

**Providing Healthcare  
For  
Adults with  
Chronic & End Stage Renal Disease  
In  
Connecticut**

**A Guide for the Renal Professional**

**Maryland Patient Advocacy Group**

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9131 Gracious End Court #103  
Columbia, Maryland 21046  
410-872-2846  
[yettapearl@comcast.net](mailto:yettapearl@comcast.net)  
[www.kidneyadvocacy.50megs.com](http://www.kidneyadvocacy.50megs.com)

## Glossary/Resources

**Advocacy Agencies:** Listing of Connecticut's advocacy agencies.

<http://www.dmbas.state.ct.us/advocacy.htm#Agencies>

**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/>

**Community Health Centers:** Provide primary healthcare for the uninsured at no or reduced cost.

<http://www.ctpca.org/hc.html>

**Connecticut Department of Social Services:** The department provides medical assistance to low income persons and people who could otherwise support themselves if not for the fact that they have excessive health care costs.

<http://www.dss.state.ct.us/svcs/medical/>

**Connecticut Overview of Health Programs:** Provides an overview of all state programs.

<http://www.healthinsuranceinfo.net/ct05.html>

**Disability Determination Service (DDS):** makes eligibility decisions on disability based on Social Security Medical Guidelines

**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.

<http://www.fha.state.md.us/opcs/pco/html/mdhlthctrs.html>

**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>

**HEALTH RESOURCES:** Listing of health resources in Connecticut.

<http://library.uchc.edu/departm/hnet/connecticut.html>

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

**Connecticut Qualified Health Centers:** MQHC Maryland Qualified Health Center. A non-profit health center that provides the same scope of services as a FQHC and offers discounted fees to the low income uninsured.

<http://www.fha.state.md.us/opcs/pco/html/mdhlthctrs.html#mqhc>

**Medicaid (MA):** A joint Federal and State program providing healthcare to low income aged, blind, disabled, pregnant women and children.

<http://www.dss.state.ct.us/svcs/medical/>

**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/>

**Medigap Policies:** Policies that cover the Medicare copayments and deductibles.

<http://www.ct.gov/cid/lib/cid/medage1.pdf>

**National Kidney Foundation of Connecticut:** Provides education, support and emergency funds for ESRD and CKD patients.

<http://www.kidneyct.org/>

**Network 1:** ESRD Network 1 oversees the delivery of ESRD in New England.

<http://www.networkofnewengland.org/>

**Office of Healthcare Access:** The mission of the Office of Health Care Access (OHCA) is to ensure that the citizens of Connecticut have access to a quality health care delivery system

<http://www.ohca.state.ct.us/>

**Office of Managed Care Ombudsman:** Assist Connecticut residents who belong to managed care/HMO health plans.

<http://www.omc.state.ct.us/>

**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/>

**Patient Advocacy Resources:** Provides a resource guide to identify health advocacy resources.

<http://library.uchc.edu/departm/hnet/advocacy.html>

**Presumptive Disability:** ESRD is one of the condition on a list accepted by their diagnosis as presumptively disabled by Social Security and the State Review Team.

**Expedited SSI Payment:** The SSA Filed Office has the authority to provide up to 6 months of emergent SSI payments and Medicaid to those on a list of Presumptive Disabilities who appear to meet the financial eligibility criteria and who are in an apparent threat of homelessness, a life threatening medical condition, etc.

<http://www.ssa.gov/notices/supplemental-security-income/text-expedite-ussi.htm>

**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>

**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/106.00-Genito-Urinary-Childhood.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/foi/foi-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/>

**Supplemental Security Income Screening Tool:** Help identify those who are eligible for SSI.

<http://best.ssa.gov/>

**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. <http://63.236.98.116/how/cashfood/tca.htm>

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# **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 Kidney Disease Program (KDP)
- 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 – Medicaid, Medicare, Medigap and Connecticut’s various programs for prescription drug, respite, home and residential care. 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. Who is responsible for determining disability in Connecticut?***

#### **Disability Determination Services**

Disability Determination Services (DDS) is responsible for determining the eligibility of Connecticut residents for the Social Security Disability Insurance (SSDI) and Supplemental Security (SSI) programs. These programs provide cash benefits to individuals who are currently unable to engage in gainful employment. ESRD patients are eligible for Presumptive Disability and almost immediate SSI if they meet the income eligibility requirements. See Expedited Eligibility below.

DDS can be reached at 1-800-842-8320 or (860) 466-6100.

#### **4. Advocacy Resources**

## **PATIENT ADVOCACY RESOURCES**

A GUIDE FOR PATIENTS AND THEIR FAMILIES

Healthnet: Connecticut Consumer Health Information Network  
Lyman Maynard Stowe Library  
University of Connecticut Health Center  
Farmington, Connecticut



[Family Village Community Center](#)

[Connecticut's Managed Care Ombudsman](#)

[Health Policy Project](#)

For a website on Education and Information on chronic and end stage renal disease, visit:  
[www.kidneyadvocacy.50megs.com](http://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?**

**Connecticut Health Reinsurance Association (HRA): Premium cap: 150%. Annual benefit limit: None; Max. Lifetime limit: \$1,000,000. Enrollment cap: None. Waiting period: 12 months. Funding Source: Premiums and assessments on insurers.<sup>2</sup>**

**Connecticut Health Reinsurance Association  
Phone 1-800-842-0004**

**2. If the family has limited income and assets they should first apply for Supplemental Security Income (SSI).**

**Depending on the income and asset level of the individual/family, and if that individual meets the Social Security definition of “disabled”, they might be eligible for Supplemental Security Income, “SSI”. If this is the case, Medicaid comes with it. This is called Categorical Eligibility. The patient must apply at their local Social Security Office for SSI.**

## Supplemental Security Income (SSI)

Effective January 1, 2004

<b>Single (living alone, SSI only)</b>	<b>\$564.00 per month</b>
<b>Couple (living alone, SSI only)</b>	<b>\$846.00 per month</b>
<b>Essential person</b>	<b>N/A</b>
<b>Asset limits</b>	<b>\$2000.00 single \$3000.00 couple</b>

## ***Medicaid***

Medicaid coverage is automatically granted to individuals receiving certain other public assistance, such as Supplemental Security Income (SSI), Temporary Cash Assistance (TCA), or Foster Care. Low-income families, children, pregnant women, women with breast or cervical cancer, and aged, blind, or disabled adults may also qualify for Medicaid. Eligibility for Medicaid is re-determined every 12 months, except that eligibility is re-determined every six months for “spenddown” cases (See Medically Needy).

Medicaid is available to low-income persons in certain categories. Federal Medicaid laws require that every state cover certain groups.

### **Low income persons eligible for Medicaid in Connecticut\***

<b><u>Category</u></b>	<b><u>Income eligibility</u> (as percent of federal poverty level)</b>
<b>Child to age 5</b>	<b>185% (monthly income of about \$2,315 for family of 3)</b>
<b>Child 6-18</b>	<b>185%</b>
<b>Parent</b>	<b>150%</b>
<b>Pregnant woman</b>	<b>185%</b>

\* Eligibility information was compiled from secondary sources, including Center for Budget and Policy Priorities, the Henry J. Kaiser Family Foundation, Families USA, and the Robert Wood Johnson Foundation Covering Kids Program, and may have changed since this guide was published. Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.

To get an idea of how your income compares to the federal poverty level, use the federal poverty guideline issued by the U.S. Department of Health and Human Services for the year 2003:

### 2003 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$ 8,980	\$11,210	\$10,330
2	12,120	15,140	13,940
3	15,260	19,070	17,550
4	18,400	23,000	21,160
5	21,540	26,930	24,770
6	24,680	30,860	28,380
7	27,820	34,790	31,990
8	30,960	38,720	35,600
For each additional person, add	3,140	3,930	3,610

**SOURCE:** *Federal Register*, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.

**For larger families add \$3,080 for each additional person**

**So, for example, using this guideline, 200% of the federal poverty level for a family of 3 would be an annual income of \$30,040, or a monthly income of \$2,503.**

**Contact your state Medicaid program for the most up to date information and for other eligibility requirements that may apply.**

***Retired or disabled people who have low incomes and are enrolled in Medicare may also qualify for help from Medicaid. Even though your income may be too high to qualify for Medicaid insurance coverage, there may be other ways Medicaid can help you.***

**If your household income is below the poverty level, Medicaid will pay your Medicare monthly premium and your Medicare deductibles and coinsurance. This is called the Qualified Medicare Beneficiary (QMB) program.**

**If your household income is below 120% of the poverty level, Medicaid will pay for your monthly Medicare premiums only. This is called the Specified Low-Income Medicare Beneficiary (SLMB) program.**

Contact your Medical Assistance Program of the Connecticut Department of Social Services for more information about other eligibility requirements.

*There may be other ways that Medicaid can help.* To find out if you or other members of your family qualify for Medicaid, contact Medical Assistance Programs of the [Connecticut Department of Social Services.](#)

### *Traditional or "Community" Medicaid*

**NEW** - Connecticut law requires that a Medicaid beneficiary be charged a \$1.50 co-payment for each prescription. Also, a Medicaid provider visit co-pay of \$2.00 is now in effect, but Medicare beneficiaries are generally exempt. Federal law provides that, if a person cannot afford to make a co-payment, he/she cannot be denied the service or prescription, but he/she is still ultimately liable for the cost. To access wallet-sized cards to show providers describing this law, visit <http://larcc.org> and click on "Hot Topics."

<b>Income limits Region A</b>	
Single	\$ 574.86
Couple	\$ 733.59
<b>Income limits Regions B &amp; C</b>	
Single	\$ 476.19
Couple	\$ 633.49
<b>Asset limits</b>	
Single	\$1,600.00
Couple	\$2,400.00
Life insurance (total face value)	\$1,500.00 per person
Irrevocable funeral contract	\$5,400.00 per person

Note that the above income limits do not include any income disregard amounts. See preceding section.

Region A is generally lower Fairfield County. The following is the current listing of towns: Bethel, Bridgewater, Brookfield, Danbury, Darien, Greenwich, New Canaan, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman, Stamford, Washington, Weston, Westport and Wilton.

Regions B & C comprise the rest of the state.

**3. What programs are there to help with home and respite care?**

**CHCPE - Connecticut Home Care Program for Elders**

Effective January 1, 2004

CHCPE	Category 1	Category 2A	Category 2B
Monthly Income	no limit	no limit	no limit
Assets:			
single	\$18,552.00	\$18,552.00	\$18,552.00
couple	\$27,828.00	\$27,828.00	\$27,828.00
Maximum monthly cost of care	\$1,033.90	\$2,067.18	\$3,308.49

For more information on CHCPE, see [Medicaid and State-funded Home Care](#) or the state [CHCPE web site](#) or call 1-800-445-5394.

Anyone who would be eligible for Medicaid coverage in a nursing home is eligible for home care services, subject to the asset limits noted above. Individuals receiving Category 3 services receive full Medicaid benefits.

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## CSRCP - Connecticut Statewide Respite Care Program

Connecticut's Respite Care Program is funded by the State Department of Social Services and operated in partnership with the Alzheimer's Association of Connecticut and the five Area Agencies on Aging.

Respite services are available for persons (1) with a diagnoses with Alzheimer's or related diseases, (2) who are at risk of long term institutional placement if the person's regular caretaker could not continue to provide caretaker services, and (3) have an annual income of less than \$30,000 and liquid assets of less than \$80,000. Medicaid beneficiaries are not eligible.

Those eligible may not receive more than \$3,500 for services or receive more than 30 days of out-of-home respite care services during the fiscal (July through June) year. Respite care may include companions, homemakers, personal care services, adult day care services, short-term inpatient care in a nursing facility, and private duty nursing. Benefits are subject to the availability of funding. There is a 20% copayment requirement. However, this copayment may be reduced or waived by the Elderly Services Division of the Connecticut Department of Social Services (DSS) based on financial hardship.

DSS regulations require that applications for this program be processed and written notice provided within 30 days of application. There is no provision for administrative appeals.

Applications may be filed with your local Area Agency on Aging. Applications can also be obtained from any Connecticut Alzheimer's Association. For more

information or an application form, call 800-994-9422 or see information on this program at the [Department of Social Services](#) web site.

**4. 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.**

*People who have high medical expenses may also qualify for Medicaid. You may qualify as medically needy if you have high medical expenses that, when subtracted from your income, would make you eligible for Medicaid coverage. For example, people who have to pay a lot for prescription drugs, nursing home care, or other long term care services sometimes qualify as medically needy if they don't have health insurance that covers these services.*

### The Community Medicaid Spend Down

Seniors placed on spend-downs by DSS have income that is in excess of the Medicaid limit set by DSS. They qualify for Medicaid if within a six-month period they incur medical expenses in an amount that equals or exceeds the amount their income exceeds the Medicaid limit. When that occurs they will receive full Medicaid coverage -- and only until the end of the six-month spend down period.

#### Eligibility

The individual must be disabled, blind or at least 65 years of age, have assets of no more than \$1600 if single or \$2400 if married, and have incomes which exceed the Medicaid limit.

Medicaid recipients living in the community – meaning in their houses, private apartments, senior housing units, congregate housing units, etc. – are eligible to be placed on a spend-down. Nursing home and residential care home residents are exempt from the community spend down process.

Recipients of State Supplement benefits also do not need to deal with the community spend-down process because Medicaid is provided automatically with a State Supplement benefit. Also, recipients of the Connecticut Home Care Program for Elders (Category 3 - Medicaid waiver) need not deal with the community Medicaid spend-down process either.

## **Determining the Medicaid Spend Down Amount**

**One must determine the senior's "applied income." Exclude certain types of income as found in Connecticut regulations (found in the Uniform Policy Manual), but most earned income (e.g., wages) and unearned income (e.g., Social Security) is counted. Subtract from the person's unearned income the standard deduction of \$183, or other standard deduction depending upon the living situation. The remaining amount will be the person's "applied income."**

**Determine whether person lives in Region A or B or C as determined by DSS for Medicaid limit purposes and determine medically-needy income limit ("MNIL").**

**Region A is generally lower Fairfield County. The following is the current listing of towns: Bethel, Bridgewater, Brookfield, Danbury, Darien, Greenwich, New Canaan, New Fairfield, New Milford, Newtown, Redding, Ridgefield, Roxbury, Sherman, Stamford, Washington, Weston, Westport and Wilton.**

**The monthly MNIL for Region A is \$574.86 for a household of one; monthly MNIL is \$733.59 for a household of two.**

**Regions B and C contain the towns in the rest of the state.**

**The monthly MNIL for Regions B and C is \$476.19 for a household of one; monthly MNIL is \$633.49 for a household of two.**

**Subtract from the senior's applied income the Medicaid limit of the applicable region. The number that remains is then multiplied by six and the result is the senior's six-month Medicaid spend down amount.**

**Of course, the above calculation is a very general overview . . .**

## **Meeting a Medicaid Spend Down**

**During the six-month Medicaid spend-down period, a person must simply *incur* medical expenses equal to the spend-down amount. One incurs a medical expense the day a service is provided. This means that a person need not pay a bill in order to incur a medical expense, but that person is legally liable for payment of such incurred bills to the provider.**

**Medical expenses that can be used for a spend-down must meet the following conditions:**

**\* expenses must be incurred by the person whose income is used to determine eligibility,**

**\* any portion of the expense must not be payable through third party coverage unless the third party is a public assistance program totally financed by the State or by a political subdivision (e.g., ConnPACE),**

**\* the person must be current liability for the incurred expense either directly to the provider or through a lender for a loan used to pay the provider, and**

**\* the expense may not have been used for a previous spend-down in which its use resulted in eligibility.**

**Medical bills paid during a Medicaid spend-down period may only count toward the current spend-down period. Medical bills incurred during a spend-down period, but not paid, may be used to meet a subsequent Medicaid spend down period.**

**Eligible medical expenses are used by DSS in the following order:**

**\* Medicare and other health insurance premiums, deductibles and coinsurance charges,**

**\* expenses incurred for necessary medical and remedial services that are recognized under State Law as medical costs but not covered by Medicaid, and**

**\* expenses for services incurred as above but covered by Medicaid.**

**The ConnPACE Exception**

**Generally, bills paid by a third party do not count toward meeting a person's Medicaid spend-down, but ConnPACE is an exception. The *full price* of the prescription drug counts toward meeting one's spend-down. That is, the amount of the ConnPACE co-payment (currently \$16.25) plus the remaining amount of the drug the State of Connecticut pays the pharmacy, is the expense to be counted toward a person's spend down.**

**This ConnPACE exception means that there can be less actual out-of-pocket expenditures by the senior than the actual amount of the Medicaid spend-down. For example, with ConnPACE, a \$1200 Medicaid spend down can be met without the senior actually spending \$1200 in medical costs.**

**Call 1-800-423-5026 for a ConnPACE application or visit the web site at [www.connpace.com](http://www.connpace.com) .**

## **TIP – What to Bring to DSS**

**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.**

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

#### **Connecticut's Community Health Center Locations**

**Community health centers play a crucial role in the well-being of the entire state of Connecticut. The following health centers are CPCA members in good standing and have all passed the strict requirements the federal government annually demands of a Federally Qualified Health Center (FQHC) in order to provide comprehensive, family-oriented, culturally competent medical, dental and social services to the people who need them.**

**Click on an individual community health center for more information.**

## Read the 2003 Position Paper

### We Care For Your Community's Health — [2003 Position Paper](#)

#### Hartford Area Community Health Centers:

- ▶ [Charter Oak Health Center](#)
- ▶ [Community Health Services](#)
- ▶ [East Hartford Community Healthcare](#)

#### Bridgeport Area Community Health Centers:

- ▶ [Bridgeport Community Health Center](#)
- ▶ [Southwest Community Health Center](#)

#### New Haven Area Community Health Centers:

- ▶ [Fair Haven Community Health Center](#)
- ▶ [Hill Health Center](#)

#### Norwich, Killingly and Willimantic Area Community Health Centers:

- ▶ [Generations Family Health Center](#)
- ▶ [United Community & Family Services](#)

#### Norwalk Area Community Health Centers:

- ▶ [Norwalk Community Health Center](#)

#### Waterbury Area Community Health Centers:

- ▶ [StayWell Health Center](#)

#### Vernon Area Community Health Centers:

- ▶ [Vernon Area Community Health Center](#)

**6. If one doesn't qualify for SSI is there any other income assistance available?**

**Temporary Assistance for Needy Families (TANF)**

See Also: [Welfare Reform](#)

- The Temporary Assistance for Needy Families (TANF) program was signed into law on August 22, 1996. This federal legislation provides block grants to states to fund programs that provide services and benefits to needy families. TANF was designed to give states flexibility to operate programs that serve one of the following purposes.
- Provides assistance to needy families so that children may be cared for in their own homes or in the homes of relatives
- Ends the dependence of needy parents on government benefits by promoting job preparation, work and marriage
- Prevents and reduces the incidence of out-of-wedlock pregnancies and establishes annual numerical goals for preventing and reducing the incidence of these pregnancies
- Encourages the formation and maintenance of two parent families

In Connecticut, TANF funds the Temporary Family Assistance program, Safety Net, Employment Services and many other programs and services for needy families. For a description of all of the programs and services funded by TANF, please go to our [TANF State Plan 2000-2002](#).

### **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.**

#### **Informational Links**

**[Dialysis Compare](#)**

**[Preparing for Emergencies](#)**

**[Federal ESRD Program under Medicare](#)**

**[ESRD Information Resource through CMS](#)**

**[American Association of Kidney Patients](#)**

### **Section IV: Providing Healthcare for those with ESRD**

**1. Where do you apply for Social Security Disability when your kidneys fail?**

**To apply for SSDI call 1-800-772-1213 and make an appointment for either a telephone interview or to go into the nearest Social Security Office. To find the**

closest office go to <http://s00dace.ssa.gov/pro/foi/foi-home.html> and put in the client's zip code.

Oftentimes it will take months, if not years to become certified for SSDI. By providing Social Security with a complete listing of all medical treatment, hospitalizations, doctor's names, and medication you can facilitate the process. Make sure to quantify the impact of pain and fatigue on your ability to function. The process can be arduous and it is sometimes best to work with an attorney who specializes in SSDI. By law they can only be paid ¼ of the amount of retroactive benefits. See the Advocacy Resources listed at the beginning of this document.

## **2. When a client is judged disabled by SS when does he/she get the first SSDI check?**

There is a 5 month waiting period from the date Social Security judges the client disabled until they receive the first check. If the client has no income and limited assets investigate SSI for that 5 month period.

## **3. What is the monthly amount based on?**

The amount is based upon the earnings of the beneficiary.

## **4. When is the beneficiary eligible for Medicare and how do you apply for Medicare?**

Medicare begins 24 months from the date of the first check or 29 months from the date of disability. Your application for SSDI is separate from the Medicare application. Make sure both completed.

## **5. If the beneficiary is covered by a spouse's employee group plan (EGHP) or under COBRA from his/her previous employer who pays first, the EGHP or Medicare?**

Medicare is the secondary payer under several circumstances – the working aged, disabled people, accidental injuries, people with kidney failure, Worker's Compensation/Black Lung and Veteran's Benefits. In these situations either the Employer Group Health Plan, the Veterans Administration, the automobile or policy responsible for an accidental injury, etc. pays first for various periods of time. Contact Medicare at 800-772-1213 for details.

To be eligible for SSDI and 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, *quarters 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 be 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 patient takes the form to their local Social Security Office and obtains a receipt.

**6. How does the ESRD patient obtain healthcare during the 3 months prior to Medicare coverage if dialyzing in a center?**

Either the patient has private insurance, is eligible for Medicaid or must Spenddown.

**7. 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 1<sup>st</sup> 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 that 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>

## **8. 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/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.

**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 Medicaid under spenddown and Medicare.

**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.

## **9. Expedited SSI/Medicaid**

### ***Understanding Supplemental Security Income Expedited Payments***

Last modified: 10/30/2003

#### **EXPEDITED PAYMENTS**

SSI makes payments more quickly than usual in  
4 different situations:

presumptive disability or blindness payment;

- emergency advance payment;
- immediate payment; and
- Expedited reinstatement cases.

## **PRESUMPTIVE DISABILITY OR BLINDNESS PAYMENTS**

We may make presumptive disability payments available for up to 6 months, if you applied for SSI benefits because of a disability or blindness and are waiting for the State Disability Determination Services (DDS) to make a final decision.



We will base the amount of these payments on your countable income. See SSI INCOME for an explanation of countable income.

We may make a presumptive disability or blindness determination if you have one or more of the following medical conditions:

- ▶ amputation of a leg at the hip;
- ▶ Allegation of total deafness;
- ▶ Allegation of total blindness;
- ▶ Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, allegedly due to a longstanding condition—excluding recent accident and recent surgery;
- ▶ Allegation of cerebral palsy, muscular dystrophy, or muscular atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands

or arms;

**Allegation of Down's syndrome;**



**an applicant filing on behalf of another individual**



**alleges severe mental deficiency for claimant who is at least 7 years of age;**

**human immunodeficiency virus (HIV) infection;**



**Allegation of a stroke (cerebral vascular accident) more than 3 months in the past with continued, marked difficulty in using arms or legs;**



**infants who weighed less than 1200 grams at birth, or less than 2000 grams at birth and they were "small for gestational age" (i.e., weigh at least 2 standard deviations below the mean, or below the 3rd growth percentile, for gestational age);**



**Allegation of inability to ambulate without the use of a walker or bilateral hand-held assistive devices more than 2 weeks following a spinal cord injury with confirmation of such status from an appropriate medical professional;**



**A physician or knowledgeable hospice official confirms that an individual is receiving hospice services because of a terminal illness; or**



**end stage renal disease with ongoing dialysis, and the file contains a completed HCFA-2728 End Stage Renal Disease Medical Evidence Report-Medicare Entitlement and/or Patient Registration.**



**If we are not able to make a presumptive disability or blindness determination, sometimes the DDS will make one for these or other severe medical conditions, if it has information that would most likely make its final decision an approval.**

**WHAT HAPPENS TO PRESUMPTIVE  
DISABILITY PAYMENTS IF WE LATER DENY  
YOUR SSI BENEFITS?**

We do not ask you to repay these presumptive disability payments, even if you are later found not to be disabled or blind. However, if you received an overpayment for other reasons, we may ask you to repay some of the presumptive disability payments.

## **EMERGENCY ADVANCE PAYMENT**

We may be able to make an emergency advance payment to new applicants, who face a financial emergency and who are due SSI benefits that are delayed or not received. We can only pay one such advance payment. The emergency advance cannot be higher than the SSI Federal benefit rate (plus any federally administered State supplement).

## **WHO CAN RECEIVE AN EMERGENCY ADVANCE PAYMENT?**

People who are:

- due SSI benefits (including presumptive disability or blindness payments) that are delayed or not received; and
- facing a "financial emergency"—which means they need money right away due to a threat to health or safety, such as not enough money for food, clothing, shelter or medical care.

## **HOW DO WE RECOVER AN EMERGENCY ADVANCE PAYMENT?**

We will subtract the emergency advance payment from the payments already due you and pay you the difference. If you are not due past payments, we will subtract the emergency advance payment from your current monthly benefits in up to 6 monthly installments.

## **IMMEDIATE PAYMENT**

We may be able to make an immediate payment to new applicants and those already receiving SSI benefits, whose benefits are delayed or not received and who face a "financial emergency". We can make only one such payment in a 30–day period. The immediate payment cannot be higher than \$999.00.

## **WHO CAN RECEIVE AN IMMEDIATE PAYMENT?**

People who:

- are initially applying for SSI benefits, or already receiving benefits; and
- are due SSI benefits (which may be presumptive disability or blindness payments) that are delayed or not received; and
- are facing a "financial emergency"—which means they need money right away due to a threat to health or safety, such as not enough money for food, clothing, shelter or medical care.

## HOW DO WE RECOVER AN IMMEDIATE PAYMENT?

We will subtract the immediate payment from the payments already due you and pay you the difference. If you are not due past payments, we will subtract the immediate payment from the first monthly payment due you.



The decision to issue these expedited payments is up to us. You do not have formal appeal rights if we decide you are not eligible for any of these payments.

## EXPEDITED REINSTATEMENT

If your benefits ended because you worked and had earnings, you can request to have your benefits started again without having to complete a new application. We call this process *expedited reinstatement*. It was effective January 1, 2001.

You can request that your benefits start again if you:

- stopped receiving SSI benefits because of earnings from work;
- are unable to work or perform substantial gainful activity because of an impairment(s) that is the same as or related to the impairment(s) that allowed you to get benefits earlier; and
- make the request within 5 years from the month your benefits ended.

While we determine whether you can get benefits again, we can give you provisional (temporary) benefits for up to 6 months. These benefits include payments

and Medicaid coverage.

If we deny your request, we usually will not ask you to repay the provisional benefits.

If we approve your request for expedited reinstatement of your SSI benefits, your benefits will begin the month after your request. You may be eligible for Medicaid coverage.

## **10. Problems:**

### **a. Oftentimes a patient declines Medicare 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, and Medicare. For information contact <http://www.akfinc.org/Programs/ProgramsContentHIPP.htm> or call 800.638.8299.

## **Medicare Savings Program**

### *Overview*

Connecticut provides assistance with health care costs for low-income individuals covered by Medicare under the Medicare Savings Program. This program pays all or a portion of the costs of Medicare premiums. In some cases, the program pays part of the cost of medical care covered, but not fully paid for, by Medicare. This program is available to those covered by Medicare who are at least 65 years old as well as those who are disabled. In some cases, benefits can amount to several thousands dollars per year and eliminate the need to buy costly Medicare supplemental insurance coverage.

The Connecticut Department of Social Services administers this program. The Medicare Savings Program was previously known as the Medicare Cost-Sharing Program or the Medicare Buy-In Program. You may find that some Department staff still refer to the program by one of the older names.

The three components of the Medicare Savings Program:

- The Qualified Medicare Beneficiary (QMB) program.
- The Specified Low-Income Medicare Beneficiary (SLMB) program.

- **The Additional Low-Income Medicare Beneficiary (ALMB) program.**

*Which program am I eligible for?*

### **Assets**

**The Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary Programs have an asset limit. The asset limit is \$4,000 for a single person and \$6,000 for a married person. If you have more assets than these limits, you may want to consider spending down enough to qualify for these programs. Some assets are not counted, such as your home, a car, a burial account for up to \$5,400 each for you and your spouse, and life insurance with a cash value of \$1,500 or less. The Additional Low-Income Medicare Beneficiary Program has no asset limit.**

### **Eligibility for Medicare**

**You must also be a citizen or legal resident of the United States and the State of Connecticut and be enrolled in Medicare *or be eligible* for Medicare Part A. You can participate in these programs even if you are not now covered by Medicare Part A or Part B, as long as you are *eligible to enroll*. To be eligible to enroll you must be a citizen of the U.S., or a permanent legal resident for at least 5 years *and* be at least 65 years old or disabled.**

### **Income**

**Income limits are increased each year on the first day of April. Social Security cost of living increases effective in January will *not* affect eligibility until April. For purposes of determining eligibility during the first three months of a year, the amount of Social Security income for December of the previous year should be used.**

#### **Qualified Medicare Beneficiary Program**

**April 1, 2003 - March 31, 2004**

Monthly income limit for one person    \$ 932.00

Monthly income limit for a couple    \$ 1,376.00

#### **Specified Low-Income Medicare Beneficiary Program**

Monthly income for one person    \$1,081.80

Monthly income for a couple      \$1,578.00

### Additional Low-Income Medicare Beneficiary Program

Monthly income for one person      \$1,194.15

Monthly income for a couple      \$1,729.50

**You may still be eligible for these programs if you have a higher income and you share housing with at least one person who is not related to you as parent, spouse or child. In this case you can have up to \$67.90 per month in income *above* the amount listed above. The income limits are \$92.30 *lower* for those who live in a licensed boarding home.**

**In determining eligibility, one's gross income is used. Thus, the Medicare Part B premiums that are normally deducted from one's Social Security check are counted as income.**

*If my application is approved, when do benefits start?*

**SLMB and ALMB benefits may be awarded retroactively, up to 3 months before the date of application. QMB benefits are awarded retroactively to the date of application.**

*How do I apply for these programs?*

**If you think you might be eligible, you can apply at the nearest office of the Connecticut Department of Social Services. For additional information or an application form, call 860-609-5627.**

## **b. Pitfalls in Obtaining Medicare/Medicaid**

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 DSS to the awarding of benefits can take months. Additionally in order for a patient to access Medicaid during the months prior to Medicare coverage, if they are eligible for SSI they should take their SSI award letter to the Department of Social Services to get Medicaid as soon as possible rather than waiting for the system to automatically notify Medicaid they are eligible. 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” 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.

### ***11. If a patient does not have Medicaid and does not want 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 Connecticut Insurance Administration (link available in Glossary) oversees the sale and implementation of those sold in this State. The website has a chart providing the names, addresses and phone numbers of companies selling these policies as well as the cost for each. Pricing is tied to the age of the patient.

[Connecticut Medigap Policies](#)

**12. Does Connecticut have a program to protect those on Medicare from paying large copayments?**

**ConnMAP - Connecticut Medicare Assignment Program**

**Effective January 1, 2004**

<b>Maximum income</b>	<b>\$34,320.00 per year</b>
<b>Single person</b>	<b>\$2,860.00 per month</b>
<b>Maximum income</b>	<b>\$46,365.00 per year</b>
<b>Married couple</b>	<b>\$3,863.75 per month</b>

The Connecticut Medicare Assignment Program (ConnMAP) is a program run by the Connecticut Department of Social Services. Doctors and other Part B providers of supplies and services are prevented from charging those who are enrolled in ConnMAP more than the rates set by Medicare. Without ConnMAP, doctors and Part B suppliers may charge up to 115% of the Medicare approved rates. For more information or an application call 1-800-443-9946.

[Connecticut Rules for Copayments for Medicare Covered Drugs](#)

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**13. Resources in Connecticut for ESRD patients**

[Network 1](#) Provides education collects data and addresses patient grievances for ESRD patients in New England.

[National Kidney Foundation of Connecticut](#)

## Section V: Synopsis of Connecticut Prescription Drug Programs

### ConnPACE - Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled

Effective January 1, 2004

Maximum income Single person	\$20,800.00 per year \$1,733.33 per month
Maximum income Married couple	\$28,100 per year \$2,341.66 per month
Co-payment	\$16.25
Annual registration fee	\$30.00
Asset limit	Effective February 1, 2004: \$100,000 single \$125,000 couple

Please note in this program, "income" is adjusted gross income for purposes of federal income tax plus any other income minus Medicare Part B premium payments.

Asset eligibility will be determined in the same manner as determined for the Connecticut Home Care Program for Elderly (CHCPE). [Click here](#) for a summary of asset eligibility for both programs. Also, effective September 1, 2003, the State of Connecticut will be able to recover, from the estates of deceased ConnPACE beneficiaries, sums equal to monies spent by the State on the behalf of ConnPACE beneficiaries since July 1, 2003. Currently the State is not enforcing this provision and bills have been introduced to repeal this provision in 2004.

For more information and/or an application, call 1-800-423-5026 or visit the [ConnPACE web site](#). Also see [Prescription Drug Assistance](#) within [CTElderLaw.org](#).

[Please click here to go to the ConnPACE website.](#)

View the ConnPACE Application on our [Publications page](#)

#### [Directory of Prescription Drug Patient Assistance Programs](#)

This website is maintained by the Pharmaceutical Research and Manufacturer's Association to help people who are uninsured or under-insured obtain prescription drugs at reduced cost.

Pharmaceutical Research and Manufacturers of America (PhRMA)

#### [Freedom Rx](#)

(877)226-5303

Freedom Rx is a prescription drug program. If you are single and your annual income is less than \$16,000- or married and income less than \$25,000 you may qualify for a U.S. Government Approved Prescription drug program. To see if you qualify, call 1-877-226-5303. Mailing address: 42113 Cottenwood Drive, Suite 100 Hammond, LA 70403

Freedom Prescription

