Providing Healthcare

For

Adults with

Chronic & End Stage Renal Disease

In

Mississippi

A Guide for the Renal Professional

Maryland Patient Advocacy Group

2003

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Glossary/Resources

American Kidney Fund: This organization has a fund that pays for Medicare, Medigap, private insurance or KDP premiums for patients who meet certain income requirements.
http://www.akfinc.org/Programs/ProgramsContentHIPP.htm

Center for Medicare and Medicaid Services (CMS): This section of the Department of Health and Human Services oversees Medicare and Medicaid.
http://cms.hhs.gov/

End Stage Renal Disease (ESRD): "…that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis treatments or kidney transplantation to survive."

End Stage Renal Disease Program: A Medicare Program that oversees the delivery of dialysis and kidney transplant care.
http://cms.hhs.gov/providers/esrd/default.asp

Federal Qualified Health Centers: FQHC Federally Qualified Health Center. A comprehensive primary care provider that offers care to all persons regardless of their ability to pay and is governed by a consumer- dominated of directors.

Federal Poverty Level (FPL): This represents the basic income levels, or percentages thereof, tied to family size as set by the Federal government and used to award various monetary or health benefits.
http://aspe.os.dhhs.gov/poverty/03poverty.htm

Managed Care Organization (MCO): An insurance company responsible for overseeing the delivery of healthcare under HealthChoice (the Maryland Medicaid system of healthcare delivery).

Mississippi Children's Health Program (MCHP): A joint Federal and State program providing healthcare for children in families within certain income levels.
http://www.dom.state.ms.us/CHIP/chip.html

Medicaid (MA): A joint Federal and State program providing healthcare to low income aged, blind, disabled, pregnant women and children.
http://www.dom.state.ms.us/

Medicaid Application: Medicaid application for aged and disabled Mississippi residents,
http://www.docguide.com/dgc.nsf/us/PEARL.LEWIS.621?OpenDocument

Medicare (MC): A Federal program which provides healthcare to the elderly and disabled.
http://www.medicare.gov/

Medicare Publications:
http://www.medicare.gov/Publications/Search/View/ViewPubList.asp?Language=English

Medicare Rights Center (MRC): The MRC educates and advocates for Medicare beneficiaries.
http://www.medicarerights.org/

Mississippi Children's Health Program (MCHP): A joint Federal and State program providing healthcare for children in families within certain income levels.
http://www.dom.state.ms.us/CHIP/chip.html

Mississippi Health Advocacy Program: Advocates for the Health needs of Mississippi citizens.
http://www.mhap.org/

Mississippi Medicare: website for Mississippi Medicare identified participating providers, etc.
http://www.msmedicare.com/default.htm

Mississippi State Department of Health: To access resources and health promotion programs go to http://www.msdh.state.ms.us/ .

National Kidney Foundation-Mississippi Chapter: Provides education, raises funds for research and assists those with kidney disease.
http://www.kidneyms.org/

Network 8 – Federal ESRD Network: Oversees the delivery of ESRD care in Mississippi and responds to patient grievances.
http://www.esrdnetworks.org/networks/net8/net8.htm

Peoples Law Library: Provides legal and self-help information on Maryland and federal law affecting low and moderate income persons and their families.
http://www.peoples-law.org/

Qualified Medicare Beneficiary (QMB): A Medicare beneficiary, within certain income limits, whose Medicare premium, co-payments and deductibles are covered by Medicaid.
http://www.peoples-law.org/Public%20Benefits/Government%20Benefits/qmb.htm

ESRD Renal Networks: Under contract to CMS, Network 8 oversees the delivery of ESRD care to Network 5 which includes Mississippi. Patients can file grievances with Network 8.
http://www.esrdnetworks.org/

Social Security Administration (SSA): An agency of the Federal government that oversees the retirement and disability system.
http://www.ssa.gov/

Social Security Blue Book: A set of medical guidelines that must be met to award disability and Medicare benefits. The link below takes you to the renal guidelines.
http://www.ssa.gov/disability/professionals/bluebook/6.00-Genito-Urinary-Adult.htm

Social Security Offices: These are local offices of the Social Security Administration at which to apply for Medicare benefits.
http://s00dace.ssa.gov/pro/fol/fol-home.html.

Supplemental Security Income (SSI): A Federal income supplement program funded by general tax revenues (*not* Social Security taxes) designed to help the aged, blind and disabled that have little or no income.
http://www.ssa.gov/notices/supplemental-security-income/

Temporary Cash Assistance (TCA) Program: This program replaced Aid to Families with Dependent Children (AFDC). Anyone who qualified for AFDC is automatically eligible for Medicaid.

MARYLAND PATIENT ADVOCACY GROUP

OBJECTIVE: To advocate for access to healthcare for all those with chronic or end stage renal disease.

MISSION STATEMENT: Maryland Patient Advocacy Group's mission is to assist all those who are afflicted with chronic or end stage renal disease, "CKD" or "ESRD", obtain necessary medical care. As a non-profit agency we are dedicated to alleviating the burden of disease and to making the day-to-day lives of these patients easier.

GOAL: Explain the various federal and state programs available to provide healthcare for adults with both chronic (CKD) and end stage renal disease (ESRD).

The purpose of this document is to:

1) Explain mechanisms that ensure access to care for adults with both CKD and ESRD

2) Identify issues delaying access to Medicare, Medicaid and any other state program.

3) Explain the Medicare ESRD Program pointing out the differences between basic Medicare and this program and how they serve this population

4) Identify various common scenarios and how they might be addressed

5) Identify barriers to care

6) Identify and address problems that patients encounter

7) Place access to Medicare in context (i.e. one portion of a continuum of programs assuring reimbursement and thus access to care)

8) Identify different advocacy resources

We look to you, the renal professional, to identify for us what information you need to ensure that your patients receive the medical care they need.

Thank you for your time and dedication.

Very truly yours,

Pearl L. Lewis, President
Maryland Patient Advocacy Group

Section I: Introduction

This document has been prepared for renal professionals to help you assist your patients with both chronic and end stage renal disease access coverage for their care. It addresses the various forms of healthcare coverage – private, Medicaid and Medicare. It identifies pitfalls that can arise and explains what can happen if one does not apply for appropriate coverage in a timely manner. It will also identify resources available to assist patients in dealing with the various forms of coverage.

1. What is a Patient's and Physician's Responsibility, once a Diagnosis of Chronic or End Stage Renal Disease is Made?

One of the most important things a patient can do for themselves when diagnosed with a chronic health condition is to educate themselves about the disease, its medical and financial implications and set in motion a plan to meet those needs. Depending of the severity of the disease, this should include not only access to healthcare but also income maintenance. Any healthcare professional working with a patient/family in this situation owes it to them to inform them of what they should do to protect themselves and their family.

2. Federal and State Healthcare Programs – Medicare and Medicaid

Healthcare does not exist without a method of reimbursement. For those with chronic kidney disease access to services can be difficult. If one does not have private insurance coverage, depending on their income level, they must turn to the various Federal and State programs for assistance. Both Medicaid and Medicare eligibility depends on the patient meeting the Social Security Disability Guidelines; only if the disease process has progressed to the point of meeting these criteria is the patient eligible for benefits.

3. Advocacy Resources When There are Insurance Problems

MISSISSIPPI
HEALTH ADVOCACY
PROGRAM
A Member of
Sisters of Mercy Ministries

The Mississippi Health Advocacy Program is a non-partisan, non-profit public interest organization.

http://www.mhap.org/

Maryland Patient Advocacy Group advocates for individuals to ensure access to all forms of healthcare reimbursement including Social Security Disability. For more information, call 410-872-2846.

For a website on Education and Information on chronic and end stage renal disease, visit: www.kidneyadvocacy.50megs.com

The Medicare Rights Center (MRC) advocates for those on Medicare nationwide. http://www.medicarerights.org/

Section II: Providing care for those with Chronic Kidney Disease

1. *If your patient has been diagnosed with chronic kidney disease has been denied insurance coverage because of a pre-existing condition or he/she has been rated causing premiums to be unaffordable how does he get coverage?*

If your patient is a resident of Mississippi and:

- **is not eligible for group health coverage, COBRA, the Mississippi Medical Assistance or Children's Health Programs, Medicare or any other government-sponsored health insurance program;**
- **Has exhausted all available group coverage or moved into Mississippi from another state's high-risk pool;**
- **Has, or has been offered, health insurance that provides limited or restricted coverage, or that excludes coverage for a specific medical condition or conditions;**
- **is receiving a federal Trade Readjustment Allowance or unemployment benefits under the Trade Adjustment Assistance program, or receiving pension payments from the Pension Benefit Guaranty Corporation; or have been refused individual health insurance for medical reasons or have a specified medical condition.**

Your patient could be eligible for coverage under the:

Have you or someone you know been turned down for health insurance?

The Mississippi Comprehensive Health Insurance Risk Pool Association may be able to help.

The following is adapted from a brochure describing the activities of the Mississippi Comprehensive Health Insurance Risk Pool Association (MCHIRPA) For complete information, read the MCHIRPA brochure, or contact the Association at (601) 899-9967 or (888) 820-9400.

- **What Is The Mississippi Comprehensive Health Insurance Risk Pool Association?**

The Mississippi Comprehensive Health Insurance Risk Pool Association (the "Association") is not an insurance company. The Association is a nonprofit legal entity created pursuant to the Mississippi Comprehensive Health Insurance Risk Pool Association Act for the purpose of allowing the availability of a health insurance program and allowing the availability of health and accident insurance care to those citizens of the State of Mississippi who, because of health conditions, cannot secure such coverage.

- **Who Is Eligible for Coverage?**

In order to be eligible to obtain coverage from the Association, a person must:

(a) have an automatically rejectable health condition, or during the 12 months prior to applying for coverage from the Association have been rejected by a licensed insurance company, nonprofit health care services plan or HMO for coverage substantially similar to the Association coverage without material underwriting restriction at a rate equal to or less than the Association plan rate;

(b) have been a legal resident of Mississippi for 6 consecutive months prior to application for coverage by the Association;

(c) not be eligible for Medicare or Medicaid benefits;

(d) not be receiving health care benefits under any federal or state program;

(e) not have received $500,000 in benefits from the Association or any organization similar to the Association; and

(f) not have substantially similar coverage under another contract or policy. The residency requirement may be waived with respect to any person who changes his domicile to Mississippi and who at the time domicile is established in Mississippi is covered by an organization similar to the Association. Eligibility requirements outlined in (a) and (b) above are not applicable to individuals eligible under the Health Insurance Portability and Accountability Act of 1996.

Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium or fraud and who is otherwise eligible for coverage may apply for coverage with the Association, and if such coverage is applied for within 63 days after the involuntary termination and if

premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

The coverage of any person who ceases to meet the eligibility requirements of the Association may be terminated immediately. Any person who terminates coverage with the Association shall not be eligible for coverage unless 12 months have elapsed since the person's latest termination.

- **How To Apply For Coverage**

An application for coverage may be obtained through any insurance agent licensed by the State of Mississippi to write health insurance. A check or money order payable to Mississippi Comprehensive Health Insurance Risk Pool Association must accompany your application. If your application is accepted, the Association will notify you of the effective date of coverage.

Generally, policies become effective on the first of the month following approval of the application. The information contained in this brochure is general in nature. For complete details of the benefits, limitations, exclusions, definitions and provisions of the health insurance plan, please consult the policy issued by the Association. Any conflicts will be governed by the policy.

The policy issued by the Association is a major medical expense Policy giving benefits solely to the named policyholder for specified medical expenses. The coverage provided is directly insured through the Association. The policy is issued through the Administering Insurer.

To obtain additional information about MCHIRPA, contact:

Mississippi Comprehensive Health Insurance Risk Pool Association
P. O. Box 13748
Jackson, MS 39236
601 899 9967
888 820 9400

Additional Information:

MCHIRPA brochure 

Mississippi ahead of many states in providing health insurance coverage - a Q&A with Commissioner Dale

2. If the family has limited income and assets they should first apply to Medicaid

Depending on the income and asset level of the family, they might be eligible for Supplemental Security Income, "SSI". To locate your local Social Security Office go to: http://www.ssa.gov/atlanta/southeast/ms/mississippi.htm If this is the case, Medicaid comes with it.

To apply for Medicaid only the patient must apply at their local Medicaid Regional Offices. To locate a local office go to:
http://www.dom.state.ms.us/MMIS/Bene/regional_offices/regional_offices.html

Eligibility Guide
Medicaid for Persons Age 65 or Over or Disabled

What is Medicaid?

Medicaid is a national health care program.
It helps pay for medical services for low-income people.
For those eligible for full Medicaid services, Medicaid is not paid to you.
Medicaid is only paid to providers of health care.
Providers are doctors, hospitals, pharmacists and other medical professionals who take Medicaid.

Be sure the provider you see takes Medicaid before you get any service.
If the provider does not take Medicaid, you must pay the bill.

Am I eligible?

You may be eligible for Medicaid if you:

- Have limited finances, which would include both your income and resources (things you own), and
- Are either age 65 or over or disabled.

How is disability defined?
Medicaid must use the same definition of disability as the Social Security Administration uses for the SSI Program

What is the total countable income?
Total countable income is the money a person or couple may get and still qualify for Medicaid. It includes the monthly payment of $58.70 for Medicare Part B (Medical Insurance). Income limits change each March.

What resources are not counted?

Some resources are not counted in the $4,000.00 per individual/$6,000.00 per couple limit. They include:

Home Property

One (1) home may be excluded if it is the person's primary place of residence.

Income-Producing Property

This property is not counted towards the limit if it produces a net annual return of 6% of the equity value to the beneficiary.

Automobiles
Up to two (2) vehicles may be excluded.

Household Goods
These items are totally excluded.

Personal Property
Personal property may e excluded if the equity value is $5,000.00 or less

Life Insurance
The cash value of whole life insurance policies is excluded if the face value of all whole life insurance policies on each person is $10,000.00 or less. The value of term life insurance is not countable regardless of value.

Burial Plots and Burial Funds
Burial spaces intended for family members are not counted in the $4,000.00 limit. Money saved for funeral expenses up to $6,000.00 is not counted.

There are five (5) Medicaid eligibility groups or programs for aged and disabled persons:

1) Disabled Children, age 18 and under, who are living at home, may qualify for Medicaid if:

- **The child needs the type care found in a nursing home or hospital**
- **The child can receive the same level of care at home**
- **The cost of caring for the child at home is no more expensive than that of a nursing home or hospital**

The income limit for the child's own income is the same as for nursing home coverage.

2) Poverty Level Aged or Disabled Group
Eligibility for full Medicaid benefits may exist if the applicant:

- **Is age 65 or over or disabled**
- **Have a total monthly income less than:**
  $1,060.00 for an individual
  $1,414.00 for a couple
- **Have total resources less than:**
  $4,000.00 for an individual
  $6,000.00 for a couple

Eligibility begins with the month a person is qualified, which may be up to three (3) months before the month of application.
If excess resources cause you to be ineligible, we will determine if you can qualify as a Qualified Medicare Beneficiary or Special Low Income Medicare Beneficiary.

3) The QMB Program

In the Qualified Medicare Beneficiaries (QMB) Program, Medi*caid* will pay your Medi*care* premiums, deductibles, and coinsurance. To be eligible for the QMB Program you must:

- **Be eligible for Medicare, Part A (Hospital Insurance)**
- **Have a total monthly income less than**
  $799.00 for an individual
  $1,060.00 for a couple

It does not matter what your resources are in this group. There is no resource test. Eligibility begins one (1) month after the date you are approved.

4) The SLMB and QI-1 Programs

If you are determined eligible in the Specified Low Income Beneficiaries (SLMB) or Qualified Individuals-1 (QI-1) Program, Medicaid will pay your Medicare, Part B premium of $58.70 per month.
To be eligible for the SLMB or QI-1 Program you must

- **Have Medicare, Part A (Hospital Insurance)**
- **Have a total monthly income less than**
  $1,060.00 for an individual
  $1,414.00 for a couple

It does not matter what your resources are in these groups. There is no resource test. Eligibility begins with the month a person is qualified, which may be up to three (3) months before the month of application.

5) Are You Working and Disabled?

To get full Medicaid in this group, a person must

- **Be determined disabled**
- **Have gross monthly earned income less than:**
  $3,807.00 for an individual
  $5,115.00 for a couple
- **Have total monthly unearned income less than:**
  $1,060.00 for an individual
  $1,414.00 for a couple
- **Have total resources less than:**
  $24,000.00 for an individual
  $26,000.00 for a couple

Application for Medicaid Application

http://www.dom.state.ms.us/MMIS/Bene/App2003AgedDisable.pdf

2. If the patient's income is too high for Medicaid and the medical expenses are high can you still be covered by Medicaid? Yes, under Spenddown also called Medically Needy.

Medicaid is not just for the very poor. If a family has extraordinarily high medical expenses because of an ongoing illness that person might qualify as Medically Needy. Each state has different eligibility criteria. Contact your local Department of Social Services.

TIP – What to Bring to the Medicaid Office

When one family member becomes ill plans that once worked no longer are workable. Families must put together various combinations of healthcare options. They cannot depend on the Department of Social Services to tell them everything that they are eligible for. Many offices are understaffed and those there have tremendous case loads. It often takes months for applications to be processed.

- **multiple copies of birth certificates for all family members,**
- **marriage certificates,**
- **income documentation,**
- **residence verification,**
- **copies of bank statements, list of liquid assets,**
- **insurance policies of all types,**
- **rent/mortgage verification,**
- **and utility bills.**

Suggest that they:

- **mail documents by certified mail,**
- **keep an ongoing record of who they speak to, date and time, what was said**
- **and keep copies of all documents**

If the patient has accumulated medical bills they can take all the bills to the Department of Social Services in their county and apply for Medicaid. If the amount they owe for past medical care is several times their monthly income they might be eligible for Medicaid under spenddown. This would make them eligible for Medicaid for 6 months.

3. If the patient/family is not eligible for Medicaid how do they get medical care?

Most states have federally funded health clinics scattered throughout the state providing healthcare free or at reduced rates for the uninsured. Many hospitals have Charity Care Funds or can arrange scheduled payment plans.

Federally Qualified Health Centers

Another possible way to lower your health care costs is to go to a Federally Qualified Health Center (FQHC). At a FQHC, you can get routine care. When you use a FQHC, the Health Care Center covers some health services like preventive care that are not covered by Medicare. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. Anyone with Medicare may go to a FQHC for health care services. They are usually in inner-city and rural areas. FQHC services that are available to people with Medicare include:

- **Routine physical exams.**
- **Screening and diagnostic tests for vision and hearing problems, and**

other health problems.
- Flu shots and other similar shots.

When you get these services at a FQHC, you do not have to pay the $100 yearly Part B deductible. If you get other services like X-rays, you will have to pay the usual Part B yearly deductible of $100. Sometimes you will not have to pay the 20 percent coinsurance for Part B services.

To find the FQHC nearest to you, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired). Ask for the telephone number of the Primary Care Association in your state.

Federally Qualified Health Centers in each state, what they cover and cost.

http://www.kff.org/medicaidbenefits/federallyqualified.cfm

Section III: History and Role of the Federal ESRD System

The federal End Stage Renal Disease (ESRD) Program was established in 1972 pursuant to the provisions of Section 2991, Public Law 92-603. This legislation extended Medicare coverage to virtually all individuals with ESRD who require dialysis or transplantation to sustain life.

This legislation and subsequent regulations also established health and safety standards applicable to providers of ESRD services and required the establishment of ESRD Network Coordinating Councils. Networks serve as liaisons between the federal government and the providers of ESRD services.

In 1978, the ESRD Network program was designed to provide an oversight system uniting dialysis providers with the common goals of:

1. Providing immediate access to treatment;

2. Treating patients with quality care through medical standards developed by the scientific community;

3. Helping patients to maintain a quality of life; and

4. Enabling each individual to live as a functioning member of society.

The 18 Networks are currently in immediate contact with 4,153 dialysis facilities and 242 transplant centers, serving in excess of 300,000 patients. The ESRD Network budget is funded through dialysis payments to facilities. The budget for the national Network program is under $12 million annually, less than .007 percent of the total Medicare budget for 1994.

Each Network is required by federal contract to be active in the areas of:

1. Data Collection;

2. Quality Improvement;

3. Patient Satisfaction; and to serve as a

4. clearinghouse for federal agencies, renal related organizations, patients and their families.

Section IV: Providing Healthcare for those with ESRD

1. How is the Medicare ESRD System Different from Standard Medicare?

To be eligible for Medicare the patient, patient's spouse, or patient's parent (if the patient is a dependent) must have worked and paid into the Social Security System for 40 quarters [*Social Security Act*, § 214(a)]. However, q*uarters are prorated for young adults if the determination is based on the patient's work record. The younger the patient, the fewer quarters needed to qualify.*

Work Quarters Needed To Qualify for Medicare Due to ESRD

If the date of onset is before age 24, they, their spouse or parent must have worked 1.5 years in the 3 years ending with the quarter of the date of onset.

If the date of onset is age 24 to 31, they or their spouse must have worked 1.5 years out of the last 3 years and 3 months.

If they are 31 and over, they need to have worked 10 years total with 5 of the years worked in the 10 years prior to the date of onset.

a. When Medicare ESRD Coverage Begins;

People who receive Social Security disability qualify for Medicare in the 25th month after the date of disability; however for those with ESRD Medicare begins;

1. **The months in which you have a kidney transplant**
2. **Three months after beginning a course of out patient hemodialysis**
3. **The month you begin a course of home peritoneal or hemodialysis**

To fill in this three months gap many states have a kidney disease program or patients rely on Medicaid or private insurance.

Due to potential penalties, non-elderly, non-disabled ESRD patients with EGHP coverage, and that includes children who are covered by their parent's policy, should be encouraged to file for Medicare Part B at the same time when filing for Medicare Part A. If application for Medicare Part B coverage is not made, enrollment in it can only take place during an open enrollment period (typically January through March of each year) with coverage becoming effective in July. This could mean a gap in coverage and higher premiums. Patients should carefully review their EGHP policy on coordinating with Medicare.

b. Who is eligible?

Anyone, with chronic renal failure, who has paid into the SS system, whose spouse has paid into the system or anyone, of any age, who is a dependant of anyone who has paid into the system is eligible for ESRD Medicare coverage. Social Security Disability Guidelines for Renal Disease as outlined in the Blue Book can be found at http://www.ssa.gov/disability/professionals/bluebook/6.00-Genito-Urinary-Adult.htm

c. What has to be done, when diagnosed, to assure coverage under the Medicare ESRD system?

By regulation, within 45 days of diagnosis of chronic renal failure a physician must fill out a CMS 2728, a patient's "birth certificate" into the Medicare End Stage Renal Disease Program. One copy must me sent to Social Security, one to the Renal Network and one retained in the medical file in the dialysis unit or transplant center. However if this is not done immediately there will be a lag time in obtaining benefits and medical coverage. Make sure the parent takes the form to their local Social Security Office and obtains a receipt.

1. ***How does the ESRD patient obtain healthcare during the 3 months prior to Medicare coverage?***

Either the patient has private insurance, is eligible for Medicaid or the State Risk Pool.

2. ***When a patient is covered under an employer group plan and chooses Medicare who pays what?***

If a patient is under age 65 and entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD), and is receiving health care benefits through his/her employer or your spouse's employer, Medicare is the secondary payer during the coordination period between the employer and Medicare.

The current coordination period is 30 months, which for dialysis patients dialyzing in a unit would be 33 months from the beginning of treatment. For transplant patients it would be 30 months from the 1st day of the month in which they were transplanted.

Medicare becomes the primary payer when the coordination period has ended or when the patient reaches age 65, even if he/she is still being covered by the employer's plan during the coordination period.

During the coordination of benefit period the group plan pays first, based on the Medicare fee schedule and Medicare pays the coinsurance/deductible. After the coordination of benefit period is over than Medicare becomes primary and the employer group plan pays the coinsurance and deductibles. This can become confusing and it is best t hat the patient consult with his/her benefits manager.

Consult with the Medicare Dialysis and Kidney Transplant Handbook on the Medicare website listing the various publications.
http://www.medicare.gov/Publications/Search/View/ViewPubList.asp?Language=English

3. Mississippi Medicare Website
http://www.msmedicare.com/default.htm

4. Sample Cases – What should this patient be eligible for?

Scenario a: The patient's/family income meets the Medicaid financial criteria and they have no healthcare coverage -

The patient should be eligible for SSI and Medicaid and possibly Medicare if he/she is the spouse of someone who would be eligible for SSDI/SSI if they themselves had ESRD. The Social Security Field Office has a "presumptive disability/presumptive eligibility" process which allows them to award SSI benefits and thus Medicaid while the patient waits for Disability Determination Services (DDS) to formally determine the medical condition and award Medicare.
http://www.ssa.gov/OP_Home/handbook/handbook.21/handbook-2187.html

Scenario b: The patient has income/assets over the MA level but no healthcare coverage.

Under this scenario the client would not be eligible for SSI. Check Medicare eligibility.

Scenario c: The patient has income and health insurance.

The patient should ascertain if his/her insurance adequately covers all ESRD costs. If a transplant is anticipated Medicare should be considered since Medicare, in the future will only cover transplant drugs if Medicare pays for the transplant. Also, if there are high co-payments and deductible under the private plan by being covered by Medicare the

providers would have to accept Medicare's capitated rates thus lowering the co-payments and deductibles which Medicare would cover.

5. Problems:

a. Oftentimes a patient declines Medicare/KDP due to its premiums.

There are penalties for not accepting Medicare initially. If an ESRD patient does not accept Medicare during the first 7 months of eligibility they will pay a higher premium in the future if they decide to seek Medicare coverage. If the family has limited income perhaps they are eligible for the Qualified Medicare Beneficiary, SLMB, etc. programs. Additionally, if the patient is a dialysis patient the American Kidney Fund has a program that will pay health insurance premiums – private, Medicare, etc. For information contact http://www.akfinc.org/Programs/ProgramsContentHIPP.htm or call *800.638.8299*.

b. Pitfalls in Obtaining Medicare/Medicaid/KDP

Access to these forms of reimbursement cannot be viewed alone; they are a part of a continuum depending on both federal and state workers each to do their job correctly. However, due to the current fiscal crisis and hiring freeze the waiting time from first contact at a Medicaid office to the awarding of benefits can take months. Additionally in order for a patient to access Medicaid during the months prior to Medicare coverage the system that should automatically enter a client once SSI has been awarded into the Medicaid system, must be functioning properly. For Medicare premiums to be paid under Qualified Medicare Beneficiary or Medicaid, state workers must be doing their job efficiently.

c. Problems Identified During the Medicare Application Process

The renal networks, under contract to the Center for Medicare and Medicaid Services, are charged with assuring "immediate access to treatment" however;

- **patients are waiting extended periods of time for Medicare/Medicaid coverage,**
- **patients who could benefit from Medicare coverage are not aware of their eligibility or the benefits of Medicare coverage.**

d. Long periods of time without MC/MA coverage.

- **While the CMS 2728 is an ESRD patient's "birth certificate" into Medicare the 2728 fails to get to Social Security and the Renal Network in a timely manner in some cases or be accepted as medical evidence in others.**

- **While the Field Office (FO) is allowed to adjudicate an ESRD patient who files for SSI/SSDI having no income and assets as one with a "presumptive disability/presumptive eligibility" based on the CMS 2728 and award SSI and Medicaid, it is not always being done. Additionally, focus is placed on one's eligibility through one's own record sometimes failing to recognize eligibility through a deceased spouse or parent.**

6. If a patient does not have Medicaid how does he/she cover the Medicare coinsurance and deductibles?

Medigap policies, designed to cover Medicare coinsurance and deductibles come in several plans and are regulated by both the federal and state government. The Mississippi Insurance Commissioner (link available in Glossary) oversees the sale and implementation of those sold in this State. Those under 65 and on SSDI pay the same price as those over 85 and can only purchase Plan C under Maryland law. Plan C covers the Part A and B deductibles and Part B coinsurance. Mississippi also mandates the availability of a Medigap policy for those under 65. Contact your state's Insurance Commissioner for a print brochure of what is available.
http://www.doi.state.ms.us/

7. Resources in Mississippi for ESRD patients

To date – 12/18/03 - I have spoken to several people in the Mississippi Department of Health it doesn't appear that there is a program similar to State Renal Disease Programs in other states.

To obtain medications are reduced cost:

Welcome to Senior Medications.com - Helping Mississippi seniors find affordable prescription drugs from Canada. Are you tired of paying high prices for your medications? Through our affiliate, licensed Canadian Internet pharmacy - McGregor Clinic - we provide a list of affordable mail order RX products.

To get started, find your medication by entering the drug name in the search box or by

using the A-Z prescription search.

Frequently Asked Questions

After I find my prescription drugs, how do I obtain my medication from your Canadian pharmacy?

The next step is to follow our Getting Started: How To Order steps. The page contains step-by-step instructions and the forms for you to complete and fax to our affiliated licensed pharmacy in Winnipeg, Manitoba, Canada. All orders will be dispensed by McGregor Clinic Pharmacy, licensed in Canada by the Manitoba Pharmaceutical Association (License # 31318).

Who sees the information I've submitted in the patient information form?

The only people that get to see your file are individuals employed by McGregor Clinic and working in a patient/customer contact position. Your file - including the payment information - is consider confidential and will not be viewed or shared with anyone outside of, or not employed, by McGregor Clinic.