us/omap/hiv_aids/spbpapp.pdf. Applications for the program for persons with schizophrenia are made on form MA 442 which can be downloaded at <http://www.dpw.state.pa.us/omap/pdfs/ma442.pdf>.

Participants enrolled in either of these programs get special cards that must be used at participating pharmacies for prescribed medications that are on the program's list.

13. Breast and Cervical Cancer Prevention and Treatment Program

This new MA program provides treatment of breast and cervical cancer for women who are screened through Healthy Woman sites, Pennsylvania's CDC (Center for Disease Control)-approved screening sites, and who are found to need treatment for either breast or cervical cancer. This includes treatment for pre-cancerous conditions and early stage cancer.

Eligibility:

To qualify, a woman must be under 65 years old; have income below 250% FPL (\$1, 940/month for individual); be uninsured (not have creditable coverage) or underinsured (health insurance does not cover or has reached the maximum coverage for Breast and Cervical Cancer Treatment); and require treatment for breast or cervical cancer which was detected by a screening at one of the Healthy Woman Project (HWP) sites or by a non-HWP provider. See Appendix A for List of Healthy Woman Project sites.

Application:

A woman who is screened by a Healthy Woman Project site is found to have positive results for breast or cervical cancer; she will be referred for further testing to confirm the diagnosis. The provider to whom the woman is referred

for further testing will fill out the application for the BCCPT Program if the testing shows a positive diagnosis, and the provider will then return the application to the Healthy Woman provider site. The Healthy Woman provider site will submit the application to the County Assistance Office for an expedited determination of MA eligibility.

If the breast or cervical cancer was diagnosed outside of a HWP site, the applicant should bring medical records documenting diagnosis and evaluation or treatment to the HWP site. The applicant completes the Healthy Woman enrollment form while at the site. Any MA provider can sign Part of the form by evaluating medical records. Applicant does not have to return to the present provider to have form completed.

Getting MA:

Women who qualify under this program will receive full Medical Assistance coverage under the FFS program, which will last as long as the woman is in treatment; coverage will not be limited solely to treatment of the cancerous condition.

C. The Medical Assistance (MA) Application Process

Applying for MA

Depending on the program the person is applying he/she may or may not need to have a face-to-face interview at the County Assistance Office or be able to have someone to appear for him/her. There are several ways to apply:

- Go to the County Assistance Office and apply in person
- Mail in an application, which can be obtained from the Pennsylvania Health Law Project by calling (800) 274-3258
- Access the appropriate application online at:
<http://dpw.state.pa.us/oim/oimappforms.asp>
- Complete an application online at www.compass.state.pa.us

D. Medical Assistance (MA) Recipient's Rights

MA Applicants/Recipients have the Following Rights in Pennsylvania:

- 1) The right to receive and file an application on the same day the application is requested
- 2) The right to bring someone to assist with completing the MA application.
- 3) The right to have an application completed by a friend, relative, or official of a hospital, agency, etc., if the applicant is ill or physically or mentally unable to do so.
- 4) The right to translation services and translated written materials.

- 5) The right to receive coverage beginning with the third month before the month of application, the recipient qualifies for retroactive MA.
- 6) The right to have DPW quickly issue an MA card if the applicant has "an immediate need for medical services."
- 7) The right to receive medically necessary treatment and services without discrimination based on national origin, race, color, sex or disability.
- 8) The right to free choice of MA enrolled health care providers, unless enrolled in the Health Choices Program (in which case the recipient has a choice of Health Choices plans and health care providers that are enrolled in those plans.)
- 9) The right to be treated with dignity and respect.
- 10) The right to apply for MA even if the applicant has no address.
- 11) The right to have the MA programs explained and to receive help in determining the best possible coverage for which the applicant qualifies.
- 12) The right to prior notice of, and a fair hearing to contest, any decision by the MA Agency or an MA HMO to deny, terminate or reduce benefits.

Appeal Rights

Any decision denying an applicant MA eligibility must be provided to the applicant in writing with a reason and with instructions on how to appeal. If the applicant is appealing a denial of a new application for Medical Assistance coverage, the appeal must be made within 30 days of the date of the denial.

Any decision terminating or reducing MA coverage must also be provided to a recipient in writing with a reason and with instructions on how to appeal. Any decision terminating or reducing benefits or services that an MA recipient has been receiving must also be provided to the applicant in writing with the reason and instructions on how to appeal. A termination or reduction of ongoing MA coverage or of ongoing benefits or services can be appealed. While the recipient has 30 days to file an appeal, if the appeal is filed within 10 days of the date of the termination or reduction notice, the benefits must continue pending the outcome of the appeal. See page 50 for more information on the appeal process and appeal rights.

III. OTHER HEALTH CARE PROGRAMS AND SERVICES

A. Medicare

Medicare is a federal program of Hospital and Medical Insurance that is available to eligible individuals age 65 or older or persons with a disability who have received Social Security Disability Insurance (SSDI) checks for at least 24 months.

In order for a vulnerable adult to be eligible for SSDI, a person with a disability must satisfy the same Social Security Criteria for Disability. In addition, they must be an eligible individual. There are 3 kinds of eligible individuals—disabled workers, disabled widow/widowers of deceased workers, and disabled children of deceased or retired workers.

- 1) Disabled Worker: A person with a disability who worked enough to have at least 40 work credits will be eligible for SSDI. A worker can earn up to 4 credits/year, earning 1 credit for each \$900 of wages or self-employment income they earn in a year. When a worker has earned \$3,600, the four credits for the year has been earned. For the most part, 20 of the credits must be earned in the last 10 years before the disability. However, younger workers may qualify with fewer credits.
- 2) Disabled Widow or Widowers: If something happens to a worker, benefits may be payable to the widow or widower with a disability if the widow or widower is between ages 50 and 60, meets the definition of disability for adults, and the disability started before worker's death or within seven years after worker's death.
- 3) Disabled Children over 18: All children under 18 receive survivor's or dependent's benefits if their deceased or retired parent had an adequate work history. Children over 18 who are disabled according to the adult disability standard and whose disability began before age 22 can receive SSDI based on their now deceased or retired parent's work history. NOTE: An individual may become eligible for a disabled child's benefit from Social Security later in life, since the trigger for the benefits is the death or retirement of the parent.

There are 2 parts to Medicare, Part A (Hospital) and Part B (Medical) Insurance. All amounts and figures reported are the official amounts and figures for the year 2004 - per Medicare.

Medicare Eligibility — PART A:

To be eligible for Medicare Part A, a person must:

- Be 65 or older and the beneficiary or beneficiary's spouse paid into Social Security or Railroad Retirement Board for 34 or more quarters while working

If you did not work and did not pay into the system or if you are a legal alien who has been a resident for 5 years, you may enroll and pay premiums for Part A (\$343/mo if 29 or fewer quarters of Social Security, \$189/mo if 30-33 quarters of Social Security).

- Note: If you buy-in to Part A this way, you must buy-in to Part B (which is otherwise optional.).
- Be under 65 but have received Social Security Disability benefits for 24 months (or under 65 and have received Railroad Retirement Disability benefits for 24 months and meet SSA disability criteria)
- Be under 65 but have End-Stage Renal Disease
- You or your spouse had Medicare-covered government employment

Medicare Eligibility— PART B:

To be eligible for Medicare Part B, you must be enrolled in Part A. Enrollment in Part B is neither required nor automatic. The person must elect to enroll and can delay enrollment. If enrollment is delayed, however, there is a penalty imposed which is added to the monthly premium and is based on the amount of delay.

Part A Coverage

Medicare Part A covers Hospitalization, Skilled Nursing Facility, Home Health Care, and Hospice. Unlike Medical Assistance (MA), there are deductibles and co-payments that a Medicare participant must pay.

Hospitalization

Generally, the amount that Medicare pays and the amount that you pay depend on how long you are in the hospital during a given benefit period or hospitalization.

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

- For days 1-60 of each benefit period/each hospitalization
 - 1) Medicare pays the cost of the hospitalization less an \$876 deductible
 - 2) Beneficiary pays an \$876 deductible (for each benefit period) - (unless you are eligible for full Medical Assistance from the state)
- For days 61-90 of each benefit period/each hospitalization
 - 1) Medicare pays the cost of the hospitalization less a \$219/day
 - 2) Beneficiary pays a \$219/day co-payment (unless you are eligible for full Medical Assistance from the state)
- For days 91-150 of each benefit period/each hospitalization—Only covered if participant has not used **lifetime reserve days (60)**
 - 1) Medicare pays the cost of the hospitalization less \$438/day
 - 2) Beneficiary pays a \$438/day co-payment (unless you are eligible for full Medical Assistance from the state)
- For Blood Transfusions while in Hospital
 - 1) Medicare pays for all pints of blood after the 1st 3 pints
 - 2) Beneficiary pays for the 1st 3 pints of blood that she requires during each benefit period/ each hospitalization (unless you are eligible for full Medical Assistance from the state)

Skilled Nursing Care in a Skilled Nursing Facility

Medicare covers semi-private room and meals, skilled nursing services, rehabilitation, drugs, and medical supplies. This is a short term coverage and not a source of coverage for long term care.

- For days 1-20 of skilled nursing in a given benefit period (in a SNF), Medicare pays it all. The Participant pays nothing.
- For days 21-100 of skilled nursing in a given benefit period (in a SNF), Medicare pays all except \$109.50/day co-pay. The Participant pays \$109.50/day (unless eligible for full Medical Assistance from the state).
- For days beyond 100 of skilled nursing in a given benefit period, Medicare pays nothing. The Participant pays everything (unless eligible for full Medical Assistance from the state).

Home Health Care

Medicare does not cover full time home health care. Medicare does cover

part-time or intermittent home health care for homebound persons who need intermittent coverage (less than 8 hours/day or less than 7 hours/day for periods of 21 days or less) of skilled nursing or therapy care.

Medicare pays the entire cost of the home health care but only 80% of the cost of any wheelchair, walker or other medical equipment the Participant needs. The participant is responsible for the remaining 20%, unless eligible for full Medical Assistance from the state.

Hospice Care for Terminally Ill Patients

Medicare pays for virtually all Hospice care with no deductibles or co-payments for 2 periods of 90 days and one subsequent period of 30 days. Medicare does require the participant 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 amount for inpatient respite.

Part B Coverage

Part B has traditionally covered physician services (for a problem not for check-up or wellness visit), outpatient hospital services, durable medical equipment/supplies, ambulance, dialysis costs, home health, x-rays, lab tests, outpatient physical therapy, vaccines, etc. Part B also covers the following preventative health items: a) Annual mammography for women age 40 and over, b) Annual pap smear and pelvic exam, c) Annual prostate screening for men age 50 and over, d) Colorectal cancer screening, e) Bone mass screening, and f) Diabetes glucose monitoring

Part B does not cover:

- Prescription drugs
- Routine office visits and wellness visits
- Eye exams and eyeglasses
- Hearing exams and hearing aids
- Long Term Care
- Transportation
- Dental care

There is an annual deductible (\$100/year) and a monthly premium (\$66.60/mo in 2004) that Medicare participants must pay unless they are eligible to have the state pay this for them. Additionally, unless eligible for full MA, the Medicare participant must generally pay 20% of the fee for a covered service visits.

Medicare provides incomplete healthcare coverage. For one, it covers

minimal home or community based services. It also does not cover prescription medications. Most participants must fill the gaps with Medical Assistance, a Medicare Supplement policy, or other patchwork of supplementary coverage.

Preexisting Conditions

Under Pennsylvania law, Medicare Supplement policies must be equally available to all Medicare participants, although there are federal rules that limit the window of time during which all plans must be made available to all participants regardless of pre-existing conditions. Medicare+Choice plans (including Medicare HMOs) and Medical Assistance are prohibited from imposing any pre-existing condition exclusions or waiting periods.

Dual Eligibility

Persons with both Medicare and Medical Assistance have certain rights and protections when it comes to accessing healthcare. They retain their right under Medicare to see any Medicare doctor they choose. By virtue of being in both programs, they receive the added protection of being protected from any balance bills. In fact, it is against the law for a Medicare provider to bill a person who has both Medicare and Medical Assistance for any balance on any Medicare covered service.

If you have questions or problems about Medicare's application to persons with disabilities, please call the Pennsylvania Health Law Project at (800) 274-3258.

B. Adult Basic

The Adult Basic Coverage or ABC Healthcare Program provides basic health care coverage for adults. This program, which began in July 2002, is administered by the Pennsylvania Department of Insurance and paid for by the Tobacco Settlement Funds.

To be eligible for this program, the applicant must be

- between the ages of 19 and 64
- with income less than \$1,552/month for an individual;
- a resident of PA for at least 90 days prior to enrollment;
- a US Citizen or a legal resident of the US;
- not be eligible for Medical Assistance or Medicare;
- without any other form of health care coverage at the time of application; and
- have had no health care coverage for at least 90 days prior to application.

The 90 day waiting period does not apply when a person is eligible to receive unemployment compensation benefits. The 90 day waiting also does not apply to persons with creditable health insurance coverage, but at the time of application for coverage was no longer employed and was ineligible to receive benefits pursuant to the unemployment compensation law. If the person is the spouse of a person who meets either of the first two exceptions and both the eligible adult and the spouse meet the income requirements of this program and are applying for coverage, then the 90 day waiting period is waived. Be sure to indicate when the health coverage will terminate on the application because the application will not be processed without this information. If the applicant meets the other required criteria, the application will be processed and will be placed on the waiting list until the current health insurance expires.

Under this program, no contractor can prohibit enrollment based upon a pre-existing condition, nor can a contractor exclude a diagnosis or treatment of condition based on the condition's existence prior to enrollment.

The following are the basic benefits that are offered under Adult Basic Coverage:

- Preventative health
- Physicians' services
- Diagnosis and treatment of illness or injury, including all medically necessary covered services related to the diagnosis and treatment of sickness and injury and other conditions provided on an ambulatory basis, such as laboratory tests, x-rays, wound dressing, and casting to immobilize fractures
- Inpatient hospitalization
- Outpatient hospital services
- Pre-natal/maternity care
- Emergency accident and emergency medical care

NOTE: Prescription drugs, dental, and durable medical equipment are not covered services under the Adult Basic Program. Also, there is no retroactive coverage.

Adult Basic requires participants to pay a \$30 monthly premium. Monthly premiums must be paid before the month of coverage starts and received before or by the due date for continued eligibility for this program. There are no grace periods. Adult Basic will terminate a participant's health coverage if premiums are received late.

Currently, Adult Basic has established an enrollment waiting list because

the program has reached maximum capacity. In the meantime, anyone on the waiting list has the option to purchase Adult Basic at full cost and still remain on the waiting list for the \$30 monthly premium rate. Currently, the monthly at cost premium ranges between \$210-\$290 depending on which region you reside. To enroll, the applicant can call the ABC contractor in his/her region.

- Highmark/Western Caring Foundation (Western PA) 1-800-543-7105
- Keystone Health Plan East (Southeastern PA) 1-800-464-5437
- Capital Blue Cross/Keystone Health Plan Central (Central PA) 1-800-543-7101
- First Priority Health (Northeastern PA) 1-800-543-7199

C. Health Centers

In Pennsylvania, there are health centers that provide free or low cost medical services. For a list of health centers in the 5 County Philadelphia area see Appendix B.

D. Dental Clinics

In Pennsylvania, there are dental clinics that provide free or low cost medical services. For a list of dental clinics in the 5 County Philadelphia area see Appendix B.

The Pennsylvania Dental Association also lists free or low cost dental clinics on their website: <http://www.padental.org/>

E. Charity Care

Many hospitals have charity care programs that will pay or subsidize the hospital costs incurred by uninsured patients who cannot afford to pay their hospital bills. Depending on the hospital, the person needing care should ask the Business and/or Admissions Department for information about the hospital's charity care programs and if he/she qualify for those funds. The hospital may require the patient to apply for Medical Assistance or any other type of funding before they apply grant charity care funds.

F. Hill Burton Free Care Program

Many hospitals and other health care facilities received Federal funds under the Hill-Burton program to meet their construction and/or modernization needs. In return, these facilities are required to provide a specific amount of free

or below cost health care (known as uncompensated services) to persons unable to pay.

To find out if an individual qualifies for Hill-Burton assistance and whether or not a facility provides the specific services needed, application must be made at the admissions or business office at a Hill-Burton facility. Please note that services fully covered by third-party insurance or a governmental program are not eligible for Hill-Burton coverage, nor are Medicare deductible or coinsurance amounts eligible. In addition, private pharmacy, laboratory and physician fees and services excluded by the facility from its published allocation plan, are not covered by this program.

Since some facilities are now reaching completion of their obligations, a person needing assistance should call the business office of the facilities that are of interest to him/her to ensure that they are still participating in the Hill-Burton program. (<http://www.hrsa.gov/osp/dfcr>)

Call the Hill Burton Hotline at (800) 638-0742 for more information.

G. Prescription Drug Coverage

Depending on their category of eligibility, most persons on Medical Assistance should have some prescription drug coverage. Persons with Medicare may be able to access prescription drug coverage through the new Medicare Prescription Discount Cards that will be in effect from May 2004 until the Medicare Prescription drug benefit takes effect in January 2006. Additionally, persons on Medicare may be able to access prescription drug coverage through Medicare HMOs or Supplemental Insurance (Medigap) policies.

For other adults age 18-59 who need prescription drug coverage, they may wish to explore:

1) Patient Assistance Programs

Most pharmaceutical companies have patient assistance programs that provide free medications.

The first step is to find out the name of the manufacturer of the medication. The individual should ask his/her pharmacist or physician for the name and phone number of the manufacturer of the prescription medications he/she is taking. This information is available on the Internet at www.needymeds.com.

Second, call the pharmaceutical manufacturer and ask if they have a patient assistance program. Ask what the requirements are for receiving free prescription drugs. Each company has different requirements. Many companies require a physician's participation.

2) Private Prescription Services

Obtain low cost prescription drugs through a private prescription service. There are several. One is called Indigent Patient Services (IPS) and can be reached at (727) 821-7333.

These services usually charge a one-time registration fee and a cost per prescription (and refill). For example, there might be a one-time registration fee of \$25 and a \$10 fee per prescription filled.

These services require a participant to submit a request for each specific prescription drug that is needed. They take the participant's phone requests and generate formal request forms that the participant and participant's doctor must sign and send to each pharmaceutical company. The company will then send the medication to the doctor to give to the participant.

3) Discount mail-order services. Another way of getting lower cost medication is by contacting discount mail-order medication services. Here are just a few of the mail-order services that we know to exist

- Preferred Prescription Plan: (800) 881-6325
- Managed Healthcare Systems, Inc.: (954) 938-7984
- RxUSA: (800) 798-7248
- U-Save: (888) 817-3784

4) Discount Prescription Drug Cards. Over the last two year, a number of Discount Prescription Drug Cards have come on the market. The website www.needymeds.com offers summaries of each of the discount prescription drug cards that are currently available. Attached as Appendix C is a copy of their summaries. Needy Meds regularly updates this info so be sure to check their website (www.needymeds.com) for current information.

A person interested in the getting prescription coverage should make sure that he/she understands all the benefits and responsibilities of each of the above options. The details can be complicated. For help or more information, call the Pennsylvania Health Law Project at (800) 274-3258.

H. Head Injury Program

The Head Injury program (HIP) administered by the PA Department of Health provides post-acute head injury rehabilitation services to adults living in Pennsylvania, who experienced a traumatic brain injury after July 2, 1985 and have exhausted all other financial resources. The HIP program addresses the social, cognitive, behavioral and physical problems of individuals who have experienced a traumatic brain injury. Call the Department of Health at (717) 772-2762 for more information.

I. Chronic Renal Disease Program

The Chronic Renal Disease Program administered by the PA Department of Health assists individuals living in Pennsylvania with end-stage renal disease with costs related to dialysis services, renal transportation, medical management, inpatient/outpatient services. Call the Department of Health at (717) 772-2762 for more information.

IV. OBTAINING SERVICES - HOW TO GET CARE AND SERVICES THROUGH MEDICAL ASSISTANCE

A. What is Covered?

The services that are covered for any individual Medical Assistance Recipient depends on his/her benefit package. The Medical Assistance benefit packages differ across eligibility categories. Thus, the services available to a vulnerable adult who has a permanent disability differs from the services available to a vulnerable adult who has been a victim of domestic violence. Some categories will include benefits such as full prescription drug coverage and access to durable medical equipment. Other categories will not cover as much. So, for example, many adults on Medical Assistance do not get any dental care except when their medical condition requires services be given in a inpatient hospital or surgical center while others get dental care that is limited to 1 exam per year, full dentures once every seven years, etc.

Information about the benefit packages available to consumers in each of the categories listed in this manual is available online at <http://www.dpw.state.pa.us/omap/recinf/ffsch/omapffschcov.asp>

The MA fee schedule lists the services that MA could cover. This is a schedule for medical providers listing the services/items MA will cover, the code # and the MA reimbursement for that service or item.

If a consumer has a medical need for something not listed in the Fee Schedule, he/she should ask DPW (or health plan if in managed care) for a "program exception". For example, if the consumer's MA coverage includes durable medical equipment (DME) and his/her medical provider believes the consumer needs a piece of DME not listed in the Fee Schedule, the provider can submit a program exception request to DPW (or to the health plan) seeking coverage of the item.

B. How to Obtain services? Healthcare Delivery Systems.

Depending on the part of the state in which the vulnerable adult resides, a Medical Assistance recipient may be required to obtain their healthcare Assistance through the Department of Public Welfare's Fee-For-Service system or through HealthChoices – the mandatory managed care program. Most of the state has moved towards mandatory managed care. Usually, where a person lives will determine whether a person must be in mandatory managed care. However, there are a small handful of people who will be in fee-for-service, even in regions where there is mandatory managed care, due to their category of

eligibility.

Each region that has mandatory managed care provides Medical Assistance recipients with a choice of one of three physical health managed care organizations (PH-MCO). When a recipient is first enrolled in Medical Assistance, he/she is given a choice as to which PH-MCO he/she would like to join. Consumers are encouraged to choose their PH-MCO based on whether their various providers participate in that PH-MCO. A consumer may change PH-MCOs at any time. To do so, they must call the Enrollment Assistance Specialists at ACS/Concera at 800-440-3989.

For Behavioral Health Services (including mental health and drug and alcohol services), Medical Assistance recipients get enrolled in only one behavioral health managed care organizations (BH-MCO). There is no choice of BH-MCO. The county in which the recipient lives has selected the BH-MCO that will serve recipients in that county.

Every three years, the contracts with PH-MCOs and BH-MCOs are revisited and, possibly, renewed. Thus, the PH-MCOs and BH-MCOs may be subject to change over time.

C. Where to Get Care? Network Access issues.

The network of providers available to a person on Medical Assistance will depend on whether he/she is in fee-for-service or in mandatory managed care. Generally, Medical Assistance recipients who are in Fee For Service are able to go to any Medical Assistance provider for Medical Assistance covered services. They can see primary care providers and specialists simply by making an appointment. By contrast, Medical Assistance recipients who are in mandatory managed care must go to providers who participate in their managed care organization's network. Additionally, Medical Assistance recipients who are in mandatory managed care must usually go through their primary care provider for referrals to specialists. Although, in certain instances, the PH-MCO or BH-MCO may permit a member to see or use non-network providers for medically necessary services. *Note that a person with Medical Assistance who also has Medicare may go to any Medicare provider, regardless of whether that provider participates in Medical Assistance Fee-For-Service or Managed Care.*

In order to obtain covered services, a person may be able to simply go out and obtain the services or they may need to get approval from their Medical Assistance Insurance. This approval is called prior authorization and more detail on how to obtain prior authorization is provided in G below. Whether prior authorization is required for particular services depends both on what the item is and on whether the person receives their Medical Assistance through Fee-For-

Service or through Mandatory Managed Care.

D. How do I find a provider?

In Fee-For-Service

A Medical Assistance recipient who is in Fee-For-Service may call local providers and ask them directly if they accept Medical Assistance patients or they may contact their local County Assistance Office for names of participating providers.

In Mandatory Managed Care

A Medical Assistance recipient who is in mandatory managed care may refer to the list of providers their PH-MCO or BH-MCO provides to members or may call their PH-MCO or BH-MCO member services number to identify a provider in their area.

There are rules for how far a person can be required to travel to see a provider in their PH-MCO or BH-MCO network. There are also rules regarding how long a person can be required to wait from the time they call for an appointment to the time the provider sees them.

Distance

The PH-MCO and BH-MCO must make available an appropriate and accessible primary care physician office within thirty (30) minutes travel time in urban areas and sixty (60) minutes travel time in rural areas. If the MCO does not have a provider within those limits, you may be permitted to see an out-of-network provider. MCOs must have at least 2 specialists in each area of specialty available within their network. Primary care physicians must be available (directly or on-call) 24 hours a day, 7 days a week.

Waiting for Appointments

Consumers with emergency medical problems must be seen immediately or be referred to an emergency facility. Those with Urgent Medical Conditions must be scheduled within twenty-four (24) hours. Routine appointments must be scheduled within ten (10) business days. Health assessment/general physical examinations and first examinations must be scheduled within three (3) weeks of enrollment.

Average office waiting time can be no more than twenty (20) minutes or no more than up to one (1) hour when the physician encounters an

unanticipated Urgent Medical Condition visit or is treating a Member with a difficult medical need.

Seeing a Specialist

For the most part, consumers in managed care must obtain referrals to see specialists. State law has provisions to allow standing referrals to specialists and to allow a specialist to serve as your PCP. So, for example, a person with HIV could have a standing referral to their HIV specialist so that he/she can go as often as necessary without having to get a referral each time or he/she can have that specialist serve as their PCP. To serve as a PCP, the specialist would have to agree to accept the PCP rate, which may be less than the specialist rate.

E. How do I get there? Transportation and other Physical Access Issues.

Medical Assistance recipients have a right to transportation to and from their Medical Assistance (or Medicare if the person has both MA and Medicare) Doctors. This means that they will be either taken to their doctor's appointments or will be provided with reimbursement for the travel to their doctor's appointments.

The Medical Assistance Transportation Program (MATP) is administered locally by grants to each county. The programs are administered separately from Medical Assistance and the County Assistance Office. There is a separate application required to participate. Each county does some things differently (like the amount that they reimburse for each mile), however, there is a set of uniform Rules and instructions that all counties must follow.

Some of the key facets of the rules and instructions that should be known by consumers are:

- Easy telephone access and ability to schedule in advance
- Patients can always be accompanied by an escort at no charge:
 - If the patient is under 18
 - If the patient medically needs an escort
 - If the patient does not speak English
- Waiting time limits at both ends of the trip
 - Pick-ups within 15 minutes of scheduled time
 - Maximum one hour wait before and after appointment
- Ability to accept reimbursement requests immediately after a trip and prompt reimbursement (within 2 weeks)
- Ability to arrange transportation for urgent care appointments (including 24-hour phone access) w/in 24 hours (currently required only in HealthChoices counties, but soon statewide)

- MATP service areas that accommodate the needs of consumers
 - In HealthChoices counties that means the entire region
 - In other counties, throughout the county and into neighboring counties
- MATP must take (or arrange to take) a consumer:
 - In HealthChoices, to any provider within HMO network
 - In other counties, to the nearest provider who meets their needs (unless the consumer proves a medical need to go further)

Consumers having problems with their County MATP services may file complaints with the County MATP program and also through DPW Fair Hearing. The County Assistance Office remains a secondary source of help with transportation costs beyond MATP responsibilities. For assistance with MATP issues, call the Pennsylvania Health Law Project at (800) 274-3258.

Physical Access - ADA Compliance

According to the Americans with Disabilities Act and a recent lawsuit settlement with the Department, Medical Assistance providers in Southeastern Pennsylvania must be physically accessible to individuals with disabilities. Many Southeast providers are not yet in compliance with the requirements of the ADA or the Anderson settlement. The Department has been pressing providers statewide to become accessible.

The law is unsettled as to whether all MA providers must be physically accessible. The mandatory managed care organizations have contractual requirements with the Department regarding access to providers in their network. If there is no physically accessible provider in the network who is within the distance limit for access, the HMO would arguably be in non-compliance with its contract and would have to allow access out-of-network providers. The MCOs should have lists of accessible providers in their network. The County Assistance Office, MA Cares persons, should have lists of accessible providers in fee-for-service.

- F. **How do I communicate with my providers? Language Access and related issues.**

Title VI

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of national origin in any program receiving Federal funding. As interpreted by Supreme Court precedent, Title V mandates that procedures and policies that discriminate against Limited English Proficient (LEP) persons are prohibited as discrimination on the basis of national origin. The recipients of funding that are

required to be in compliance with these LEP requirements might be doctors' offices, HMOs, nursing agencies, hospitals, nursing homes, health clinics, and any other program receiving government funding.

An Executive Order interpreting the Title VI requirements issued by President Clinton in 2000 requires Federal agencies that offer funding to outside entities to issue policy guidance to ensure compliance with these legal requirements protecting LEP persons. In August of 2003, the Department of Health and Human Services issued its most current policy guidance – which is still open to public comments – to guide the Office of Civil Rights in enforcing Title VI and the rights of LEP persons.

The HHS guidance requires recipients of funding to take reasonable steps to allow LEP persons access to programs and resources. This includes requirements ensuring that funding recipients have translation resources, as well as requirements about the competency of interpreters. For oral translation, the guidance also requires funding recipients to ensure LEP persons are aware of these rights, regardless of whether the LEP individual might have a family member available to translate. For written translation, the guidance requires translation of written resources depending on the quantities of LEP persons expected to need translated materials, and the importance of the documents to be translated.

The requirements mean that, for example, health plans should have a procedure in place to identify LEP persons. They should provide an LEP client with adequate notice of the client's rights in his or her own native language. This could include everything from initial eligibility interviews to denial notices to plan manuals. The plan would also be responsible for making sure the doctors within its network have adequate bi-lingual staff or resources to ensure translators for client appointments. The plan is responsible for making sure these translators are competent, including not only their conversational fluency, but also their ability to translate medical terminology or written materials when appropriate.

The HHS guidance also has very important requirements for funding recipients to develop broad language access implementation plans, to guide compliance within the Title VI requirements for all of the programs within a funding recipients operations. These plans should include procedures to identify and inform LEP persons, a staff training component, and an internal monitoring process. The training component is encouraged to specifically target employee orientation and public contact positions. Funding recipients who do not take such measures, or in any other way violate LEP rules, can be reported to the Office on Civil Rights, who is charged with enforcing the Title VI requirements. Federal law specifically mandates that Pennsylvania's Medical Assistance program

comply with these Title VI requirements.

Hill Burton

When dealing specifically with hospitals, advocates should be aware that most hospitals have received Hill-Burton funding for structural and modernization costs pursuant to the Hill-Burton Act. The Act requires that hospitals receiving Hill-Burton funds meet community service obligations. First, the Act requires hospitals to be compliant with Title VI's requirements barring discrimination on grounds of national origin, so LEP persons must have equal access. This is especially mandated for patient admissions. Hill-Burton hospitals also must post notices about these public service obligations in English, Spanish, and any other language represented by 10% or more of the local community. All of these requirements are also monitored by the Office of Civil Rights, who investigates Hill-Burton complaints and Title VI complaints.

Medical Assistance and Medicare

Pennsylvania's Medical Assistance program must comply with Title VI. In addition, the program has specific requirements that mandate MA to communicate with LEP persons in their native language, offer translators at hearings, provide protections Long-Term Care and EPSDT recipients, and provide translators for Medical appointments. When Medical Assistance services are provided by an HMO or other state-contracted entity, the same LEP rules apply. Medicare provides reimbursement to hospitals for inpatient translations services.

Civil rights

Pennsylvania has laws prohibiting discrimination on the basis of national origin. So do some local cities or municipalities. It is possible that LEP issues may also be pursued as civil rights cases under these laws.

Accrediting Agencies

Agencies which conduct private accreditation of hospitals and other health care providers have incorporated LEP accessibility standards into their accreditation process. Accreditation will be effected by the hospital or providers ability to demonstrate clear procedures for adequately treating LEP persons. Accreditation agencies may focus on LEP problems with patient admission, patient notice of rights, written materials, translator competency, bilingual staff, and other issues.

EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) places requirements on Medicare participating hospital for the treatment, stabilization, and informed consent for transfer of emergency patients – even if the patients are uninsured. If the inability of a hospital to treat an LEP person affected their ability to meet these requirements for a patient, the hospital could be in violation of this Federal EMTALA law.

The Consumers Rights Summarized

Consumers' rights include the following:

- Right to be free from discrimination in your receipt of health care services
- Right to meaningful access to health care services
- Right to free interpreter services for health care visits
- Right to have vital documents available in your language and to have other documents interpreted orally if they are not available in writing in your language

Where to turn for help?

If an consumer needs help locating someone who speaks his/her language or arranging for interpreter services, he/she should call the HealthChoices HMO or CAO's MA Cares Unit. If a consumer feels that her right have been violated, she should contact her local Office of Civil Rights within 180 days of the discriminatory action to file a complaint. Lastly, consumers may call the PA Health Law Project (800) 274-3258 for assistance in filing obtaining services and filing complaints.

G. How to get the care that has been prescribed? Prior Authorization and related issues.

What is Prior Authorization?

When an item or service requires prior authorization, it means that a doctor must prescribe it and the payer (the HealthChoices MCO or FFS) must review and approve the item or service before the MA recipient can receive it. A prior authorization request is reviewed for Medical Necessity, according to the applicable definition of Medical Necessity. There are separate definitions in FFS and Managed Care.

How Prior-Authorization Works

In FFS, a prescriber should use the MA97 Form to request prior

authorization of an item or service. In HealthChoices, the process varies by health plan. When DPW or the HMO receive the prescription and supporting documents (letter of medical necessity, etc.), they must have a qualified individual review the prior authorization request. They may also contact the doctor who prescribed the item for clarification or more information.

When will a Decision be Made?

In Fee For Service, the Department of Public Welfare must respond to the request within 21 days, or the request is automatically approved. Denials or partial approvals must always be in writing, and provide a rationale. DPW must provide some reason for its decision, though not necessarily a clinical one. The notice must always inform the MA recipient of the right to a Fair Hearing.

Under state law, HealthChoices plans have to meet faster response times than FFS. They must make a decision within 24 hours for items or services needed on an urgent basis, within 1 business day for ongoing services, within 2 business days for new services, and within 21 days for services already provided. Emergency services must be reviewed immediately. All decisions must be provided to the consumer in writing and must be accompanied with a clinical rationale for the decision and with instructions on how to appeal. Sometimes the plan will approve a lower level of services, or propose an alternative treatment. This may be a denial in disguise.

Under state law, the HealthChoices HMOs are required to contact the prescriber within 48 hours for additional information needed to make the decision, though they often do not.

HMO Formularies

Each HealthChoices plan has what is known as a "formulary," a list of drugs and alternates the plan will pay for. For all drugs not on the formulary, and for some on it, prior-authorization is required. Often, prior authorization has not yet been obtained when the consumer goes to the pharmacy. If the drug is denied at the pharmacy, the plan must pay for a temporary supply. In fact, they must provide a 72 hour supply of the medication if it is a new medication and a 15 days supply of the medication if it is an ongoing medication.

In the meantime, the MA recipient must receive written notice of the denial, and may file a grievance or expedited grievance if necessary. The procedure is described on page 51.

H. Accessing Behavioral Health Services

In FFS

If the Medical Assistance recipient is in the Fee-For-Service System, she/he must go through the county to obtain Behavioral Health Services. For mental health service the consumer needs to contact the County Mental Health/Mental Retardation Program. For Drug and Alcohol Services, the consumer needs to contact the County Drug and Alcohol Commission. The consumer will either be scheduled for an assessment by the county or will be given the names of at least two mental health or drug and alcohol programs to call directly for an assessment.

Mental Health Benefits

The following Mental Health treatments are covered by FFS:

- Outpatient Services
- Partial Hospitalization
- Inpatient Hospitalization

Drug and Alcohol Benefits

The following Drug and Alcohol treatments are covered by FFS:

- Outpatient
- Hospital Detoxification
- Hospital Rehabilitation
- Methadone Maintenance

NOTE: The level of drug and alcohol services that an individual receives is based on the Pennsylvania Client Placement Criteria (PCPC), a statewide assessment tool that each provider uses to determine the level of drug and alcohol treatment an individual needs.

Depending on a consumer's category of eligibility, there may be limits on the type or amount of treatment that she/he can receive. Check the MA "Fee-for-Service" handbook for more information about the consumer's coverage.

In Managed Care

If the Medical Assistance recipient is enrolled in an MCO, there are three paths she/he can take to access mental health and drug and alcohol services.

The consumer can call the MCO. Member services will give the member

the names of at least two mental health or drug and alcohol programs that can schedule the member for an assessment. The member will then need to call the programs directly to schedule an appointment. In non-emergencies, the member has the right to be seen for an assessment within seven days. If no program can see the member within seven days, the member can call the MCO back and get the names and phone numbers of other programs.

The consumer can call the County directly. For mental health service the consumer needs to contact the County Mental Health/Mental Retardation Program. For Drug and Alcohol Services, the consumer needs to contact the County Drug and Alcohol Commission. The consumer will either be scheduled for an assessment by the county or will be given the names of at least two mental health or drug and alcohol programs to call directly for an assessment.

The consumer can call a mental health or a drug and alcohol treatment provider from the MCO's network directly for an assessment. To find out if a provider is in the MCO's network, the consumer can ask when he/she calls. The MCO can also provide a list of the providers that are in their network. If the provider cannot give the consumer an appointment within seven days, the consumer can call another provider.

Mental Health Benefits

The following Mental Health services must be covered by all MCOs:

- Outpatient Services
- Partial Hospitalization
- Inpatient Hospitalization
- Crisis Intervention
- Case Management Services
- Intensive Case Management (ICM)
- Resource Coordination
- Clozapine Services

Drug and Alcohol Benefits

The following Drug and Alcohol services must be covered by all MCOs:

- Outpatient
- Intensive Outpatient
- Partial Hospitalization
- Halfway House
- Hospital Detoxification
- Hospital Rehabilitation
- Non-hospital Detoxification
- Non-hospital Rehabilitation

- Methadone Maintenance

NOTE: As with FFS, the PCPC is used to determine the level of drug and alcohol treatment that an individual needs.

The above Mental Health and Drug and Alcohol services are the minimum services that all MCO's are required to provide. Contact the consumer's MCO about other services that may be included.

All services have admission criteria that an individual must meet in order for the MCO to approve that level of care.

I. What if I am having a problem getting care or services? Grievances, Complaints, and Fair Hearings.

The appeal process available to a consumer depends on whether the individual receives MA through a Managed Care Organization (MCO) or Fee for Service (FFS). Both state and federal law include requirements for these processes.

1. The Fee For Service (FFS) Appeal System

Individuals receiving MA through the FFS system who have been denied medical care or services can appeal the decision by asking for a DPW Fair Hearing. This is how the process works:

- When a notice of decision is received, request a Fair Hearing within 30 days from the date of the decision by writing to the address listed on the denial
- The hearing is conducted either in person or by phone. In person hearings take place in Philadelphia, Erie, Pittsburgh, Harrisburg, Reading, or Scranton. For the telephone hearing, the consumer will be called at the home number. For individuals who do not have a phone, go to your County Assistance Office for the phone hearing.
- An Administrative Law Judge will hold the Fair Hearing. The consumer can be represented at the hearing by an attorney, advocate or friend. Witnesses are also permitted. Before the hearing, the consumer should ask for copies of all information DPW may have that relates to the consumer's case.
- The Administrative Law Judge has 90 days from the date the hearing

was requested a Fair Hearing to hold the hearing and send out a decision. If the decision is unfavorable, the consumer may file for Reconsideration to the Secretary of DPW and/or appeal the case to Commonwealth Court.

How to continue to get services during the appeal process?

If an individual has been receiving the services that are being reduced, changed or terminated and wishes to continue receiving the services, the individual should file a request for a Fair Hearing which postmarked or hand-delivered within 10 days of the date on the decision being appealed. The services will be continued until a hearing decision is made.

2. Appealing a Managed Care Organization (MCO) Decision

Individuals receiving MA through an MCO who are unhappy with the care they have received or are denied services have several appeal options:

- The consumer can request a complaint or grievance within the MCO and/or
- The consumer can request a DPW Fair Hearing

What is a Complaint? A complaint is a dispute or objection about a participating provider, or about the coverage, operations or management of the plan. Appeals to the MCO about any of the following matters will be considered a Complaint:

- The health plan denies payment for a service a consumer received because the MCO claims the service was given by a non-MA provider without its approval
- The health plan denies a service or payment for a service because it has decided the service is not a covered benefit under the individual's plan
- The health plan did not meet the required timeframes for providing the consumer with a service
- The health plan failed to decide a complaint or grievance a consumer filed within the required timeframes

What is a Grievance? A Grievance is an appeal from a denial of service because the MCO determines the service is not medically necessary or appropriate. Examples of Grievances include:

- MCO has decided to reduce or terminate a consumer's home nursing care hours as no longer medically necessary even though the consumer's condition has not changed
- MCO will not pay for surgery or services the consumer's doctor

prescribed because the MCO decided the surgery or services are not medically necessary

a. How does the Complaint Process Work? (For Physical Health MCOs and Behavioral Health MCOs)

There are two levels within the MCO's Complaint process-the First Level Complaint and the Second Level Complaint. At each Complaint Level, the consumer may bring someone to represent him/her or to help present the member's case. In the alternative, a consumer can request the Health Plan to provide one of their staff to act as an advocate for the member and help with the appeal. A consumer can also ask for copies of all documents the MCO may have that relate to the Complaint, and he/she can submit to the MCO additional information or documentation that supports the Complaint.

First Level Complaint

If a consumer is not satisfied with the care or treatment given by the MCO or the providers, or a consumer disagrees with a decision the MCO made for reasons other than medical need, he/she can file a First Level Complaint. If the Complaint involves one of the 4 matters listed above, it must be filed within 45 days of the incident or the date the notice was received. If the Complaint is about other issues, it can be filed at any time.

Complaints can be made orally or in writing. In either case, the consumer will receive a written confirmation from the MCO that the Complaint was received.

A consumer can choose to participate in his/her First Level Complaint in person, by phone or by videoconference, if available. If the consumer wants to participate, he/she must tell the MCO within 5 business days of the date of the Complaint Acknowledgement letter.

The First Level Complaint is reviewed by a committee of 1 or more people within the MCO not involved in the initial decision. A summary of the issues presented to the committee and the decisions made must be prepared and made part of the record.

The First Level Complaint will be decided within 30 days of the date the Complaint request was received. If additional time is needed to submit information to the MCO, a consumer can request up to a 14 day extension. Once the First Level Complaint review is completed, the consumer will receive a written decision from the MCO that must include: the decision; all reasons for the decision; any authority in policy, guidelines, etc. for the decision; and information

on how to appeal if the consumer is not satisfied with the decision.

If a consumer's health would be harmed by waiting 30 days for a First Level Complaint decision, he/she should contact his/her MCO and request that his/her Complaint be decided faster. The consumer's doctor will need to submit a statement within 3 business days of the request stating that the consumer's health would be harmed by waiting 30 days for a Complaint decision. Once the statement is received, the MCO must issue an Expedited Complaint decision within 48 hours of receiving the doctor's statement or within 3 business days of the request, whichever is shorter.

Second Level Complaint

If a consumer is not satisfied with the decision from the First Level Complaint, he/she may file a Second Level Complaint orally or in writing within 45 days of receiving the First Level decision.

The Second Level Complaint is heard by a committee at least one of whom must be a member of the MCO. The consumer will be given an opportunity to appear before the Committee and must be given at least 15 days advance written notice of the meeting of the Committee. The Second Level Complaint must be heard and resolved within 30 days (if the dispute is with a Behavioral Health MCO) and within 45 days (if the dispute is with a Physical Health MCO).

External Review for Complaints

If a consumer is not satisfied with the Second Level Complaint decision, he/she can file for an External Review of the decision outside the MCO. The External Review must be requested within 15 days of the date the consumer received the Second Level Complaint Decision. The appeal goes to the Department of Health (for quality of care or services issues) or the Department of Insurance (for coverage or other insurance issues).

The Department of Health (or the Insurance Department) will get the consumer's file from the MCO to review. The consumer can also send them any additional information. Once a decision is made, a copy will be sent to the consumer. The letter will tell the consumer the reasons for the decision and what the consumer can do if he/she disagrees with the decision.

b. How to continue getting services during the Complaint process?

If the Complaint involves disputing a decision to discontinue, change, or reduce services already being received on the basis that the service is not a

covered benefit, a consumer can continue to receive the services pending the outcome of the Complaint as long as the Complaint is postmarked or hand-delivered within 10 days of the date on the MCO's notice.

c. Grievance Process (Physical Health and Behavioral Health)

There are two levels within the MCO's Grievance process—a First Level Grievance and a Second Level Grievance.

First Level Grievance

If a consumer disagrees with the MCO's decision to deny, reduce or terminate the consumer's services, he/she can request a First Level Grievance orally or in writing. The Grievance request must be made within 45 days of the date the MCO's notice was received.

Grievances can be made orally or in writing. In either case, the consumer will receive a written confirmation from the MCO that the Grievance was received.

A consumer can choose to participate in his/her First Level Complaint in person, by phone or by videoconference, if available. If the consumer wants to participate, he/she must tell the MCO within 5 business days of the date of the Grievance Acknowledgement letter.

The First Level Grievance is reviewed by a committee of 1 or more people within the MCO not involved in the initial decision. At least one person on the Committee must be a doctor of the same or a similar specialty as the prescribing doctor. A summary of the issues presented to the committee and the decisions made must be prepared and made part of the record.

A First Level Grievance must be decided within 30 days of the date of the date the MCO receives the Grievance request. Within 5 business days after the First Level Grievance review is completed, the consumer will receive a written decision which must include: the decision; all reasons for the decision; any authority for the decision in policy, guidelines, etc.; and information on how to appeal if the consumer is not satisfied with the decision.

Second Level Grievance

If a consumer is not satisfied with the decision from the First Level Grievance, he/she may file a Second Level Grievance orally or in writing within 45 days of receiving the First Level decision.

The Second Level Grievance review is conducted by a committee within the MCO. The Committee must include: at least one doctor of the same or a similar specialty to the prescribing doctor; and at least one consumer member of the MCO. The consumer will be given an opportunity to appear before the Committee and must be given at least 15 days advance written notice of the meeting with the Committee. The Second Level Grievance must be heard and resolved within 30 days (if the dispute is with a Behavioral Health MCO) and within 45 days (if the dispute is with a Physical Health MCO).

External Review for Grievances

If a consumer's doctor believes that his/her health would be harmed by waiting the usual time for a Grievance decision, the consumer can contact the MCO and request that the Grievance be decided faster. The consumer's doctor will need to submit a statement within 3 business days of the request that the consumer's health would be harmed by waiting for a Grievance decision. Once the statement is received, the MCO must issue an Expedited Grievance decision within 48 hours of receiving the doctor's statement or within 3 business days of your request, whichever is shorter. If the decision is not satisfactory, a consumer can seek an Expedited Grievance outside of the MCO.

If a consumer is not satisfied with the Second Level Grievance decision, he/she can file for an External Review of the decision outside the MCO. The consumer must send a letter to the MCO within 15 days of the date of receiving the Second Level Grievance decision. The appeal goes to the Department of Health who will assign someone outside of the MCO (called a Certified Review Entity or CRE) to review the MCO's decision. The CRE will obtain a copy of the consumer's grievance file from the MCO to review. The consumer can also send the CRE any additional information. An External Review decision will be issued within 60 days of the date the External Grievance was filed. Once a decision is made, a copy will be sent to the consumer. The letter will tell the consumer the reasons for the decision and what the consumer can do if he/she disagrees with the decision.

d. What to do to continue getting services during a Grievance.

If the Grievance involves disputing a reduction, change, or termination to services already being received, a consumer can continue to receive the services pending the outcome of the Grievance as long as the Grievance is postmarked or hand-delivered within 10 days of the date on the MCO's notice.

e. Department of Public Welfare Fair Hearings

In all Grievance matters and in most Complaints, a consumer can file a

DPW Fair Hearing request instead of, or in addition to, filing a Grievance or a Complaint. A consumer can ask for a Fair Hearing at the same time he/she files a Complaint or Grievance or can ask for a Fair Hearing after the MCO decides the First or Second Level Complaint or Grievance. A consumer must file for a fair hearing in writing within 30 days of the date of the decision from the consumer is appealing.

Expedited DPW Fair Hearings

If a consumer's doctor believes that his/her health would be harmed by waiting for the usual timeframe for a Fair Hearing decision, the consumer can request that the Fair Hearing be decided more quickly. The consumer's doctor will need to certify that the consumer's life, health, or ability to attain, maintain or regain maximum function would be jeopardized by waiting 90 days for a decision. The Fair Hearing will be held by telephone. As with expedited complaints and grievances, DPW must give a decision within 48 hours of when the harm statement is received from the provider, or within 3 business days of the date the request for an expedited process was received, whichever is shorter.

f. What to do to continue getting services during a Fair Hearing

If the Fair Hearing involves disputing a reduction, change, or termination to services already being received, a consumer can continue to receive the services pending the outcome of the Fair Hearing as long as the Fair Hearing request is postmarked or hand-delivered within 10 days of the date on the decision being appealed.

V. CONCLUSION

The Pennsylvania Health Law Project is a non-profit, public interest law firm that provides free legal assistance to consumers who need information about or assistance in accessing healthcare coverage or services through the publicly funded healthcare systems.

We are hopeful that this manual is helpful. If you need any assistance in accessing healthcare coverage or services, please call our toll-free help line at (800) 274-3258. You can visit us on the web at www.phlp.org.

Appendix A

Breast and Cervical Cancer Prevention and Treatment Program (BCCPTP)

This program provides free Medical Assistance coverage to women who have breast or cervical cancer (or pre-cancerous conditions) and who meet the other eligibility requirements. Women who are eligible receive comprehensive health care coverage through the Fee-for-Service Medical Assistance Program.

BCCPTP Requirements:

Women in PA are eligible for this program who:

- have a household income under 250% FPL;
- are under age 65;
- are PA Residents;
- are US Citizen or lawfully admitted immigrants;
- are uninsured (No creditable coverage);
- are Screened/Diagnosed through a CDC-approved Healthy Woman site.

BCCPTP Income Limits for 2004 *

# in HH	Monthly Income	Annual Income
1	\$1,940	\$23,275
2	\$2,603	\$31,225
3	\$3,265	\$39,175
4	\$3,927	\$47,125
5	\$4,590	\$55,075

*These income limits will change each year in mid-February when the Annual Federal Poverty Income Guidelines are released.

For more information, call the **PHLP Help Line at (800) 274-3258** or see the **PHLP Website at www.phlp.org**. You can also access the **Department of Health Website at www.health.state.pa.us** or the **Department of Public Welfare Website at www.dpw.state.pa.us**.

Southeastern PA Contact Names and Numbers for the BCCPTP:

PA Health Law Project (PHLP) (for free legal assistance) (800) 274-3258

Healthy Woman sites:

Bucks County:	Bucks County DOH (Kara Stenella)	(215) 345-3350
	(Monica Cope)	(215) 345-3389
Chester County:	Family Planning Council (Glenda Radical)	(215) 985-2610
Delaware County:	Delaware County Memorial Hospital	(610) 284-8112
	Crozer-Chester Medical Center	(610) 447-2629
Philadelphia County:	Family Planning Council (Glenda Radical)	(215) 985-2610
	Phila. Health Department (Nancy Britt)	(215) 685-6706

County Assistance Office Contacts:

Bucks County:	Ray Rizzo (Bristol)	(215) 781-3313
	Jan Tolia (Warminster)	(215) 443-3205
Chester County:	Cheryl Wilson	(610) 466-1019
Delaware County:	Mary Norman	(610) 447-3234
Montgomery County:	Susan Senycz (Norristown)	(610) 270-3542
	Jenny Osborne (Pottstown)	(610) 327-5630
Philadelphia County:	Dennis Klaus	(215) 560-3428

For more information, call the **Pennsylvania Health Law Project Help Line** at **(800) 274-3258** or see the **PHLP Website** at www.phlp.org. You can also access the **Department of Health Website** at www.health.state.pa.us or the **Department of Public Welfare Website** at www.dpw.state.pa.us.

Appendix B

Health Clinics-Free or Low Cost Care

BUCKS COUNTY

Free Clinic of Doylestown
595 W. State Street
Doylestown, PA 18901
(215) 345-2260

*HealthLink Medical and
Dental Center*
1775 Street Road
Upper Southampton, PA 18966
(215) 364-4247

CHESTER COUNTY

Community Volunteers in Medicine
300 B Lawrence Drive
West Chester, PA 19380
(610) 836-5990
www.cvim.org

Project Salud
219 Birch Street
Kennett Square, PA 19348
(215) 444-5278

DELAWARE COUNTY

ChesPenn Health Services
(3 Centers)
1300 West 9th Street
Chester, PA 19013
(610) 874-6231

2600 West 9th Street, Suite B
Chester, PA 19013
(610) 859-2059

619 Welsh Street
Chester, PA 19013
(610) 872-6131

MONTGOMERY COUNTY

Delaware Valley Community Health,
Inc.
Norristown Regional Health Center
55 East Marshall Street
Philadelphia, PA 19401
(610) 278-7787

PHILADELPHIA COUNTY

Health Care Center #1
1400 Lombard Street
Philadelphia, PA 19146
215-685-6570
STD Clinic & HIV Testing
Does not provide the comprehensive
health care

Health Care Center #2
1720 South Broad Street
Philadelphia, PA 19145
215-685-1803

Health Care Center #3
555 South 43rd Street
Philadelphia, PA 19104
215-685-7500

Health Care Center #4
4400 Haverford Avenue
Philadelphia, PA 19104
215-685-7600

Health Care Center #5
1900 North 20th Street
Philadelphia, PA 19121
215-685-2930

Health Care Center #6
301 West Girard Avenue
Philadelphia, PA 19123
215-685-3803

Health Care Center #9
131 East Chelton Avenue
Philadelphia, PA 19149
215-685-5700

Health Care Center #10
2230 Cottman Avenue
Philadelphia, PA 19149
215-685-0600

Strawberry Mansion Health Care
Center
2840 Dauphin Street
Philadelphia, PA 19132
215-685-2400

Abbottsford Community Health
Center
3205 Defense Terrace
Philadelphia, PA 19129
(215) 843-9720

Schuylkill Falls Community Health
Center
4325 Merrick Road
Philadelphia, PA 19129
(215) 843-2580

Covenant House Health Services
251 East Brighthurst Street
Philadelphia, PA 19144
(215) 844-1020

Delaware Valley Community Health,
Inc. (2 Centers in Phila.)
Fairmount Primary Care Center
1412 Fairmount Avenue
Philadelphia, PA 19130
(215) 235-9600

Maria de los Santos Health Center
452 West Allegheny
Philadelphia, PA 19133
(215) 291-2500

Greater Philadelphia Health Action,
Inc. (5 Centers)
Frankford Avenue Health Center
4510 Frankford Avenue
Philadelphia, PA 19124
(215) 744-1302

Hunting Park Health Center
1999 Hunting Park Avenue
Philadelphia, PA 19140
(215) 228-9300

Southeast Health Center
930 Washington Avenue
Philadelphia, PA 19147
(215) 339-5100

Wilson Park Medical Center
2520 Snyder Avenue
Philadelphia, PA 19145
(215) 755-7700

Woodland Avenue Health Center
5501 Woodland Avenue
Philadelphia, PA 19143
(215) 726-9807

Phila. Health Mgmt Corp.-Phila.
Health Care for the Homeless Project
260 South Broad Street
Philadelphia, PA 19102
(215) 985-2500

Quality Community Health Care, Inc.
(3 Centers)
Finley Place Family Health Center
2813 West Diamond Street
Philadelphia, PA 19121
(215) 763-4445

QCHC Family Health Center
2501 W. Lehigh Avenue
Philadelphia, PA 19132
(215) 227-0300

Vaux Family Health Center
23rd & Master Street
Philadelphia, PA 19121
(215) 684-5433

Spectrum Health Services (2
Centers)
Broad Street Health Center
Progress Human Services Center
1415 North Broad Street, 2nd Floor
Philadelphia, PA 19122
(215) 235-7944

Haddington Health Center
Progress Haddington Plaza
5619-25 Vine Street
Philadelphia, PA 19139
(215) 471-2761

DENTAL CLINICS

BUCKS COUNTY

Free Clinic of Doylestown
595 W. State Street
Doylestown, PA 18901
(215) 345-2260
Services: Screening exams and X-
rays, Referral to volunteer
community dentists for treatment.
Patient Eligibility: Resident of central
and upper Bucks County
No dental insurance, I=Income
below 200% of the FPL
(\$1,497/month for an individual)

HealthLink Medical/Dental Center
1775 Street Road
Upper Southampton, PA 18966
(215) 364-4247
Services: cleanings, fillings,
extractions and root canals
Patient Eligibility: Employed adult
residents of Montgomery or Bucks
counties, No dental insurance,

Income must fall within 200% of the
FPL (\$1,497/month for an individual)

CHESTER COUNTY

Community Volunteers in Medicine
300 B Lawrence Drive
West Chester, PA 19380
(610) 836-5990
www.cvim.org
Services: Cleanings, sealants,
fillings, extractions, and limited
number of root canals and crowns.
Patient Eligibility: For individuals
who live or work in Chester County.
No dental insurance, Income must
fall within 200% of the FPL
(\$1,497/month for an individual)

DELAWARE COUNTY

ChesPenn Health Services
2602 West 9th Street
Chester, PA 19013
(610) 497-2900
Services: General dentistry plus oral
surgery, orthodontics, periodontics,
endodontics, and prosthodontics

MONTGOMERY COUNTY-See
Bucks County

PHILADELPHIA COUNTY

Clinics providing all dental services:

*Univ. of Penn. School of Dental
Medicine-Dental Clinic*
4001 Spruce Street
Philadelphia, PA 19104
(215) 898-8965

Temple Univ. Dental School Clinic
3223 North Broad Street
Philadelphia, PA 19140
(215) 707-2900 (appointments)
www.temple.edu/dentistry/info

Clinics providing general dentistry plus periodontics, endodontics, and prosthodontics

Delaware Valley Community Health, Inc. (2 Locations)

Fairmount Primary Care Center
1412 Fairmount Avenue
Philadelphia, PA 19130
(215) 235-9600

Maria de los Santos Health Center
452 West Allegheny
Philadelphia, PA 19133
(215) 291-2500

Clinics providing general dentistry

Covenant House Health Services
251 East Brighthurst Street
Philadelphia, PA 19144
(215) 844-1020

Greater Philadelphia Health Action, Inc. (4 Locations)
Frankford Avenue Health Center
4510 Frankford Avenue
Philadelphia, PA 19124
(215) 744-1302

Hunting Park Health Center
1999 Hunting Park Avenue
Philadelphia, PA 19140
(215) 228-9300

Wilson Park Medical Center
2520 Snyder Avenue
Philadelphia, PA 19145
(215) 755-7700

Woodland Avenue Health Center
5501 Woodland Avenue
Philadelphia, PA 19143
(215) 726-9807

Phila. Health Mgmt Corp-Phila. Health Care for the Homeless Project
260 South Broad Street
Philadelphia, PA 19102
(215) 985-2500

Quality Community Health Care, Inc. (4 Locations)
Finley Place Family Health Center
2813 West Diamond Street
Philadelphia, PA 19121
(215) 763-4445

Meade Family Health Center
18th & Oxford Street
Philadelphia, PA 19121
(215) 765-9501

QCHC Family Health Center
2501 West Lehigh Avenue
Philadelphia, PA 19132
(215) 227-0300

Vaux Family Health Center
23rd & Master Street
Philadelphia, PA 19121
(215) 684-5433

Appendix C



Comparative Chart of Pharmaceutical Manufacturers' Drug Discount Cards

Last update 12/3/03

All programs require that applicants be Medicare recipients and have no other prescription coverage. These drug discount cards have no enrollment or annual fees.

Program	Prescriptions Covered	Annual Income Below <i>(For households of 3 or > people, there may be higher income limits)</i>	Benefit	Contact & Misc. Info.
GlaxoSmithKline Orange Card	All drugs	\$30,000/Individual \$40,000/Couple	At participating pharmacies receive a 30% average savings	1-888-672-6436 Patients can participate in either the Orange Card or Together Rx for GSK medications (the Orange Card has higher income limits)
LillyAnswers (Eli Lilly & Company)	All drugs except controlled substances	\$18,000/Individual \$24,000/Household	At participating pharmacies pay \$12.00/prescription for a 30-day supply	1-877-795-4559 www.lillyanswers.com
Novartis Care Card	Select drugs	Two Income Categories: A. \$18,000 /Individual \$24,000/Couple B. \$28,000/Individual \$38,000/Couple	At participating pharmacies: A. Pay \$12.00/mo. (per prescription) B. Receive 25% - 40% off	1-866-974-2273 www.NovartisCarePlan.com Enrollment for the Novartis savings program will be through Together Rx.



Comparative Chart of Pharmaceutical Manufacturers' Drug Discount Cards

Last update 12/3/03

All programs require that applicants be Medicare recipients and have no other prescription coverage. These drug discount cards have no enrollment or annual fees.

Program	Prescriptions Covered	Annual Income Below <i>(For households of 3 or > people, there may be higher income limits)</i>	Benefit	Contact & Misc. Info.
Pfizer For Living Share Card	All drugs	\$18,000/Individual \$24,000/Couple	At participating pharmacies pay \$15.00/prescription for up to a 30-day supply	1-800-459-4156 www.pfizerforliving.com
Together Rx Card <i>This one card can be used for many medications manufactured by: Abbott Laboratories, AstraZeneca, Aventis Pharmaceuticals, Bristol-Myers Squibb Company, GlaxoSmithKline, Johnson & Johnson, and Novartis.</i>	Select drugs	\$28,000/Individual * \$38,000/Couple * *Alaska & Hawaii have higher income limits	At participating pharmacies receive a 20-40% savings off the regular prescription price of over 170 medications	1-800-865-7211 www.together-rx.com

Other Drug Discount Cards

Last update 12/3/03

Program	Prescriptions Covered	Income Guidelines	Benefit	Contact & Misc. Info.
Nonprofit Warehouse	All drugs	No income limits	At participating pharmacies receive up to 50% off regular retail price on generic drugs and up to 15% on brand name prescriptions	1-770-541-7777 www.nonprofitwarehouse.com