

## CHAPTER 5: MEDICAL ASSISTANCE

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### § 5.1 Medical Assistance Overview

Medical Assistance (MA, also known as “Medicaid”) is a state health insurance program provided through the Pennsylvania Department of Human Services (DHS – formerly DPW) to low-income individuals and families. In Pennsylvania, many people with HIV who have limited income should qualify for MA coverage. The Affordable Care Act (ACA)

expanded MA in Pennsylvania so that more low-income individuals qualify for MA without regard to their assets or health.

Advocates should be aware that there are many different ways to establish eligibility for various categories of MA, under the original rules, and post ACA. This chapter is written to explain these categories.

**The basic rules on MA eligibility (original MA):** In order to be eligible for MA an individual must meet the following eligibility criteria:

- Be a **Pennsylvania resident** (there is no minimum time requirement)
- Have an **immigration status** that allows a person to receive MA coverage (except emergency MA)
- Meet **income**
- Be **categorically** eligible.

The ACA became fully effective in 2014, expanding Medicaid to people with household income equal to or less than 138% percent of the Federal Income Poverty Guidelines (FPIG). (This percentage amount is written into law to read that a person's income needs to be below 133% of the FPIG and an additional 5% income disregard will be given if the individual does not qualify for MA). Advocates only need to look at an individual's income at 138% of the FPIG as given in the chart 5-1 below to find eligibility for MA under ACA (see § 5.2a below). The income amounts in the chart increase every year when the U.S. Department of Health and Human Services announces updated FPIGs.

In addition to expanding MA for low-income persons, the ACA also created health insurance exchanges where individuals can purchase private insurance with subsidies from the government. The ACA allowed people with employment-related insurance to remain in those plans. (For more information on provisions of ACA see Chapter 6 of this manual).

In January 2015, Pennsylvania expanded MA to everyone under age 65 and under 138% FPIG who are not eligible for original Medicaid. Some people who were on original MA remained in those eligibility categories (example: adults disabled from HIV). Others moved to different income-counting methodologies (examples: children and pregnant women). Since the implementation of the ACA, individuals applying for MA may be categorized as **MAGI** (Affordable Care Act) (§ 5.2) or **Non-MAGI (Original)** (§5.3).

**TIP:**

People over age 65 and Medicare recipients are not eligible for expanded Medicaid.

**MA eligibility analysis:** For all persons applying for MA in Pennsylvania, it is useful

to ask these questions and have the following analysis done:

- (i) What category does this individual belong? MAGI or Non-MAGI?
- (ii) If MAGI, what is the household size of the applicant for MA?
- (iii) Is the person under the income limit for that category and household size?

## § 5.2 MAGI (Modified Adjusted Gross Income)

### § 5.2a —MAGI Income Counting Methodology

Since January 2015, Pennsylvania applies the MAGI income counting methodology for most MA recipients. MAGI income counting method applies the Internal Revenue Service (IRS) rules on counting income. The “counted” and “excluded” income for MAGI is based on what is included in the individual’s *Adjusted Gross Income* (AGI) when filing a tax return with the IRS. The rule is all income counts, unless exempted by tax rules.

Under the MAGI income counting methodology, DHS will determine eligibility of each person applying for benefits on an individual basis based on: (1) the person’s household size, (2) the combined income of all household members, and 3) the income limit for that household size. (see Charts 2-1 and 2-2 for income and household limits). Applicants need not have a disability.

### § 5.2b — MAGI Household

When DHS determines a person’s eligibility for MAGI-related MA it will first determine *tax filing status* and *tax relationships* between the individuals in the household.

**Tax Filer:** a person who expects to file a tax return for the current year (includes tax filer, spouse and tax dependents). If an applicant files a tax return, DHS needs to know about everyone on that applicant’s tax return.

**Tax Dependent:** a person who expects to be claimed by another taxpayer

- **If children**
  - Must be related to the tax filer
  - Must live with the tax filer more than half the year
  - Must be under age 19 at the end of the year (under 24 if a full-time student)
  - Can’t provide more than half of their own support
- **Other tax dependents**
  - Must be related to the tax filer or live in his or her home all year
  - Must provide less than half of their own support
  - Must earn less than \$3,900

**Non-Filer:** a person who does not expect to file a tax return and does not expect to be claimed by another taxpayer

The *Tax Filer* and *Tax Dependent* status always refer to the expected status for the current coverage year or renewal year. It does not refer to the filing status from the prior year.

### § 5.2c — Income

DHS will count the total amount of the MAGI income of all individuals in the household as defined above. Income is counted on a person-by-person basis and counts the actual monthly income for eligibility purposes. DHS will use income from the 30 days prior to submitting an application. DHS will count all monthly “earned” and “unearned” income of every individual in the individual’s tax household when evaluating eligibility for MA under the MAGI related categories, unless income is excluded by tax laws. If a person’s monthly income is 138% of the FPIG or less, the person qualifies for MA regardless of assets or other categorical eligibility. If the monthly income exceeds 138% and is expected to decrease or end, DHS can use a monthly average of the person’s annual income.

NOTE: The income of children and tax dependents is not counted unless they are expected to file tax returns.

There is no resource or asset limits for MAGI categories.

The following types of earned income are taken into consideration for MAGI. This is not an exhaustive list. All income needs to be reported to DHS.

- Wages (including tip wages)
- Salaries
- Commissions
- Bonuses
- Severance pay
- Self-employment
- Lump Sum-earnings (only in the month received)
- Foreign earned income -US citizens living abroad (not reportable to IRS, but need to report to MA)

The following types of unearned income are taken into consideration for MAGI related

MA categories:

- Social Security Retirement, Survivors, and Disability Insurance (not reportable to IRS, but need to report to MA)
- Tax-exempt interest (not reportable to IRS, but need to report to MA)
- Private pensions
- Annuities
- Unemployment Compensation
- Railroad Retirement
- Sick benefits
- Union benefits
- Dividends, royalties and interest posted or received in the calendar month, including tax exempt interest.
- Rental income
- Prizes and awards
- Child's unearned income that is reportable to IRS
- Lump sum-unearned (only in the month it is received)
- Cash support received (only if the person providing the cash support is claiming the individual as a tax dependent, and the tax dependent is not their spouse or their child)

The following income does not count towards MAGI income limits:

- SSI
- Alimony payments for settlements after 01/01/2019
- Child Support
- Any benefits paid by the Department of Veterans Affairs
- Worker's Compensation

- Black Lung Benefits
- Assistance payments (SSI, TANF, foster care, and adoption subsidy payments)
- A lump sum (only counted as income in the month received)
- Scholarships, awards or fellowship grants used for education purposes and not for living expenses
- Inheritances
- Loans (e.g. student loans, bank loans, personal loans).
- Gifts
- Difficulty of Care payments - made to a non-relative or relative who is under contract with a public or private agency to give care to a person with a mental disability in his or her home (Examples: child or adult foster care, supplemental payment to a domiciliary care provider, parent of an intellectually disabled child, adult and family living services)
- Payments made for care of an individual based on the individual's (HCBS) waiver plan (some conditions apply)
- American Indian or Alaska Native income

#### **§ 5.2d — MAGI Categories**

The following categories of people are evaluated for MA under the MAGI income-counting methodology:

- Adults ages 19 to 64
- Pregnant women
- Children, newborn to age 18
- Parents (biological, adoptive or step)
- Caretakers

The income limits and additional information on the aforesaid categories are detailed

below.

**§ 5.2e — Adults, age 19 to 64 (Medicaid expansion population)**

The ACA increased the income limit of the original MA for the adult population. This update is now known as Medicaid Expansion. Adults aged 19-64 can apply for MA without regard to health and/or resources. The income limit for this category is 138% of the Federal Income Poverty Guidelines (FPIG) including a 5% income disregard. Adults with Medicare are not eligible for the MAGI category.

<b>Chart 5-1: Income Level for Adults aged 19-64, under the MAGI category (138 % FPIG incl. 5% income disregard) - 2020</b>		
<b>Family Size</b>	<b>Monthly Income</b>	<b>Annual Income</b>
1	\$1,468	\$17,609
2	\$1,983	\$23,791
3	\$2,499	\$29,974
4	\$3,013	\$36,156
5	\$3,529	\$42,338
6	\$4,044	\$48,528

**§ 5.2f — Pregnant Adults and Children**

Families with children may be eligible for MA through either the *Healthy Beginnings* category or the *Children's Health Insurance Program* (CHIP) depending on their income. A child can remain in either one of these programs until their 19<sup>th</sup> birthday. The younger a child is, the easier it is for that child's family to qualify for Healthy Beginnings (see income chart below). There is no resource limit for these categories.

A child born to a parent on MA remains eligible for Healthy Beginnings for one year regardless of income, although the new parent's Healthy Beginnings coverage ends 60 days after the baby's birth. The new parent may be eligible for other categories, and DHS is obligated to review eligibility for other programs before discontinuing coverage.

**§ 5.2g — Healthy Beginnings**

Healthy Beginnings, the primary MA program for children and pregnant adults was created as a result of increasing recognition of the importance of prenatal and early childhood health care.

Healthy Beginnings has three separate income categories: (1) pregnant adults and children under age one; (2) children ages 1-5; and (3) children ages 6-18. For each of these categories, DHS will count parental income to determine a child's eligibility.

1. Pregnant adults and newborns up to age 1 can qualify in this category if the family's monthly income is 220 % (\$3,162– in 2020) or less of the FPIG. This income limit is for a family of two because the unborn child is always considered in the household size. (see Chart 2-2 for income limits for additional family members). There is no resource limit for this category.
2. Children ages 1-5 can qualify if the household 's monthly income is 162 % (\$2,328 for a family of two in 2020). **Chart 5-2** sets forth these income limits.
3. Children ages 6-18 can qualify if their household's monthly income is 138 % (\$1,983 for a family of two in 2020). **Chart 5-2** sets forth these income limits.

<b>Chart 5-2: Income Level for Children age 0 through 18 under the MAGI category – 2020 (including the 5% income disregard)</b>			
<b>Family Size</b>	<b>Pregnant Adults &amp; Children under 1 year (220% FPIG)</b>	<b>Children Ages 1-5 (162% FPIG)</b>	<b>Children Ages 6-18 (138% FPIG)</b>
1	\$2,340	\$1,723	\$1,468
2	\$3,162	\$2,328	\$1,983
3	\$3,982	\$2,932	\$2,499
4	\$4,803	\$3,537	\$3,013
5	\$5,626	\$4,142	\$3,529
6	\$6,447	\$4,748	\$4,043
7	\$7,267	\$5,351	\$4,559
8	\$8,089	\$5,956	\$5,074
Each Add'l	\$820	\$604	\$514

\*No asset limit

### § 5.2h — Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program (CHIP) provides health insurance for uninsured children of parents whose earnings are too high for MA eligibility (See Chart 5.2) but are nevertheless low to moderate. This program is run by the Pennsylvania Insurance Department and administered by private health insurance companies. Under the “Cover All Kids” initiative, uninsured children and teens, who are not eligible for MA, may have access to comprehensive health-care coverage through this program. Children whose immigration status is undocumented are not eligible for CHIP.

To qualify, the child must be (1) uninsured and not eligible for MA, (2) under age 19, (3) a U.S. citizen or an immigrant who is lawfully residing in the U.S, and (4) a Pennsylvania resident.

Since the implementation of the Affordable Care Act in 2014, CHIP uses calculations based on federal income tax rules with some modifications to determine household income. CHIP requires that applicants provide information including income for *everyone* who lives with the applicant and everyone who is expected to be included the household’s tax return, even if they do not live in the same household.

Household Size	Free CHIP Monthly 213%	Low-cost monthly 319%
2	\$3,060	\$4,593
3	\$3,855	\$5,774
4	\$4,651	\$6,965
5	\$5,626	\$8,156
6	\$6,241	\$9,347

\*Child must be uninsured and over income for Medicaid.

Like Healthy Beginnings, there is no resource or asset limit for CHIP eligibility. The “counted” and “excluded” income for CHIP is based on what would be included in the household’s Adjusted Gross Income (AGI) when filing a tax return with the IRS. The rule is all income counts, unless exempted by tax rules. CHIP coverage is available with or without payment of premium depending on the household income and family size. The CHIP income guideline chart can be found at this link along with the average monthly premium per child and the out of pocket costs: (these amounts usually increase each year). <https://www.chipcoverspakids.com/Eligibility/Documents/CHIP%20income%20guidelines%20chart.pdf>

**NOTE:**

Unlike MA, CHIP does not include an unborn child in the household calculation.

The same application can be filed for both MA and CHIP. There is no waiting list to get CHIP coverage. Generally, a child who exceeds the income limit for the Healthy Beginnings program is automatically referred by DHS to CHIP. The applicant will be notified of the referral.

CHIP applications can be completed online through COMPASS, by mailing a paper application (available at [www.chipcoverspakids.com](http://www.chipcoverspakids.com)) to the selected health insurance company, or over the phone by calling **1-800-986-KIDS**. More information on the CHIP program can be found here:

<https://www.chipcoverspakids.com/Eligibility/Documents/CHIP%20Eligibility%20and%20Benefits%20Handbook%202017.pdf>

### § 5.2i —Former Foster Care Youth

Young adults under age 26 who have aged out of foster care can qualify for this MA as Former Foster Care Youth. Former foster care youths who were receiving MA (in federal or state-funded foster care on or after their 18th birthday) continue to qualify for MA in this category without regard to income or assets if they are not otherwise eligible for MA.

### § 5.2k —Parents and Caretakers

A parent (biological, adoptive or step) or a caretaker can receive MAGI-related MA. The income limit for this group needs to be equal to or less than 33% of the FPIG. In addition, they must have care and control of a child age 0-17 or age 18 and a full-time secondary or vocational/technical school student.

Persons other than parents with care and control of a child in this MAGI-related household can be caretakers if the parent is not living in the household. For MAGI-related MA, an individual does not need to be related to the child to be a specified relative in the parent/caretaker category. Caretakers are individuals 19 years or older.

**NOTE:**

Families receiving MAGI-related MA coverage who lose eligibility due to an increase in income may be eligible for Transitional Medical Assistance (TMA) See § 5.3.b.2. The period of eligibility depends on the source of income. If loss of MA eligibility is due to earned (work) income the TMA can extend to twelve (12) months. If MA eligibility is lost due to spousal support/alimony TMA will extend only to four (4) months.

**Chart 5-4: Income Level for Parents and Caregivers  
under the MAGI category (33% of FPIG)**

Family Size	Monthly Income	Annual Income
1	\$351	\$4,212
2	\$475	\$5,700
3	\$598	\$7,176
4	\$721	\$8,652
5	\$844	\$10,128
6	\$967	\$11,604
7	\$1,091	\$13,092
8	\$1,214	\$14,568
Each Add'l	\$124	\$1,488

### NON- MAGI

**§ 5.3a.** The original Pennsylvania MA program provides free or low-cost health insurance to residents with low income, low resources, and who meet certain “categorical” requirements for eligibility. Prior to Medicaid expansion in Pennsylvania in 2015, all MA recipients were covered under various categories using non-MAGI income methodology.

The original categories followed the SSI related income counting methodology: i.e. a \$20 disregard from any “unearned” income; and a \$65 disregard and an additional 50% deduction from all “earned” income. See **chart 5-5** below.

Although, all adults ages 19-64 with income less than 138% FPIG are now covered under “Medicaid expansion,” there are others who are not eligible under MAGI. Original MA programs remain available to people who are not eligible for MAGI. The income counting methodology for the following categories did not change with the implementation of ACA and is explained in detail in [§ 2.5a](#).

“Original” MA categories are as follows:

- Adults 65 and older (Healthy Horizons)
- Persons with disabilities, including people found disabled from HIV (Healthy Horizons)
- Workers with disabilities (MAWD)
- Children with Disabilities

- Individuals for whom income determinations are not required
  - Supplemental Security Income (SSI) recipients (Chapter 5)
  - Federal foster care assistance
  - Adoption recipients or recipients
  - Breast and Cervical Cancer Prevention and Treatment (BCCPT) services
- Individuals evaluated for Long Term Care (LTC) facility services or Home and Community Based Services (HCBS)
- Individuals eligible for Medicare cost sharing.
- Individuals evaluated for Medically Needy Only (MNO)
- Individuals evaluated for General Assistance (GA) related MA.

**TIP:**

**For Medical Assistance eligibility purposes, counting one family member's income against another is only mandatory for spouse-to-spouse and parent-to-child (not child-to-parent).** Thus, if a child has their own income, such as Social Security survivors' benefits, it should have no effect on the parent's eligibility.

These original MA categories listed here do not use MAGI income counting methodology:

- **Recipients of SSI or TANF:**
  - People who receive SSI (**Chapter 2**) or Temporary Assistance for Needy Families (TANF) (**Chapter 8**) are automatically eligible to receive MA. (No separate application is needed for MA (§ 5.3b.1).
- **Adults with Disabilities:**
  - An adult with a disability who has countable income over the SSI level, but at or below 100 % of the federal poverty level may be eligible for MA under the 'Healthy Horizons' program (§ 5.3c.1).
  - A disabled adult, not eligible for Healthy Horizons may be eligible for MA if they can "spend down" their excess income to the SSI limit (§ 5.3c.2).
- **Adults with Disabilities Who are Working:**
  - Adults under 65 who are working and have a disability may be eligible for the 'Medical Assistance for Workers with Disabilities' (MAWD) program. The income limit for this program is significantly higher than other MA programs, and less than half of the earned income counts for this program (§ 5.3c.4).
  - An adult who requires medication to continue working may be eligible for the 'Health-Sustaining Medications Program' (§ 5.3c.5).
- **Adults at Risk for Entering a Nursing Home:**

- A person in need of home-based care and who otherwise would be hospitalized or enter a nursing home may be eligible for the ‘Community HealthChoices’ Waiver program. The income limit for this program is significantly higher than for regular MA (§ 5.3c.6).
- **Children with Disabilities:**
  - A child under age 18 with a disability who is ineligible for SSI because the family income is too high can get MA without regard to the parents’ income or resources. This is known as the “PH 95” category. (§ 5.3c.7).
- **Non-Disabled Adults:**
  - An individual who does not qualify under any other category may be eligible for MA under the ‘Medically Needy Only’ (MNO) Program (§ 5.3c.7) if they meet strict income limits and are in one of several narrowly-defined groups.
- **Women with Cervical or Breast Cancer:**
  - An adult with a diagnosis of a specified medical condition and meeting certain income limits may be eligible for MA through the ‘Breast and Cervical Cancer Prevention and Treatment Program’ (BCCPTP) (§ 5.4b).

Before you decide that someone is not eligible for MA, be sure you have thought about all possible categories of coverage, which are explained in this Chapter. Remember that DHS caseworkers are required to consider eligibility under every category, before denying an application or terminating coverage.

**TIP:**

Applications who report them as “disabled” will generally be routed to non-MAGI categories stated in these sections.

### § 5.3b.1 — SSI and TANF Recipients

In Pennsylvania, anyone who receives SSI, or Temporary Assistance for Needy Families (TANF), is automatically eligible for MA. Therefore, knowing how to qualify for SSI (**Chapter 2**) or TANF (**Chapter 8**) is critical. People who get Social Security Disability Insurance (SSDI) benefits (**Chapter 2**) may be eligible for MA, depending on their income. For families who lose TANF benefits as a result of earned income, MA is extended up to one year under the *Transitional Medical Assistance* (TMA) program § 5.3.b.2.

No matter how small the SSI or TANF benefit, the person is still automatically eligible for MA. Even a person who loses eligibility for SSI because of earned income may still be eligible for MA (see *1619(b) status* § 5.3b.3). Furthermore, a working individual who earns more than the 1619(b) threshold amount can be eligible for MAWD coverage, which has a higher income limit. (§ 5.3c.4).

If you believe your working client may be eligible for MA under the 1619(b) status or

the MAWD program, contact the AIDS Law Project for additional assistance moving them from SSI-MA category to programs with higher income limits.

### **§ 5.3b.2 — Transitional Medical Assistance (TMA)**

Families who lose TANF because their earned income earnings are too high or because they have an increase in spousal support/alimony remain eligible for MA for one year under the TMA program. To qualify, families must have been receiving TANF based MA for at least three of the six months prior to losing eligibility. (Note that child support is NOT counted as income for this determination). For the first six months after TANF stops, the family is eligible for TMA regardless of income. For the second six months, the family is eligible as long as their monthly income is below 185 % of the FPIG under the MAGI income counting methodology. In 2020, for two people, this is \$2,658 monthly. For three people, the limit is \$3,348 monthly.

Families who lose TANF due to increased child support payments can get four months of TMA regardless of the income amount.

### **§ 5.3b.3 — 1619(b) Status:**

This section refers to a work incentive rule in the Social Security Act that provides for extended MA coverage. 1619(b) Status allows an individual to receive MA while working and earning below the 1619(b) threshold amount. A client whose earned income exceeds the SSI limit, and thus does not receive any cash payment, may still be eligible for MA under this program. To be eligible for this status, the beneficiary must need MA in order to work, have income inadequate to replace the cost of MA coverage (In Pennsylvania, \$38,431 for 2019, and increases annually), and continue to be disabled. SSA's detailed description of this program along with the threshold amounts for each state for 2018-2019 is included here: <https://www.ssa.gov/disabilityresearch/wi/1619b.htm>

### **§ 5.3c — Programs for Disabled Adults**

The Department of Public Welfare has several MA programs for adults with disabilities. Healthy Horizons is for adults with disabilities and people over 65 years old with income under 100% of FPIG. (§ 5.3.c.1). Adults with disabilities who have too much income for Healthy Horizons, may be eligible for MA under the DHS “spend down” program. (§5.3.c.2). Adults who are working despite their disability may be eligible for Medical Assistance for Workers with Disabilities (MAWD) (§ 5.3.c.3). Finally, adults who need medications to maintain their ability to work may be eligible for the limited Health-Sustaining Medications Program § 5.3.c.4).

#### **§ 5.3c.1 — Healthy Horizons**

Healthy Horizons category is available for (1) adults with disabilities and (2) people age 65 or over, whose income is less than 100 % of the FPIG (with a \$20 exclusion) and who are under the resource limit [\$2000 (single), \$3000 (couple)].

The following chart provides the 2020 benefit levels for Healthy Horizons:

<b>Chart 5-5: Income Level for Healthy Horizons, and QMB (100 % FPIG) - 2020</b>		
<b>Family Size</b>	<b>Monthly Income</b>	<b>Annual Income</b>
1	\$1,064	\$12,760
2	\$1,437	\$17,240
3	\$1,810	\$21,720
4	\$2,184	\$26,200
5	\$2,557	\$30,680
6	\$2,930	\$35,160
7	\$3,303	\$39,640
8	\$3,677	\$44,120
Each Add'l	\$373	\$4,476

In calculating countable income for Healthy Horizons, DHS uses the SSI method (explained in detail in Chapter 2 § 2.5a). As when calculating income for SSI purposes, earned income is subject to a \$65 exclusion, and then half of the balance is counted.

**TIP:**

When determining if an SSDI recipient is eligible for Healthy Horizons, do not forget to use gross income including the money that Social Security may be taking out of the benefit check to pay for the client's Medicare Part B.

In calculating monthly income, recipients can deduct any expenses paid in order to get the income, such as transportation costs, bank fees, or legal fees to receive this income. For individuals whose income is very close to the Healthy Horizons limit, it is especially important to look for income exclusions and/or deductions and the cost of obtaining that income. For clients who are over income for Health Horizons, see “spend down” category (§ 5.3.c.3) or MAWD (§ 5.3.c.4).

The resource limit for an individual Healthy Horizons recipient is \$2,000. A couple cannot have resources more than \$3,000. Similar to other public benefits programs, the home in which the beneficiary lives, one car, and personal items are not counted towards

resource limits.

**TIP:**

If a child under age 21 is in household, there is no resource limit for a parent's Healthy Horizons eligibility.

### § 5.3c.3 — Medical Assistance “Spend Down” Eligibility

Disabled adults with income over a particular MA category limit may become eligible for MA by “spending down” the excess income to that MA category limit. Spend down works like a deductible. The idea of the spend-down program is that a person incurs medical expenses each month, and then MA pays the medical expenses for rest of the month. To determine the spend down amount, subtract the MA income limit from the person's income. The recipient must spend or incur medical bills for the remaining amount.

**TIP:**

Individuals who are over the income limit for the Healthy Horizons category need to spend down to the SSI benefit level and not the Healthy Horizons income limit to be eligible for the “spend down” program.

The recipient does not actually have to pay the spend-down amount, as long the unpaid bills show the charges incurred. The bills must be due and owing (that is, not written off as a bad debt by the provider), and not previously used for spend down calculation.

Medical expenses should be either incurred or paid in the month of eligibility determination. Medical care that was received for free, such as services at a health clinic, can be used if the values of those services are documented. Each month the beneficiary needs to provide receipts and bills to the county assistance office to show the payment or the incurred charge of the spend down amount. Monthly review of the recipient's spend-down eligibility is not required when their income and non-MA-covered medical expenses are expected to remain the same for the next 11 calendar months, or the balance of calendar months remaining until the next re-determination.

The spend-down program allows client to use bills incurred in the past three months to meet MA eligibility for future months. For example, a recipient who has a \$10,000 hospital bill incurred in April can use that bill to meet the spend down on a new MA application made either in the months of May, June and July. However, if they apply for MA in August, they cannot use a bill from April because it is more than three months old.

For an unmarried adult with a disability, the spend-down amount is the SSI income limit, which is \$805.10 in 2020. For a couple the amount is \$1,208.30.

**EXAMPLE:**

Mr. Jones lives alone and is disabled. He gets a monthly SSDI check of \$1,190 a month. Even after reducing his income by bank fees and transportation costs, his income is still too high for Healthy Horizons. To be eligible for MA, he must spend down. Since he is disabled, he can spend down to the SSI income limit of \$805.10 per month. His monthly income (\$1,190) minus the SSI income limit (\$805.10) is \$384.90. Therefore, Mr. Jones must spend or incur \$384.10 on his medical needs each month before he becomes eligible for MA. Once he spends or incurs that amount, MA will pay the rest of his medical expenses for that month.

### § 5.3c.4 — Medical Assistance for Workers with Disabilities (MAWD)

Individuals under 65 years old who meet the SSA standard of disability and who work can purchase MA through the Medical Assistance for Workers with Disabilities (MAWD) program if their countable income (after disregards and deductions using the SSI method (see **Chapter 2, § 2.5a**) does not exceed 250% of the FPIG. The MAWD monthly income levels are set forth below in **Chart 5-6**. MAWD charges a premium of 5% of the recipient's countable income for full MA benefits. MAWD has no pre-existing condition exclusion for services.

MAWD can be used as primary insurance, or to supplement Medicare coverage.

Individuals receiving SSDI or SSI do not need to document disability. Applicants with chronic conditions who have not been determined disabled by the SSA can show disability by their medical provider certifying their disability. DHS will authorize MAWD “presumptively” for three (3) months based on a correctly completed Employability Assessment Form (Form 1663), Health Sustaining Medication Form, or a letter from the applicant's provider indicating the diagnosis and the duration the condition is expected to last. The applicant should then submit medical records to the CAO for onward transmission to the DHS Medical Review Team (MRT) for a determination of ongoing eligibility. The presumptive period can be extended an additional three months if there is difficulty obtaining the medical documentation.

The link to the forms and the rules of finding disability can be found here:

[http://services.dpw.state.pa.us/oimpolicymanuals/ma/316\\_MAWD/316\\_02\\_Deciding\\_on\\_Eligibility.htm](http://services.dpw.state.pa.us/oimpolicymanuals/ma/316_MAWD/316_02_Deciding_on_Eligibility.htm)

There is no minimum number of hours of work required to be eligible for MAWD and the work does not have to be “on the books.” Examples of work may include running an errand for an elderly neighbor or pet-sitting. Generally, one hour a week is enough with earning preferably the hourly minimum wage. Documentation can be a letter from the employer that includes the name of the worker, work done, amount paid, frequency of work and payment, and contact information for the employer.

MAWD beneficiaries must have resources below \$10,000, and be between age 16 and 64. The monthly premiums are 5% of the recipient's countable; Clients who have earned income (income from work) are eligible for earned income exclusion of \$65 plus a 50 % income disregard (see **Chapter 2, § 2.5a**). These exclusions make a client earning annual income up to **\$63,900** (in 2020) financially eligible for MAWD. Remember, the cost of “impairment related work expenses” can also be deducted from income. (This concept is discussed in **§ 2.12e**.)

The following chart provides the 2020 benefit levels for MAWD:

<b>Chart 5-6: Monthly Countable Income Level for Medical Assistance for Workers with Disabilities (250% FPIG) - 2020</b>	
<b>Family Size</b>	<b>Income</b>
1	\$2,659
2	\$3,592

\*Asset limit: \$10,000

DHS will include the income of the applicant's spouse living with the individual and use a two-person income limit to assess eligibility for the applicant. However, DHS will not count the income of children under age 21 living with the applicant.

Disabled workers enrolled in MAWD who continue to meet the SSA standard of medical disability do not have a minimum hours or earnings requirement. However, a client whose health has improved to the point that they are no longer medically disabled must work at least 40 hours per month at minimum wage in order to qualify.

MAWD coverage can start either in the month of application or the following month, at the applicant's choice. Retroactive coverage is available for the eligible applicant who can pay the premium for prior months. MAWD-eligible applicants with unpaid medical bills from the three calendar months prior to application can request retroactive coverage and pay the MAWD premiums for those months to have those bills paid by MAWD.

Premiums can sometimes be waived for up to two months if the recipient has temporary income changes due to health or loss of employment. A client can also choose to have his MAWD premium paid by payroll deduction. Recertification for MAWD eligibility is usually done every six (6) months.

A MAWD application form can be found here:

<https://www.dhs.pa.gov/Services/Assistance/Documents/Benefits%20Applications/PA-600-WD-AS-8-19.pdf>

### **§ 5.3c.5 — Health-Sustaining Medications Program**

The Health Sustaining Medications Program is a limited program of MA is available for adults who need medication in order to work. The program income limit is very low (See **Chart 7-1**). The resource limit is \$250 for one person and \$1,000 for two or more people.

Generally, individuals who are not eligible for any other MA category may obtain coverage under this program. Applicants for this program need to have their primary health care provider complete the DHS "Health-Sustaining Medication Assessment Form" (Form PA 1671 – linked here: [http://services.dpw.state.pa.us/oimpolicymanuals/ma/PA\\_1671-](http://services.dpw.state.pa.us/oimpolicymanuals/ma/PA_1671-)

[SG.pdf](#)

Applicants whose income is higher than the TANF/GA level will need to “spend down” to become eligible (see § 5.3.c.3 for a discussion of spending down). Because the amount to be spent down is often very high, this program is most useful for retroactive MA coverage of a catastrophic medical bill. For ongoing benefits, clients should be evaluated for eligibility for coverage through other programs or through marketplace coverage under the Affordable Care Act. (see Chapter 6)

### § 5.3.c.6 — Home and Community Based Services Waivers

**Home and Community Based Waiver programs:** The Waiver programs provide medical and non-medical services to individuals who need nursing home level care in their homes or in community-based settings. These programs allow older adults and individuals with disabilities to live independently as an alternative to nursing or other institutional care.

The designation “Waiver” relates to the procedure by which the federal government waives the states’ compliance with certain MA program requirements, and to permit home and community-based services to be provided to specific groups of recipients who may not otherwise qualify for MA.

In addition to MA coverage, Waivers provide services like personal assistance (assistance at home with activities of daily living such as bathing, dressing, toileting, medication reminders, meal preparation and some cleaning), home health, non-medical transportation, adaptive technology, and more. Services under Waiver programs are available as long as the estimated cost does not exceed the cost of institutional or inpatient care.

Applicants for Waiver programs must be over 21 years of age.

The income eligibility for the Waiver program is three times the federal SSI benefit rate each year. In 2020 the income limit is \$2,349 (\$783 x 3) a month. The income and resources of a spouse are not included in determining eligibility for Waivers. There are no income exclusions or disregards for calculating income for Waiver programs.

**TIP:**

There is a rare exception to the income limits for Waiver. If a Waiver recipient qualifies for MAWD (See § 5.3.c.4), they can use the higher MAWD income limits and MAWD income counting rules.

The Waiver programs have a resource limit of \$2,000 and a resource disregard of \$6,000. A Waiver recipient can therefore have up to \$8,000 in resources.

In addition, the program has spousal “impoverishment” allowances, which protects the resources of a spouse of a Waiver recipient. Recipients are also permitted to reduce excess resources above the resource limit on very specific medical or burial expenses.

Waiver beneficiaries age 55 and older need to be aware that DHS, through its Medicaid Estate Recovery rules, can file a claim against the Waiver service recipient's estate (after death) to recover the cost of Waiver services. If the beneficiary started receiving Waiver services prior to age 55, Estate Recovery only applies to the costs incurred after they turned 55.

**Waiver services for People living with HIV:** Waiver services are available to people living with HIV who need home health care and other supports and services because of the severity of their symptoms. The former AIDS Waiver program has been eliminated and people living with HIV may receive services under other Waiver programs.

Authorization for Waiver programs is a two-step process. First, applicants must be found clinically eligible for the program under the "Nursing Facility Clinically Eligible" (NFCE) standard. Individuals who, on a regular basis, have intermediate care needs (such as needing help with non-medical activities like bathing, dressing, transferring) OR skilled care needs (primarily medical in nature like skilled nursing, physical therapy, occupational therapy) can qualify as NFCE. Second, clients need to be found financially eligible for the program.

Applications for Waiver services can be initiated calling the PA Independent Enrollment Broker (IEB) at **877-550-4227**, or online through COMPASS, or on paper. A copy of the paper application can be found here:

[http://services.dpw.state.pa.us/oimpolicymanuals/ltc/PA\\_600\\_L\\_8-19.pdf](http://services.dpw.state.pa.us/oimpolicymanuals/ltc/PA_600_L_8-19.pdf).

Regardless of how the application is started, the IEB will do an in-home visit to explain the process and help with the application. The IEB will advise applicants to obtain a physician's certificate establishing they are NFCE. The local Area Agency on Aging is charged with assessing if applicants are NFCE. Based on this assessment and the physician's certificate, a Functional Eligibility Determination is performed and applicants will be found either NFCE or Nursing Facility Ineligible (NFI). If applicants are determined NFCE, their application will be forwarded to the local CAO for financial a eligibility determination. If they are found ineligible for Waiver services, a denial notice will follow, from which applicants have a right to appeal.

Once approved for Waiver services, recipients need to enroll in a Community HealthChoices (CHC) plan, to receive services. (§ 5.10). The CHC plans have contracted with home health agencies to provide the community-based services for Waiver beneficiaries.

Like all MA programs, Waiver services beneficiaries are required to do periodic recertification of their eligibility. Case managers should take an active role in assisting clients with the recertification process to make sure that their clients receive continuing coverage.

### § 5.3c.7 — Children with Disabilities (PH 95 category)

Disabled children whose parents’ income is too high for them to qualify for MA under the Healthy Beginnings program may be eligible under a special program historically known as “Loophole Children” category. The Department of Human Services categorizes this program as “PH 95.”

A child who meets the disability standards for SSI, but is ineligible because of a high family income, may get MA without regard to the parents’ income or resources. The child’s own income, however, is still counted, with a maximum amount being 100 % of the FPIG (\$1,064 in 2020). DHS will evaluate a child for this category as a last resort. Chart 2- on page 2- sets forth these income limits. Examples of children’s income are earnings from a job, interest or dividends from bank accounts or other investments in the child’s name. Court-ordered child support and Social Security survivor’s benefits are not considered.

This MA category does not have a resource limit. If the child eligible for PA 95 has private health insurance, MA will pay for services that are not covered by the private insurance.

**§ 5.3c.8 — Programs for Non-Disabled Adults**

Non-disabled adults not otherwise eligible for MA may get coverage through:

- Medicaid expansion with income up to 138% of the FPIG (§ 5.2)
- “Medically Needy Only” Program (MNO) (§ 5.3.c.9);
- Health-Sustaining Medications Program which is a limited program for clients who need medication in order to maintain work activity (§ 5.3.c.5).

**§ 5.3c.9 — “Medically Needy Only” Program**

Single adults who do not qualify for any other MA categories may apply for MA under the “Medically Needy Only” (MNO) program if they meet strict income limits and are in one of several narrowly-defined groups. Applicants are evaluated for this program only if they are not eligible for other MA coverage due to excess income or resources, but their income and resources are insufficient to meet their medical needs. This program is also used to provide retroactive coverage for recent medical bills through a spend down.

The income limits for MNO are determined by looking at the beneficiary’s household income over a six-month period. The income limit for one person for six months is \$2,550 (or \$425 a month); for two people the limit is \$2,650 (or about \$442 a month). The resource limit for one person is \$2,400.

<b>Chart 2-6: Medically Needy Only Program (2020)</b>	
<b>Family Size</b>	<b>Income Level (6 month period)</b>

1	\$2,550
2	\$2,650
3	\$2,800
4	\$3,400
5	\$4,050
6	\$4,550
Each Add'l	\$550

In addition to meeting the income limits, the beneficiary must belong to one of the following categories:

- parents or step-parent caring for a dependent child under 21 years of age
- adults age 59 or older
- adults between ages 21 to 58 working 100 hours or more a month and earning at least a total of the minimum wage times 100 (note: individuals working at this level, may not be income eligible without a significant spend down).

In unusual circumstances, MNO may be the program of choice for a few clients. However, with the Medicaid expansion, most non-disabled adults can now qualify for MA (§ 5.2).

Non-disabled adults without children can spend down to the MNO limit based on their income or expected income over a six-month period, or they can spend down to the lower GA income limit each month. For the six-month spend-down, the client's income has to be \$425 or less per month. For the one-month spend-down, the client's income must be \$205 a month or less. Remember that there are income deductions for working people that will decrease the spend-down amount.

There are several other categories of clients who may be eligible for MA given their income, household composition and circumstances. A few such categories follow.

#### **§ 5.3c.10 — TANF “Spend Down” Program**

MA may be available for families without regard to disability (non-disabled parents with non-disabled children) if they can spend down to the TANF limit for their family size, even though the family is not eligible for TANF because of income.

The TANF limit is the amount of the TANF grant for that family size. For example, a parent with two children would currently receive a TANF grant of \$403 a month; thus, that family must spend down to that income limit (TANF benefit levels are set forth in **Chart 8-1**). In calculating spend down, keep in mind that a family can deduct expenses incurred to receive or obtaining the income, such as travel expenses, bank service charges, and attorney's fees. There are other allowable deductions including: earned income incentive deductions, work expenses, dependent care expenses and medical expenses.

#### **§ 5.3c.11 — Persons Residing with Minor Child under 13 or Disabled Child over 13**

MA may also be available to parents residing in the same household with a child who is under age 13 or a child over 13 receiving SSD or SSI benefits, even if the child does not qualify for TANF benefits.

#### **§ 5.3c.12 — Caretaker of an Ill or Disabled Household Member**

Caretakers of an ill or disabled household member or of an unrelated child younger than 13, are eligible for MA. The income limit of the caretaker cannot exceed \$205 a month and the resource limit is \$250 for one person and \$1,000 for two persons. If the caretaker is exercising care and control of a child under 21 then there is no resource limit. The caretaker should provide a physician's note explaining the disability of the person for whom they are providing care, and the care needed. They should also demonstrate that there is no one else in the household who can take care of the disabled person.

#### **§ 5.3c.13 — Custodial Parent**

MA also is available for a custodial parent exercising care and control of a dependent child under age 21. The custodial parent must be between the ages 21-58. The custodial parent can be eligible for MA even if the child is away from home in college but maintains a legal residence with the parent and the child is under the care and control of the applicant parent. Furthermore, even if both parents of the child reside in the same household, the unmarried (custodial) parent may receive this MA without consideration of the other parent's income.

#### **§ 5.3c.14 — Persons in Drug and Alcohol Treatment**

A person undergoing drug and alcohol treatment can be eligible for MA if the treatment program precludes work. This MA category has a lifetime limit of nine (9) months, so establishing eligibility in another category if possible is advised. The income limit for this program is \$205 per month for one person in most counties, including Philadelphia; for two people, \$316 per month; and for three people, \$403 per month. The resource limit is \$250 for one person and \$1,000 for two or more people.

#### **§ 5.3c.15 — Victims of Domestic Violence**

Medical Assistance is also available for victims of domestic violence who are receiving or trying to receive services. This MA category also has a lifetime limit of nine (9) months. So establishing eligibility in another category if possible is advised. The income limit for this

program is \$205 per month for one person in most counties, including Philadelphia; for two people, \$316 per month; and for three people, \$403 per month. The resource limit is \$250 for one person and \$1,000 for two or more people.

#### § 5.4 Special Programs

There are several other programs that can provide help to individuals with income too high for MA. Some of these programs are discussed below.

##### § 5.4a — Special Pharmaceutical Benefits Program

Pennsylvania's Special Pharmaceutical Benefits Program (SPBP) is a program funded by the Ryan White C.A.R.E. Act and administered by the Pennsylvania Department of Health. SPBP pays for prescription medications and some laboratory testing for people living with HIV or diagnosed with schizophrenia. More information on the SPBP can be found here: <https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx>

SPBP is not an MA program. It is a program designed to help low-to-moderate-income people living with HIV receive their medications. SPBP is a payer of last resort which means all other insurance must be billed before SPBP will pay for the participants' medication and labs.

SPBP determines eligibility based on **500%** FPIG using *gross* income. There is no asset limit for SPBP eligibility. The income limits for 2020 are as follows:

Chart 2-7 Income Limits for Special Pharmaceutical Benefits Program	
NUMBER HOUSEHOLD MEMBERS	ALL APPLICANTS (new applicants and re-enrollees)
1	\$63,800
2	\$86,200
Each additional person	Add \$22,100

<https://www.health.pa.gov/topics/Documents/Programs/HIV/Income%20Quick%20Reference%20Guide.pdf>

**SPBP and Other Coverage:** To be eligible, an applicant cannot have prescription drug coverage through MA. SPBP participants who have Medicare should enroll in Medicare-SPBP partnered prescription drug plan. SPBP will then cover their plan premiums, co-payments and deductibles. (See **Chapter 4** for more information on SPBP and Medicare). For those with private insurance, SPBP will cover co-payments and deductible for SPBP formulary drugs.

**TIP:**

People with both Medicare and MA (“dual eligible”) generally do not have prescription coverage through MA. These individuals can have SPBP as a supplement to their Medicare Part D Plans (See Chapter 4).

**SPBP Eligibility:** Applicants must submit an application and documentation which shows:

- Current Pennsylvania residency (not institutionalized)
- Social security number
- Physician's certification of HIV diagnosis with prescription for a SPBP-covered medication
- Annual income (See **Chart 5-7**).

Applicants should closely follow the instructions in the SPBP application form when applying for the benefit. The SPBP paper application form can be found here:

<https://www.health.pa.gov/topics/Documents/Programs/HIV/Special%20Pharmaceutical%20Benefits%20Program%20Full%20Application%20-%20Effective%2004-17-18.pdf>

SPBP information and its online application can be found here:

<https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx>

SPBP beneficiaries must comply with a semi-annual re-determination of eligibility. The semi-annual reporting form can be found here:

<https://www.health.pa.gov/topics/Documents/Programs/HIV/Special%20Pharmaceutical%20Benefits%20Program%20Express%20Application%20-%20Effective%2004-17-18.pdf>

For more information on this program, call the SPBP office at **1-800-922-9384**.

#### **§ 5.4b — Breast and Cervical Cancer Prevention and Treatment Program**

Under the Breast and Cervical Cancer Prevention and Treatment Program (BCCPTP), full MA coverage is available to uninsured Pennsylvania women with cancer, or pre-cancerous conditions of the breast or cervix. The program extends MA to women screened for these diseases through the Pennsylvania Breast & Cervical Cancer Early Detection Program (PA-BCCEDP), administered by the Pennsylvania Department of Health.

There is no income or resource limit for the BCCPTP program. However, to qualify for the screening by the PA-BCCEDP program screening, household income may not exceed 250 % of the FPIG; (See **Chart 5-6** above). Additionally, to be eligible for BCCPTP a woman must be: (1) under 65, (2) screened and diagnosed through the PA-BCCEDP site, (3) uninsured or have no creditable healthcare insurance, (4) a resident of Pennsylvania, (5) a U.S. citizen or qualified alien, and (6) have a social security number.

Unlike most other MA categories, eligibility for this program is diagnosis-dependent. Eligibility begins on the date of positive diagnosis for breast or cervical cancer, including

pre-cancerous conditions of the breast or cervix, and will continue until the individual no longer needs treatment; turns 65; obtains creditable medical coverage; or fails to complete a redetermination or verify creditable coverage.

Additional information can be found here:

<https://www.health.pa.gov/topics/programs/Pages/PABreastandCervicalCancerEarlyDetectionProgram.aspx>

### § 5.4c — Pharmaceutical Company Patient Assistance Programs

**HIV Patient Assistance Programs:** Clients who are financially ineligible for SPBP (§ 5.4.a) or do not have any prescription coverage through MA or private insurance may consider applying for Patient Assistance Program (PAP). These programs, run by pharmaceutical companies, offer free HIV drugs to people who do not have any drug coverage and cannot afford medication. To be eligible for PAP coverage, the individual cannot have private insurance, Medicare, MA or SPBP. Eligibility for PAP is based on income and varies for each drug company. In some instances, drug companies are able to make exceptions to their income guidelines and provide coverage if applicants can show economic hardship. Case manager advocacy is important in seeking exceptions.

See **Chart 5-9** below for drugs covered and for contact information for drug companies in this program. For more information on the drug companies, eligibility requirements, and drug coverage visit the Medicine Assistance Tool at [medicineassistancetool.org](http://medicineassistancetool.org)/or call 1-888-4PPA-NOW (1-888-477-2669).

<b>Chart 5-9 - Pharmaceutical Company Patient Assistance Programs</b>		
<b>Name of company</b>	<b>Drugs covered</b>	<b>Contact information</b>
Abbvie (formerly Abbott)	Kaletra, Norvir	1-800-441-4987 (visit individual product website)
Boehringer Ingelheim	Aptivus, Viramune	1-800-556-8317 <a href="http://www.boehringer-ingelheim.us/our-responsibility/patient-assistance-program">www.boehringer-ingelheim.us/our-responsibility/patient-assistance-program</a> .
Bristol-Myers Squibb	Evotaz, Reyataz, Sustiva,	1-888-281-8981 ( <a href="https://www.bms.com/patient-and-caregivers/get-help-paying-for-your-medicines.html">https://www.bms.com/patient-and-caregivers/get-help-paying-for-your-medicines.html</a> )
Genentech	Fuzeon, Invirase	1-866-422-2377 <a href="http://www.genentech-access.com">www.genentech-access.com</a>

Gilead Sciences	Atripla, Biktarvy, Complera, Descovy, Emtriva, Genvoya, Stribild, Truvada, Tybost, Viread	1- 877-505-6986 (visit individual product website)
Janssen Therapeutics	Edurant, Intelence, Pezcobix, Prezista, Symtuza	877-227-3728 or www.janssencarepath.com/
Merck & Co	Delstrigo, Isentress, Pifeltro	1-800-727-5400 www.merckhelps.com/
Pfizer GlaxoSmithKline ViiV Health Care	Combivir, Epivir, Epzicom, Juluca, Lexiva, Rescriptor, Retrovir, Selzentry, Tivicay, Triumeq, Trizivir, Viracept, Ziagen	844-588-3288 or www.viivconnect.com

#### § 5.4d — PACE and PACENET

These programs, administered by the Pennsylvania Department of Aging, are designed to provide low-cost prescription drug coverage to senior citizens. To be eligible for these programs the client must be (1) 65 or older, (2) a resident of Pennsylvania for 90 days, (3) meet the program income limit, and (4) not receiving prescription drug benefits from MA. These programs function as a wraparound program for Medicare. Applicants cannot be receiving prescription drug coverage from MA.

PACE and PACENET programs do not have an asset/resources limit. The income limits for both these programs, based on the applicant's previous calendar year's gross income, are as follows:

<b>Chart 5-10: Income Levels for PACE and PACENET (2020)</b>			
<b>Family Size</b>	<b>PACE</b>	<b>PACENET</b>	<b>Resources Limit</b>
Single	\$14,500	\$14,500 - \$27,500	None
Married	\$17,700	\$17,700 - \$35,500	None

**PACE and PACENET Co-pays:** Program enrollees pay the following co-pay for each prescription drug at the pharmacy:

<b>Program</b>	<b>Generic drug</b>	<b>Brand name drug</b>
PACE	\$6	\$9
PACENET	\$8	\$15

For clients on Medicare and PACE/PACENET, see **Chapter 4**

The state contracts with Magellan, an independent broker, for enrollment in these programs. Individuals can enroll in in these two programs through Magellan’s website at: <https://pacecares.magellanhealth.com/>

For assistance with the application process, call PACE/PACENET Cardholder Services toll free at **1-800-225-7223** or visit the Pennsylvania Department of Aging website at <https://www.aging.pa.gov/aging-services/prescriptions/Pages/default.aspx>

#### **§ 5.4e — Chronic Renal Disease Program (CRDP)**

The Chronic Renal Disease Program (CRDP) is run by the Pennsylvania Department of Health and provides life-saving care and treatment for adults with end-stage renal disease. The CRDP assists with costs related to dialysis services, renal transplant, medical management, inpatient and outpatient service, home dialysis supplies and equipment, medications, and limited patient transportation.

To be eligible for the program, applicants must (1) have end-stage renal disease and be receiving dialysis or have had a kidney transplant, (2) be a U.S. citizen or permanent resident, (3) have lived in Pennsylvania for at least 90 days prior to the date of the application or show that they plan to live permanently in the state, (4) have income under 300% of the Federal Poverty Guidelines.

Application and additional information on the CRPD can be found here: [https://www.health.pa.gov/topics/Documents/Programs/Chronic%20Renal%20Disease/CRDP\\_CrdHldr\\_Enrlmnt\\_App.pdf](https://www.health.pa.gov/topics/Documents/Programs/Chronic%20Renal%20Disease/CRDP_CrdHldr_Enrlmnt_App.pdf)

Additional information on CRDP and how it works with Medicare Part D can be found in **Chapter 4**.

#### **§ 5.5 Emergency Medical Assistance**

Emergency Medical Assistance (EMA) is the only type of MA available to people whose immigration status makes them ineligible. To qualify, individuals must meet the residency, income and resource, and categorical requirements, and have an “emergency medical condition” as defined by the DHS.

EMA is not a separate MA program, but a way to get care for an emergency despite immigration status. The applicant still has to prove they meet the eligibility requirements for MA.

DHS defines an Emergency Medical Condition (EMC) as a “medical condition with acute symptoms of such severity, including severe pain, that without immediate medical attention, the result may be: (1) patient’s health is in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any body organ or part.” Unfortunately, chronic conditions do not qualify as EMCs.

The applicant must have documentation from a physician certifying the emergency condition, the need for immediate treatment, the type of treatment and the anticipated end date of the emergency condition. The PA 1917 form may be used to verify the applicant's emergency medical condition. That form can be found here:

<https://www.aidslawpa.org/wp-content/uploads/2020/04/PA-1917.pdf>

Advocates should work with medical providers on EMC verification. Make sure that the medical provider:

- Primarily identifies the Emergency Medical Condition (and not the underlying chronic condition);
- States that the patient meets one (or more) of the EMC definitions using the exact language of the definitions
- Specifies the need for immediate medical treatment resulting from the Emergency Medical Condition (use the language from the definition as appropriate) (e.g. “without immediate medical attention this condition could reasonably be expected to result in serious jeopardy to Patient's life.”)
- Provides an end date for the Emergency Medical Condition using real calendar dates. As a general rule, asking for more than a 6-month authorization decreases the chance of approval. It is better to ask for a shorter period of time and a re-authorization if needed.
- States that the need for treatment is “immediate.”
- Specifies the kinds of treatments which will be needed; for example, doctor's visits, hospitalization, pharmaceuticals, or surgery.
- States the specific treatments, including duration/frequency of treatments, necessary diagnostic testing, and names of medications that are or may be required.
- If possible, explains the consequences if no treatment is administered (paralysis, death, future expensive emergency treatment)

EMA will only cover the medical care needed to diagnose and treat the emergency medical condition.

## § 5.6 Medical Assistance Application Process

**Applying in person/paper:** Individuals can apply for MA at the CAO by filling out the common application form, Form PA 600 linked here:

<http://services.dpw.state.pa.us/oimpolicymanuals/ma/PA%20600.pdf>. Form PA 600 is

called the common application form because you can also apply for cash assistance, SNAP benefits and other benefits with this form. The applicant should be sure to bring all the paperwork documenting identity (birth certificate, Social Security card, or driver's license) and residence (such as a lease, rent receipts, bills addressed to the applicant at their address). Individuals should not delay applying because they lack a particular document. The CAO caseworker should tell the applicant exactly what they need and will provide an appointment for them to return and complete the application. A face-to-face interview is not required for Medical Assistance.

**Applying Online:** Applications can be completed online at COMPASS (The Commonwealth of Pennsylvania Application for Social Services) for Medical Assistance, SNAP and TANF benefits at (<https://www.compass.state.pa.us/compass.web/Public/CMPHome>). Online applications are routed to the local CAO that serve the applicants' geographical area.

**Applying by phone:** Applicants can call DHS' Customer Service Center for Health Care Coverage at 1-866-550-4355 to start the application process.

**DHS Interim Approval:** If an applicant reports on their application that they need medical treatment right away (e.g., to get a prescription filled immediately, or to see a physician), DHS can issue an emergency card (known as an "interim medical card") or MA number within 24-48 hours. The applicant need not prove that they already have a physician's appointment or an urgent medical need. If the caseworker refuses to issue an interim card or MA number, the applicant should speak to a supervisor and explain why the authorization for service is needed right away. Caseworkers can also issue a temporary paper card, valid for 30 days, which will provide coverage for physician's visits necessary to complete MA paperwork.

**Expedited MA Approval:** Generally, DHS has 30 days from the date of application to make a decision to authorize or deny client's application. The caseworker, however, is supposed to authorize coverage as soon as the applicant returns all the requested paperwork. DHS has a procedure to expedite the process of MA applications when an applicant indicates a medical emergency and will expedite the MA applications, making every effort to complete them within *five business days* of receipt of the request for emergency MA.

Note that the Waiver Programs, § 5.3.c.6), Special Pharmaceutical Benefits Program § 5.4.a), Breast and Cervical Cancer Prevention and Treatment Program § 5.4.b), PACE and PACENET (§ 5.4.d) and Chronic Renal Disease Program § 5.4.e) have their own application procedures, as described in those sections.

## § 5.7 Covered Services

When approved for MA, and applicant's benefit package will depend on their age, the category under which they were approved, and the program status code. Generally, MA pays for all medically necessary services, such as, doctors' visits, hospital stays, mental health services, prescriptions, medical supplies, most dental care, and nutritional

evaluations and supplements for some. A detailed list of MA benefits packages for different categories can be found here:

[http://services.dpw.state.pa.us/oimpolicymanuals/ma/health\\_care\\_benefit\\_packages.pdf](http://services.dpw.state.pa.us/oimpolicymanuals/ma/health_care_benefit_packages.pdf)

In Pennsylvania, most forms of MA are administered through private insurance plans paid for by MA, called HealthChoices and Community HealthChoices. These plans are required to cover all the services in the MA benefit package. They may offer more services than DHS' HealthCare Benefits Package, but cannot offer less. New recipients will be offered plan options through HealthChoices or Community HealthChoices. When selecting the best plan, beneficiaries should choose a plan that has their providers in its network, and should keep in mind their specific health needs,

If a plan refuses to provide something a plan member needs, the options are to switch to a different plan, the client can switch to an HMO that does provide the service. Be sure to check that the new HMO covers as many of your client's needs as possible. You can also appeal or file a grievance, as described in this Chapter.

### **§ 5.8      Appealing Denials or Terminations of MA**

If individuals receive a notice that their MA is being terminated or their application for MA is being denied, it is important to file an appeal right away. There are 30 days to file an appeal from the date of the notice of denial or discontinuance of benefits. If the appeal is not filed timely, the right to appeal may be lost, unless the person can show that DHS was, in some way, at fault for the delay. If an appeal of a termination is filed within **15 days of the notice**, the benefits will continue until the appeal is resolved.

Winning on appeal means that the benefits will be authorized back to the date of wrongful discontinuation or denial.

If the welfare office discontinued or reduced benefits without a written notice, the beneficiary has a right to ask the CAO to reinstate the benefits and send proper notice first. DHS must comply with this request and reinstate the benefits without any lapse in coverage.

Clients who receive an adverse notice should always be encouraged to file an appeal immediately to make sure that benefits continue and that the appeal deadline is not missed. There is no harm in filing an appeal and withdrawing it later. Upon filing an appeal, the CAO should offer a prehearing conference to see if the appeal can be resolved without a hearing. Clients should provide the welfare office with verification to prove continuing eligibility for benefits and keep proof that they supplied it. The CAO should never ask appellants to withdraw their appeals until a notice of eligibility has been received.

If your client needs legal representation with an MA termination or denial, refer them to the AIDS Law Project or your local legal service organization without delay.

### **§ 5.9      Reopening Benefits**

Beneficiaries whose MA was recently denied or discontinued, but who complete the application/recertification process late by submitting all items needed to establish or re-establish eligibility within 60 days, do not need a new application.

A client still within the appeal deadline should file an appeal from the denial, discontinuance or reduction and pursue the appeal.

### § 5.10 Pennsylvania Managed Care Overview

HealthChoices is the name of Pennsylvania's mandatory managed care program MA recipients. All MA recipients are required to enroll in the managed care program to obtain their healthcare coverage.

**Managed Care:** Under the managed care program, a health maintenance organization (HMO) receives a flat capitated monthly payment for each MA recipient enrolled in the plan. In turn, the HMO is responsible for ensuring that the enrollees have access to a comprehensive range of medical services. Each HMO provides the same basic services although each may have a different network of physicians, hospitals and pharmacies that provide services under their plan.

All MA recipients, whether they have MA only or have Medicare with MA, must join a Managed Care Organization (MCO). When an MA recipient is enrolled in a MCO, all eligible services should be covered by the monthly payment to the managed care plan. The MCO receives the same monthly payment from DHS per member whether a patient receives no medical care, sees their physician a few times a year for minor ailments, or has complex medical needs. One of the challenges of managed care programs is to ensure that there is no cost cutting and cost saving by limiting the expensive care needed by people living with HIV and other illnesses.

**Physical Health Managed Care Organizations (PH-MCO):** A stated goal of a (PH-MCO) is for recipients to receive quality medical care and timely access to all appropriate physical health services, whether the services are delivered on an inpatient or outpatient basis. The Office of Medical Assistance Programs (OMAP) arm of DHS oversees the physical health components of the managed care program.

Recipients are encouraged to choose their PH-MCOs based on whether their medical providers participate in the plan that they choose. Recipients may change their PH-MCO at any time. A list of PH-MCOs and their contact information can be found here: <http://www.healthchoices.pa.gov/info/about/physical/index.htm>

**Behavioral Health Managed Care Organizations (BH-MCO):** The stated goal of a (BH-MCO) is for recipients to receive quality and timely access to appropriate mental health and/or drug and alcohol services. The Office of Mental Health and Substance Abuse Services at the DHS oversees the mental health components of the managed care program.

For Behavioral Health Services (including mental health and drug and alcohol services), MA recipients are enrolled in the BH-MCO available in their county and do not have the option of choosing their BH- MCO. A list of BH-MCOs for all Pennsylvania counties can be found here: <http://www.healthchoices.pa.gov/providers/about/behavioral/>

**Community HealthChoices (CHC):** Community HealthChoices is Pennsylvania’s mandatory managed care program for beneficiaries aged 21 or older who have both Medicare and Medicaid, or beneficiaries who receive long-term services and supports through Medicaid because of their need for help in activities of daily living. CHC is overseen by the DHS’ Office of Long-Term Living.

**CHC plans** are responsible for providing all services that an MA recipient was receiving before CHC was introduced in Pennsylvania in 2018. CHC is currently being rolled out in the entire Commonwealth other than the Southwest and the Southeast regions, where CHC was implemented in 2018 and 2019 respectively.

The implementation of CHC does not affect the receipt of Medicare services. Medicare recipients (who also have MA with CHC) will continue to see their Medicare provider with either their Medicare card or their Medicare Advantage card and continue getting treatment. Any services not covered by Medicare and the Medicare cost sharing will be paid by the CHC card. Medicare providers need not be enrolled or be in the CHC plan’s network to be able to bill for the balance services. They can also refuse to bill the CHC plan. If they decide not to bill the CHC plan for the balance, they are prohibited by law from balance billing the client. If clients are being balance-billed by a Medicare provider’s office, Case Managers should advocate to have balance-bills waived or call the AIDS Law Project of Pennsylvania.

MA recipients in CHC plans who do not have Medicare need to compare plans and makes sure that all of their medical providers are in the network of the CHC plan that they choose to enroll in.

Clients and case managers can call the PA Independent Enrollment Broker (IEB) 1-844-824-3655 or use [www.enrollchc.com](http://www.enrollchc.com) to enroll in a CHC.

**Fee-For-Service (FFS):** Under the fee-for-service program, medical providers are paid directly by the DHS for every MA eligible service rendered to the client. Services under the FFS program are obtained with an ACCESS card. FFS is available only in the following situations (1) the few days/weeks following MA approval before enrollment in an MCO plan; (2) when retroactive medical coverage is authorized to have medical bills paid (3) Emergency Medical Assistance coverage (§ 5.5) (4) clients on 5-year bar on state funded GA-related MA (See **Chapter 9**)

### **§ 5.10a — Managed Care Organization Mandated Services**

All medical services that were available to MA recipients before the implementation of the managed care programs are still available under HealthChoices and Community

HealthChoices. There is no pre-existing condition exclusion in HealthChoices or any other health-based restrictions on joining an HMO.

### § 5.10a.1 — Physical Health Mandated Services

HealthChoices HMOs are required to provide all medically necessary services to children, and only required to provide adults with medically necessary MA covered services. The services offered to MA recipients for physical health can be found here:

[http://services.dpw.state.pa.us/oimpolicymanuals/ma/health\\_care\\_benefit\\_packages.pdf](http://services.dpw.state.pa.us/oimpolicymanuals/ma/health_care_benefit_packages.pdf).

The HMOs may choose to offer more, but may not provide less.

“Medically necessary care” is defined as services reasonably expected to:

- prevent the onset of an illness, condition or disability;
- reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;
- assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

Federal regulations list the following as covered by MA:

- physician visits
- basic dental care, including periodontal and orthodontic care
- family planning
- vitamins
- emergency care 24 hours a day
- emergency transportation (ambulance)
- hospitalization (except for mental health and substance abuse, covered by the behavioral health care plans)
- laboratory tests and diagnostic tools
- home health care
- prescription drugs

- hospice care
- first consecutive 30 days of nursing home care, then members are provided with fee-for-service coverage
- physical therapy
- speech therapy
- purchase and rental of durable medical equipment such as wheelchairs, hearing aids, nebulizers and apnea monitors

### **§ 5.10a.2 — Mental Health and Substance Abuse Mandated Services**

Mental health and substance abuse services, referred to as “behavioral health care,” are provided through BH-MCOs. When clients enroll in a HealthChoices HMO, they are automatically assigned to a BH-MCO of their county. MA recipients do not get to choose their BH-MCOs. A client’s HealthChoices HMO or PCPs should be able to explain how to obtain mental health and substance abuse care.

BH-MCOs must offer the following services:

- Drug and alcohol detoxification
- Drug and alcohol rehabilitation
- Drug and alcohol outpatient services
- Methadone maintenance clinic
- Psychiatric hospital services
- Partial hospitalization
- Outpatient psychiatric services
- Psychiatric clinic
- Behavioral health services for children and adolescents
- Residential treatment for children and adolescents
- Lab services
- Other behavioral health prescriptions (filled by your physical health plan’s pharmacies)

Each plan may provide more services. Clients or case managers may contact the behavioral health plan for more specific information about the additional services provided by the BH-MCOs.

**Emergency Psychiatric Services:** In the event of a psychiatric or other behavioral health emergency, case managers or other advocates should call the telephone numbers listed in the Appendix for the BH-MCOs. If there is no response, or if the client also has a physical health emergency, the client should go to a hospital in their “physical health” HMO plan.

#### **§ 5.10b — Services Not Provided**

Certain categories of health care services are not provided under HealthChoices:

- experimental treatment
- nursing home care for more than 30 days (at which time the person will be switched back to fee-for-service)
- cosmetic/plastic surgery, unless needed because of an injury
- personal items or services while in the hospital, such as a phone or television

#### **§ 5.10c — HealthChoices HMO Enrollment**

PA Enrollment Services has contracted with DHS to act as the benefits consultant for enrolling clients in HealthChoices. The HMOs are not permitted to directly market to MA recipients. PA Enrollment Services will assist the client in comparing plans available in their county based on the client’s medical needs.

Enrollment and change in HMO can be done in one of the following manners:

- Phone: **1-800-440-3989**
- TTY: **1-800-618-4225**
- Online: **www.enrollnow.net**
- Email: **PAenrollnow@maximus.com**

The enrollment website provides useful information on enrollment procedures, advice on choosing a doctor, health benefits and services, children and teen services, transportation assistance and similar services. MA recipients may also call the HMOs directly to enroll. Recipients who wish to designate a specialist as a PCP or remain with their out-of-network provider will need to contact the HMO directly.

To locate the name and number of an HMO in your area you can go to the PA Enrollment Services website or if your client has chosen the HMO you may check the link above for the contact information and enroll directly with the HMO.

### § 5.10c.1 — Selecting an HMO

**Provider Networks:** The HMOs contract with doctors, nurses, and hospitals to become part of their provider networks. Once a person selects an HMO, the patient is generally allowed to get health care only from a provider who is in the HMO's network. There are a few rules that permit seeing an "out of network" provider, but only in exceptional cases. The HMO networks are required to have an adequate number of PCPs specializing in the treatment of persons living with HIV.

Each HMO is required to give its members a copy of its Provider Directory, which lists the names and addresses of its participating PCPs and their affiliated hospitals. The directories should also identify languages spoken at primary care sites. The HMOs must have adequate numbers of pediatricians in the network to permit all parents wishing to have a pediatrician as their child's PCP within the travel requirements.

If a visit to a specialist is needed, the HMOs can require a member to see one in their network. They must, however, have at least two specialists in every specialty area, or the member can request an out-of-network specialist. A member who is denied this request has a right to appeal.

Each MA recipient enrolled in HealthChoices must select an HMO. Recipients who do not enroll in an HMO will be auto-enrolled. Each MA recipient enrolled in HealthChoices must also select a primary care physician (PCP). A recipient can select a provider specializing in HIV treatment as their PCP as long as the provider is within the HMO's network and agrees to act as the PCP. Recipients will be assigned a PCP if they do not choose one.

Case managers should be prepared to give clients assistance in selecting an HIV-experienced PCP. In southeastern Pennsylvania, clients may check the website of the AIDS Library, a project of Philadelphia FIGHT ([www.aidslibrary.org](http://www.aidslibrary.org)) for a listing of HIV-experienced providers. To assist an MA recipient in selecting a PCP, case managers may also search on the PA EnrollNow website, or call PA Enrollment Services.

The PCP is responsible for:

- providing primary and preventive care
- recommending and arranging for care
- maintaining continuity of each member's health care

- making referrals for specialty care and other medically necessary services both in and out of plan

### § 5.10c.2 — Auto-Assignment

MA recipients who fail to select an HMO will be automatically assigned an HMO according to a formula developed by DHS. Generally, however, MA recipients are required to select their HMO upon MA approval. Auto-assignment rules require that:

- All family members will be assigned to the same HMO.
- A person who loses MA eligibility and regains it within six months will automatically be reassigned to the most recent HMO, unless they signed a disenrollment form.

If an assignment mistake has been made, it should be corrected immediately.

Once an individual is assigned to an HMO, but has not selected a PCP, the HMO is required to contact the person within seven days to provide information on selecting a PCP. The HMO must immediately contact members requiring a high level of care.

If the member does not choose a PCP within 14 days of enrollment, the HMO will select a PCP for the member. The HMO must consider the special needs of each member when assigning a PCP and ensure that the member's PCP is trained and experienced in treating the member's needs. The HMO should take into account the following factors:

- the member's current health care provider
- whether there are children requiring a pediatrician
- special medical needs, such as HIV
- language needs

Members can change PCPs if dissatisfied after the first visit.

### § 5.10c.3 — Special Concerns of People living with HIV

**Selecting a specialist as a PCP:** many people living with HIV need a physician specializing in infectious disease (ID). Normally, services of a specialist are only available upon referral from a PCP. These clients should be encouraged to designate their ID specialist as their PCP. HealthChoices allows a specialist to be designated as a PCP, eliminating the need for constant referrals. HMOs must also provide a pediatrician as a PCP for children if requested by a parent.

**Maintaining Continuity of Care:** Many people living with HIV have an established relationship with their physician and are on a complicated course of treatment. They may experience adverse health effects when switching to another physician because of the interruption in treatment.

When an HMO member receives care from a provider who is not included in the HMO's network, the HMO must ensure continuity of care without interruption by authorizing the recipient to continue receiving treatment from the current provider, or by facilitating an uninterrupted transition into an equivalent course of treatment received from providers within the HMO network. In other words, it may be possible to stay with the current doctor, at least temporarily, but it might require work to ensure this happens. Clients in this situation can call the Special Needs Unit of any one of the HMOs to discuss this issue prior to enrolling with that HMO.

#### **§ 5.10c.4 — Changing HMOs or PCPs**

An HMO member can change to a new HMO at any time for any reason. To change HMOs, the member should call PA EnrollNow at **1-800-440-3989** and request that they be enrolled in a new HMO. Generally, coverage from the new HMO begins on the first of the following month. It can take between 15-30 days for the change to take effect, depending on when in the month the member requests the change. While the change is being processed, the member may continue to see their current PCP.

A member can change PCPs within an HMO network at any time by contacting the HMO's member services representative. The HMO should simply change its computer listing and there should be no interruption of services. The member should verify that the change will be immediate without any interruption in access to the new provider.

#### **§ 5.10c.5 — HMO Card and ACCESS Card**

After clients have been approved for MA, the DHS will send the client an ACCESS card. MA recipients should carry this card at all times and use it whenever they receive health care services. After they are enrolled in an MCO, the MCO will send their HMO cards. Clients should start using the HMO card to receive health care.

#### **§ 5.10c.6 — Minimum Standards for HMO Services**

The HealthChoices rules establish that HMOs must provide 24-hour service, make services available in the member's geographic area, and adhere to specific scheduling standards for office appointments.

#### **§ 5.10c.7 — Twenty-Four Hour Service**

The HMO must provide medical services to its members 24 hours a day, seven days a week, either directly through the PCP or through other providers as needed on an emergency basis. Each HMO must have a toll-free member hotline staffed 24 hours a day,

seven days a week. The hotline must be accessible to those with hearing impairments and provide necessary translation services. Hotline staff must be trained in the special needs of members, including people living with HIV. The HMO hotline is required to be answered within five rings and can put people on hold for no more than three minutes.

#### **§ 5.10c.8 — Travel Time to Providers**

Every HMO must make available to every member a PCP whose office is located no further away than **30 minutes** travel time in urban areas, and **60 minutes** travel time in rural areas.

#### **§ 5.10c.9 — PCP Appointment Scheduling Standards**

Emergency patients must be seen immediately or referred to an emergency facility. Urgent cases must be scheduled within 24 hours. Routine appointments must be scheduled within 10 business days. Health assessment/general physical exams and first exams must be scheduled within three weeks.

The average waiting room time should be no longer than 20 minutes, or up to one hour when the provider has an unanticipated urgent visit or is treating a patient with a difficult medical need.

A PCP/specialist appointment should be scheduled within seven days of enrollment of anyone known to be living with HIV unless the enrollee is already in active care with a PCP or specialist.

Prenatal appointments during the first trimester must be scheduled within 10 business days of request; during the second trimester, within five business days of request; and during the third trimester, within four business days of request.

Appointments for high risk pregnancies must be scheduled within 24 hours of identification of high risk to the HMO or maternity care provider or immediately if an emergency exists.

#### **§ 5.10c.10 — Transportation Services**

MA recipients who have difficulty in accessing their HMO services because they have no transportation can contact the Medical Assistance Transportation Program (MATP). This program can provide transportation services or reimbursement for travel expenses. The contact numbers of local transportation services for each county can be found here: <http://matp.pa.gov/CountyContact.aspx>. If MATP cannot provide the necessary transportation, the recipient should contact their local CAO office for additional help.

#### **§ 5.10c.11 — Language Accessibility and Cultural Competency**

Anti-discrimination laws require MA-funded services to provide complete and equal access to medical care to all recipients, regardless of language or cultural background. In addition, the MCOs contract includes several important requirements:

**Enrollment Counseling:** PA Enrollment Services is required to communicate effectively with non-English speaking recipients. In addition, all HMO membership materials and marketing information must be available in Spanish.

**Non-Discrimination:** An HMO and/or its providers cannot discriminate on the basis of language or national origin.

**HMO enrollment procedures:** DHS or PA Enrollment Services Hotline (EnrollNow) must notify the HMO of the special language and cultural needs of members who do not speak English. In addition, the HMOs must provide general services in any language spoken by more than 5 % of the region's Medical Assistance population. Currently, these languages are English, Spanish, Vietnamese, Cambodian, and Russian. Assignment of PCPs where none is selected should take into account the member's language.

**Interpreter Services:** All HMOs must have interpreter services available by telephone and/or in person to ensure that members are able to communicate with the HMO and providers and receive services in a timely manner. Written notification of upcoming or missed appointments for children which are distributed by an HMO must take into account language and literacy needs of its members. Health care initiatives' outreach and educational activities should target the health care need of the culturally and ethnically diverse populations served.

**Member Handbooks and Directories:** The HMO must make its member handbook in any language spoken by more than 5 % of the region's MA population. Currently, these languages are English, Spanish, Vietnamese, Cambodian, and Russian. Provider directories are required to indicate the languages spoken at primary care sites.

**Cultural competency:** According to the HealthChoices contract, "Both the HMO and participating providers must demonstrate cultural competency and must understand that cultural differences (between provider and patient) cannot be permitted to present barriers to accessing and receiving quality health care; willingness and ability to make the necessary distinctions between traditional treatment methods and/or non-traditional methods that are consistent with the patient's cultural background and which may be equally or more effective and appropriate for the particular patient; and the demonstration of consistency in providing quality care across a variety of cultures. For example, language, religious beliefs, cultural norms, social-economic conditions, diet, moral code, etc. may make one treatment method more palatable to a patient of a particular culture than to another of a differing culture."

#### § 5.10c.11 — Preauthorization Requirements

Certain healthcare services and prescriptions require prior authorization from the HMO. A

PCP must get permission from the HMO before providing these services or prescribing these medications. An MCO is not permitted to expand the list of services requiring preauthorization without written approval by DHS.

MA law requires that all requests for preauthorization must be resolved within 21 days, except for emergency care. If no written denial is provided within 21 days, the service is considered approved. Preauthorization must be approved within 24 hours for services needed on an “urgent basis,” one business day if it is to continue ongoing services, within two business days for new services, and within 21 days for services already provided. Emergency services require immediate review.

The HMO must provide their decision in writing, with an explanation and appeal instructions. If the HMO needs more information to decide make the decision they are required to contact the prescriber within 48 hours.

DHS has allowed HealthChoices HMOs to implement a restrictive formulary and require prior authorization for many FDA-approved drugs. A “formulary” is a list of prescription and over-the-counter drugs that are available automatically from the plan pharmacy with a prescription. Prior authorization is required for drugs that are not on the formulary. In the event that a prescribed drug is not on the HMO’s formulary, then the member must be given a 72-hour (if the medication is new) or a 15-day supply (if it is an ongoing medication) of the drug at no charge, while the PCP asks for authorization from the HMO. The HMO must provide an answer to the PCP within 24 hours. If the HMO does not authorize the drug, then the member can appeal.

#### **§ 5.10c.12 — Special Needs Unit and Case Management Services**

Within its organizational structure, each HealthChoices MCO has a dedicated Special Needs Unit to ensure that members with special needs receive access to appropriate primary care, access to specialists trained and skilled in the needs of the member, and information about the access to a specialist as PCP, if appropriate. To be referred to a Special Needs Unit (SNU) members should contact the member services number found on the back of their card.

#### **§5.10c.13 — Health Choices Dispute Resolution**

There are two different routes to resolve a dispute with an HMO:

- 1) An internal HMO complaint or grievance (pursuant to Act 68), or
- 2) A DHS “Fair Hearing” appeal.

A recipient can pursue one or the other, or both. For assistance with HMO complaints/grievances and DHS fair hearing appeals, clients should be referred to the AIDS Law Project of Pennsylvania.

**Written Notice:** If a member's services are denied, reduce or terminated, the member is entitled to written notice.

The notice must state the reason for the denial, reduction, or termination of service. The notice must also inform the member of their right to appeal from the adverse notice. These rights include the right to file a complaint or grievance with the HMO, the right to appeal to DHS, and the right to be present and represented at the DHS appeal hearing. Additionally, the notice will also include information on how to file an appeal, complaint or grievance. Finally, the notice will inform the member that services will continue if a DHS appeal is filed within 10 days.

#### **§5.10c.14 — HMO Internal Dispute Resolution (Act 68)**

A Pennsylvania law (Act 68) governs resolution of disputes between members and their HMOs. This law applies both to physical health HMOs under HealthChoices, as well as to the behavioral health HMOs. This law does not affect recipients' rights under the DHS fair hearing process. The law distinguishes between "grievances," which involve disputes as to whether a particular service is medically necessary, and "complaints," which involve all other disputes.

A **grievance** is appropriate when the plan denies any covered service, or treatment, or denies a claim for covered service or treatment on the basis that the service or treatment is not "medically necessary" or not appropriate to treat the member's condition, while a **complaint** is appropriate regarding disagreements that don't involve a judgment regarding medical necessity. Disputes about a health care provider, HMO's coverage, operations, or management policies are all subject to complaint, not grievance. In the event that the matter in dispute cannot be categorized as either a grievance or complaint, the HMO will treat it as a complaint.

**Complaints:** The HMO should be contacted to obtain its procedure for the filing of a written complaint (although complaints need not be in writing, it is better to make written complaints). When in doubt whether the dispute should be addressed by a complaint or a grievance, it is probably better in most cases to file a grievance because of the legal protections available for grievances. Also, if a dispute that should have been resolved as a grievance is filed as a complaint, it should be re-filed as a grievance, but valuable time may be lost.

**First Level Review:** When a member dissatisfied with care or treatment or disagrees with a decision made by the HMO, a first level complaint may be filed within 45 days of the incident or the receipt of the adverse notice. The HMO will send a letter acknowledging the receipt of the complaint. The member who has the right to participate in the complaint process, in person or by phone, must inform the HMO within five days business days of this acknowledgement letter of their intention to participate. The complaint will then be reviewed by a committee of one or more people within the HMO that were not involved in the original decision. A decision must be reached within 30 days of the day the complaint

was received, and a decision must be sent within five days of the decision. A 14-day extension can be requested by the member to submit further information supporting a claim. The decision must include the basis of the decision and the procedure to be followed for the second level review.

In the case of a health-based emergency, a member can request a decision be expedited and the member's doctor will need to submit a statement within three business days stating the member's health would be harmed by waiting 30 days for a decision to be reached. Once the doctor's statement is received, the HMO must issue an expedited decision within 48 hours of receiving the doctor's statement, or within three business days of the initial request, whichever is shorter.

**Second Level Review:** A member dissatisfied with the first level review may file a complaint to the second level Review Committee within 45 days of receiving the first level review decision and may appear in person. The complaint is heard by a committee of three or more people, who were not involved in the original decision, and at least one person who is a member of the HMO. The member will be given an opportunity to appear in person and should be given at least 15 days notice of the meeting of the committee. The second level review decision must be rendered within 30 days for behavioral health and 45 days for physical health, and a decision sent to the member within five days of the decision.

**External Review:** A member not satisfied with the second level complaint may request an external review of the decision outside of the HMO to the Department of Health (for quality of care issues) or the Department of Insurance (for issues such as contractual interpretation of coordination of benefits provision). This review must be requested within 15 days of receipt of decision of the second level review. External review can result only in a request for the HMO to reconsider its decision, a request for an independent review, or the issuance of a recommendation to the HMO.

**Grievances:** The HMO should be contacted to obtain their procedure for the filing of a written grievance. If in doubt about whether to file a complaint or a grievance, it is better to file a grievance. In the event that it later appears that the dispute was originally subject to complaint, not grievance procedures, it will be re-filed as a complaint. If requested, an HMO representative must help a member write a grievance.

Clients or case managers may call the Member Services Department at the HMO for assistance.

The grievance must be in writing. Write "GRIEVANCE" at the top of the letter. The member should explain what happened, why they disagree, and what should be done to fix the problem. Be sure to include the member ID number, ACCESS card number, and identify the PCP involved. State where the response should be sent, and whether a copy should be sent to an advocate or another person assisting the member.

Include copies of supporting documents, if available. Retain a copy of the grievance and supporting materials. Information submitted with the grievance can be updated at any time.

**First Level Review:** A member disagreeing with the HMO's decision to deny, reduce or terminate services may request a grievance orally or in writing within 45 days of the date the HMO's notice was received. If the member requires the continuation of the discontinued or reduced services, the grievance needs to be postmarked or hand-delivered within 10 days of the receipt of the decision. A written confirmation that the grievance was made will be received by the member. The member can participate in the grievance hearing in person, by phone or videoconference and must inform the HMO within five business days from the time of the grievance confirmation of their intention to participate in the hearing process.

The grievance will be reviewed by a committee of one or more employees within the HMO not involved in the initial decision, of which at least one will be a doctor of the same or similar specialty as the member's prescribing doctor. A decision will be made within 30 days from the time the grievance was requested and the member informed within five days of the decision.

**Second Level Grievance:** Second level grievances may be filed orally or in writing within 45 days of receiving the first level grievance decision, unless there is a medical emergency. The grievance is reviewed by a committee within the HMO that must include at least one doctor with a specialty similar to the prescribing doctor, and at least one consumer member of the HMO. The member will be given an opportunity to appear with 15 day's notice of the meeting time. The second level grievance will be heard and resolved within 30 days for Behavioral Health and 45 days for Physical Health.

If the member disagrees with the decision at the second level of a grievance, they can appeal to the Pennsylvania Department of Health. This appeal must be filed within 30 days of the decision.

**Emergency Grievances:** If the grievance involves an emergency, the member can contact the HMO and ask for an expedited decision. The member should write "EMERGENCY GRIEVANCE" at the top. The member's doctor must, within 3 business days of the grievance, submit a statement that waiting 30 days for the decision will jeopardize the patient's health and request an expedited decision. The HMO must then issue a decision within 48 hours or within 3 day of the grievance, whichever is sooner.

**External Review for Grievances:** A member not satisfied with the second level grievance decision must send a letter requesting external review within 15 days of receiving the decision. The appeal then goes to the Department of Health, which assigns it to a Certified Review Entity (CRE) to review the HMO's decision. The member can submit additional documents to the CRE. A decision will be issued within 60 days by the CRE.

#### **§5.10c.15 — Department of Human Services Fair Hearing Appeal**

Federal law also allows a recipient to file for an administrative hearing (called a "Fair Hearing") with DHS if the recipient's services with the HealthChoices HMO, or by a behavioral health HMO have been denied, reduced or terminated.

The AIDS Law Project recommends filing a grievance with the HMO and an appeal with DHS at the same time. To file an appeal, send a letter requesting a hearing to DHS at:

Department of Public Welfare  
Office of Medical Assistance Programs, HealthChoices Program  
P.O. Box 2675  
Harrisburg, PA 17105-2675

If possible, send this letter certified mail, return receipt requested, or by delivery confirmation mail. Keep the proof of delivery. Also, keep a copy of any correspondence that is sent to DHS on behalf of the claim. The letter should contain:

- the member's DHS record number, address, and phone number;
- a request for a face-to-face hearing;
- the name of the HMO and the member's subscriber number;
- an explanation of what happened, why the recipient disagrees, and what should be done to fix the problem; and
- a request for continuation of current services while the appeal is being decided.

**Continuation of current services:** A member has 30 days to appeal to DHS. If an appeal is filed within ten days (postmarked or hand delivered) from the date of the notice of the reduction or termination of current services, the recipient can request the continuation of services while going through the appeal process as long as the physician's prescription has not changed. If a member hasn't received the required written notice about the reduction or termination of healthcare services, the person can file an appeal at any time.

DHS must make a decision within 90 days of the date when the member first appealed. This means that DHS must hold the hearing and the MA recipient must receive the Hearing Officer's decision and have the opportunity to request reconsideration and receive a final decision from the Secretary of DHS – all within 90 days.

This can be expedited. The member's doctor must certify that waiting for the decision for 90 days will jeopardize the member's health and request an expedited decision. The DHS must then give a decision within 48 hours of the doctor's statement or within three business days of the date that the request for expedited decision was received, whichever is sooner.

If individuals do not receive a final decision within 90 days, they can request "interim assistance," which means the individual will receive the requested services or equipment on a temporary basis until a final decision is made. The recipient can make a written request for interim assistance to the HMO and DHS. This means that the HMO or DHS must begin

providing the services on the 91st day after the request for a hearing until the appeal process is complete.

At the hearing, a member has a right to representation by anyone, including a lawyer, an advocate, or even a family member. They can bring witnesses, ask questions, and give the Hearing Officer any information about the claim. Hearings are provided by phone or in person.

**Request for Reconsideration and Further Appeal:** If the Hearing Officer denies the appeal, the member has 15 days to request reconsideration from the Secretary of the Department of Human Services. The hearing decision should include the address to mail requests for reconsideration. The Secretary will either overturn the Hearing Officer's decision and rule in the recipient's favor; remand the case back to the Hearing Officer for a new hearing; or affirm the Hearing Officer's decision. A person who loses at the reconsideration level has 30 days from the date of the decision to appeal to Commonwealth Court.