



2019/2020 EAHP Annual Report

Equal Access to Healthcare Program

MISSION STATEMENT

To help people affected by HIV/AIDS, substance use, or mental health issues better realize opportunities by providing integrated legal, social, and health services that address the broad range of social risk factors that impact wellness and limit potential.

VALUES

WE ASPIRE TO PROVIDE SERVICES THAT:

- Give clients the knowledge they need to make their own choices.
- Aid all clients in a culturally-appropriate way.
- Utilize a client-centered model, emphasizing one-on-one and group relationships.
- Are easy to access.

WE ASPIRE TO BE AN ORGANIZATION THAT:

- Is culturally competent and diverse across all levels, from volunteers to our staff to our board.
- Respects and seeks participation from all agency stakeholders, including people living with HIV, in all areas of the organization.
- Operates at all levels with accountability, honesty and integrity.

WE ASPIRE TO MEET THE NEEDS OF ALL PEOPLE AFFECTED BY OR AT RISK FOR HIV, INCLUDING:

- People of any sexual orientation or gender identity.
- Immigrants, regardless of immigration status, and people with limited English proficiency.
- People who are (or who have been) incarcerated; ex-offenders; people with dependents; people of color; people with mental or physical disabilities, including the deaf and hard of hearing; women; youth; seniors; sex workers; active drug users; and people in recovery.



Dear Friends,

After completing our sixth year, we are pleased to share the accomplishments of PRC's Equal Access to Healthcare Program (EAHP) with you. EAHP continues to adapt in order to meet the needs of the San Francisco residents living with

HIV who we serve. During our first year in PRC's Integrated Service Center, the EAHP team stepped up to welcome new, as well as existing clients, to our new space. The move has allowed for expanded client services and enhanced our ability to effectively serve and advocate on their behalf.

PRC's EAHP team understands the needs of the community are changing and we have been focused on reaching out to underrepresented members of our San Francisco community living with HIV. This year, EAHP saw an increase in services provided to minority groups, with over 15% of our clientele identifying as African American/Black and over 20% identifying as Latino/Hispanic. We have also continued outreach efforts to female and transgender community members, recognizing that they are often more likely to lack healthcare or healthcare advocates.

In this time of ever-changing federal and state healthcare programs, we feel it is important to help our community understand the avenues available to appeal unfavorable decisions by various healthcare programs and providers. In this report, we focus on the path to appealing within three major programs, Medicare, Medi-Cal, and private healthcare providers, outlining the procedures available to dispute charges or denials of service. We hope this information will help empower our community to effectively advocate for their healthcare in a system which can often feel designed to misdirect or confuse clients and advocates.

Finally, at the time of this printing we are still under the Shelter-In-Place orders for San Francisco due to the COVID-19 pandemic. We remain awestruck by the unprecedented changes and challenges we face as a community. At the same time, we are encouraged and thankful for the proactive steps so many agencies and frontline advocates have taken to keep our community healthy and safe. This truly is an amazing network of passionate and compassionate professionals, and we feel privileged to be part of it.

We would like to thank you, our community partners and friends, who continue to support our mission. We want to expressly thank the San Francisco Department of Public Health, Gilead Sciences, Inc., Magellan Cares Foundation, Horizons Foundation and the Bigglesworth Family Foundation for their continued sponsorship of our work.

Beth Mazie

Beth Mazie, Esq.
Managing Legal Director

Jason Cinq-Mars

Jason Cinq-Mars, Esq.
Supervising Attorney

TOP FIVE PRESENTING ISSUES

- 1 Medi-Cal
- 2 Income/Asset
- 3 MEDICARE
- 4 ADAP
- 5 Lack of Coverage

SERVING OUR COMMUNITY

EAHP serves a diverse and multi-cultural clientele who share common concerns about how to obtain or maintain access to healthcare within a complex landscape. Clients seek our assistance in times of change. Many come to us when their access to healthcare is at risk, either due to a health coverage denial or denial for specific services. EAHP provides free legal advice, healthcare advocacy, and community trainings to help ensure that clients and their service providers are aware of the options available so that they can maintain the best coverage to meet their individual needs.

SERVICES AND ACCOMPLISHMENTS

Total Clients Served

583

Clients Received Consultation and Advice With SSA Case

303

Clients Received Legal Advocacy and Representation

290

64

Clients With Closed Cases Who Obtained, Preserved or Increased Health Care Access

56

Community Providers Received Consultation and Advice

23

Outreach and Training Events Conducted

CHARACTERISTICS OF EAHP CLIENTS 2019-2020

ETHNICITY

15%	AFRICAN AMERICAN/BLACK
6%	ASIAN OR PACIFIC ISLANDER
54%	CAUCASIAN/WHITE
20%	LATINO/HISPANIC
2%	NATIVE AMERICAN
3%	OTHER OR UNKNOWN

GENDER

90%	MALE
7%	FEMALE
3%	TRANSGENDER

SEXUAL ORIENTATION

6%	BISEXUAL
72%	GAY/HOMOSEXUAL
14%	HETEROSEXUAL
.2%	LESBIAN
7.8%	UNKNOWN, DECLINE TO STATE OR UNSURE

AGE

22%	60+
37%	50-59
24%	40-49
14%	30-39
3%	20-29

MEDICARE

MEDICARE is the federal health insurance program for people who are 65 or older, certain younger people, and adults with disabilities or End-Stage Renal Disease.



A person becomes eligible the month of their 65th birthday, or the 25th month after their entitlement to Social Security Disability Insurance (SSDI) benefits. Most, but not all, people are automatically enrolled into Medicare.



You must enroll in Medicare when you are eligible in order to avoid a late enrollment penalty.

PATH TO APPEAL

If you are denied services or coverage by Medicare, you can appeal. The appeals process for Original Medicare, Parts A and B, begins with the Medicare Summary Notices (MSN). The MSN shows what service or supplies were billed to Medicare, what Medicare paid, and what you owe the provider(s). If you disagree with the notice, you can appeal.

EXPEDITED OR "FAST APPEAL" (PART A)

You may have the right to a "fast appeal" if you think your Medicare-covered services are ending too soon.

1) Fast Appeals in a Hospital

If you believe you are being discharged from a hospital too soon, you have the right to request an immediate review of your case.

- A hospital cannot force you to leave before a decision is made.
- You must request a "fast appeal" no later than the day you are scheduled to be discharged.

2) Fast Appeals from Non-Hospitals

- You should get a "Notice of Medicare Non-Coverage" at least 2 days before Medicare-covered services end.
- Request a "fast appeal" no later than noon of the first day after the day before the termination date listed on your "Notice of Medicare Non-Coverage." Follow the instructions on the notice.

ORIGINAL MEDICARE APPEALS

If you disagree with Medicare's denial of a service, item or drug that you think should be covered or how much you are being asked to pay:

1) Fill out and submit a "Redetermination Request Form," available online, within 120 days of receipt of the MSN and send it to the company that handles claims for Medicare. Their address is listed in the "Appeals Information" section of the MSN.



- Include your name, address and Medicare number.
- Circle the item you disagree with on the MSN or list the services for which you are requesting redetermination and the dates of service.
- Include an explanation of why the items or services should be covered.
- Ask your healthcare provider for any information that may help your case.

2) You will generally get a decision called a "Medicare Redetermination Notice" within 60 calendar days after your request is received.



If you think your health could be seriously harmed by waiting for a decision about a service, request a fast decision. A decision must be made within 72 hours.

If denied, you have 180 days in which to fill out and file a "Medicare Reconsideration Request Form."

3) Include in your written request:

- Your name and Medicare Number.
- The specific item(s)/services and dates of service for which you are requesting a reconsideration.
- The name of the company that made the redetermination or the redetermination notice.
- An explanation of why you disagree with the decision.

4) You will generally get a decision called a "Medicare Redetermination Notice" within 60 calendar days after your request is received.

5) If you disagree with the reconsideration decision, you have 60 days after you receive the "Medicare Reconsideration Notice" to request a decision by the Office of Medicare Hearings and Appeals (OMHA).

To receive a hearing or review by OMHA, the amount of your case must meet a minimum dollar amount. (\$170 in 2020)

Send your request for hearing to the OMHA Central Operations by filling out a "Request for Medicare Hearing by an Administrative Law Judge" or submitting a written request.

6) If you disagree with the OMHA's decision, you have 60 days after you receive the decision to request a review by the Medicare Appeals Council.

7) If you ultimately disagree with the Medicare Appeal Council's decision, you have 60 days after you receive the decision to request judicial review by a federal district court.



Appeals for Parts D and C plans are managed by your plan. To appeal a decision follow the instructions on the plan's initial denial notice.

"My experiences with PRC are outstanding."

- EAHP Client

"Very helpful, informative and super nice."

- EAHP Client

MEDI-CAL

Medi-Cal is a program that offers no-cost or low-cost health coverage to adults and children with limited income and resources.

INFORMAL RESOLUTION:

If you believe you were wrongly denied benefits or your benefits have been discontinued, the first step is to contact your local Medi-Cal office to see if they can resolve the issue without a formal complaint. Ask the representative if they can make the corrections or adjustments on their own. If not, request that your case be escalated to a supervisor.



- Have any letters Medi-Cal has sent you to reference when you call.
- Make sure to get the name of any representatives that assists you.

FORMAL APPEALS PROCESS:

If your benefits or services were modified or denied, you have a right to request a Fair Hearing.



You must file your request for hearing within 90 days of receiving the Notice of Action (NOA).

1) Submit your "Request for State Hearing" form to the county welfare department AND to the California Department of Social Services State Hearings Division, or to the California Department of Social Services. Instructions can be found online at <https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx>.



If you are currently receiving benefits and have been notified that your benefits will be discontinued, you can continue to receive services while your case is under review if you appeal within 10 days and ask for Aid Paid Pending.

2) An appeals specialist may contact you to gather information and may be able to resolve your issue without the need for a hearing. If the issue cannot be resolved, a hearing will be scheduled where you will be able to provide any evidence that supports your claim. At your hearing, you will be allowed to present your evidence, make arguments and give a closing statement. The decision of the formal hearing is binding.

3) If you receive an unfavorable hearing decision, you may request a rehearing by sending a written request to the Rehearing Unit of the State Hearings Division within 30 days of receiving the decision. Be sure to include the date of the adverse decision, the reason a rehearing should be granted and any additional evidence that will be submitted with an explanation why it was not submitted at the original hearing.

4) You can also request judicial review of the adverse decision by filing a petition for a Writ of Mandate in Superior Court within one year of receiving notice of the final decision from the hearing.

"Your services are extraordinary, and I am very grateful!"

- EAHP Client

"PRC makes me feel protected and cared for."

- EAHP Client

PRIVATE HEALTH INSURANCE

The Affordable Care Act (ACA) guarantees the right to appeal denials by private health insurance plans. If a beneficiary disagrees with a decision not to pay for services they have the right to appeal through their health plan.

HEALTH PLAN OBLIGATIONS

You must receive adequate notice of the reason why the service or claim was denied, and be provided instructions and a deadline on how to submit an appeal. If you are dissatisfied with the appeal outcome, you are entitled to an external review process.

APPEALS PROCESS

There are two levels of appeals provided within the ACA, an internal appeal and an external appeal.

1) Internal Appeal

If you disagree with a termination of benefits, or denials of benefits or services by your private health plan:



The insurance plan must provide the reason for the denial in writing with instructions on how to appeal.

- Call the plan's customer service number to see if the denial was a clerical or data entry mistake that can be corrected by customer service.
- An internal appeal must be filed within 180 days of receipt of the denial notice. If there is an urgent health situation, ask for an external review at the same time as the internal review.



Keep copies of ALL information related to the claim and the denial.

- Get the name of any health plan representative that you talk to. Keep a log with the representative's name, the date you spoke with them, and any information provided.
- The health plan must complete its internal review within 30 days if the appeal is for a requested service that has not been delivered, or within 60 days for a service that has already been received.

2) External Appeal

If your claim is still denied, the insurance must tell you how to request an External Review.

- You must file a written request for an external review within four months of a notice or final determination from the plan.

NOTE: In California, these appeals are handled by the California Department of Managed Health Care (DMHC) Independent Medical Review (IMR) process and can be filed by mail, fax, or online at Healthhelp.ca.gov.

- The external review is usually decided within 45 days, and can uphold the insurer's decision or decide in your favor.
- If the complaint is decided in your favor, the insurers must accept the external reviewer's decision to provide or pay for the service, or do whatever is needed to resolve the complaint. If the complaint is not decided in your favor, you cannot appeal the decision, but you may still be able to take legal action and should consult with a private attorney to explore your options.

COBRA/CAL COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that grants workers and their families the right to remain on their employer group health plan for an additional 18 to 36 months if they lose those health care benefits due job loss or reduced hours.

Eligibility:

- Employer must have 20 or more employees;
- Employee must have been enrolled in their employer's group plan when they lost coverage; and
- The health plan must continue for active employees.

Employer Obligation:

Employers must notify eligible employees of their COBRA rights and offer them at least 60 days to enroll. If you have not received notification contact your employer.



The Employee is responsible for the full cost of the healthcare premiums.

- COBRA benefits can end before the 18-month period if the beneficiary
 - becomes eligible for Medicare,
 - obtains coverage under another group plan, or
 - the former employer discontinues the group health plan.
- When the 18 month COBRA eligibility period is exhausted, the employee may be entitled to an additional 18 months of coverage under Cal-COBRA, a California law that applies to employers with less than 20 employees. It can provide up to an additional 36 months health coverage.

EAHP STAFF



Bill Stewart, Esq. **Staff Attorney**

Bill is a long-time resident of San Francisco, having spent decades living in, or near, the Castro. Bill followed his passion for helping fellow members of the LGBTQ+ and HIV+ communities by starting a second career in the law and by joining PRC's legal advocacy team.



Brittany Peck, Esq. **Benefits Advocate**

Brittany believes that client-centered advocacy is essential for clients to make fully informed decisions that match with their legal goals. Brittany obtained her B.A. from University of Hartford and attended Suffolk Law School.



Ryan Leong, Esq. **Supervising Attorney**

Ryan believes that healthcare access is a fundamental human right and is grateful for the opportunity to help clients navigate the often complex world of healthcare services. Ryan graduated from the University of San Francisco School of Law and was previously a private practice attorney representing a wide variety of clients.



Kalli Leal, **Legal Assistant**

Kalli has a Bachelor's degree from University of California, Santa Cruz in Psychology and Latin American and Latino Studies. Kalli comes from a child welfare background and understands the importance of diverse representation and compassionate delivery of public service.



Jason Cinq-Mars, Esq. **Supervising Attorney**

Jason firmly believes that taking the time to help clients understand the legal process is vital to their success in any legal arena. Jason is an Air Force veteran, obtained his MSA from Central Michigan University and attended UC Davis, King Hall School of Law.



Beth Mazie, Esq. **Managing Legal Director**

Beth was previously a Senior Supervising Attorney in the Equal Access to Health Program. She has worked as a Social Security benefits attorney at Rubicon Legal Services and is currently a volunteer mediator with Community Boards. Beth is committed to empowering people to learn about and access resources and benefits that enable them to stabilize and improve their lives.

Legal Advocacy Team

Alisa Jackson, Supervising Legal Assistant
Amanda DeHart, Staff Attorney
Beth Mazie, Managing Legal Director
Bill Stewart, Staff Attorney
Brittany Peck, Benefits Advocate
Dawn Evinger, Communications Coordinator
Elizabeth Cermak, Staff Attorney
Elizabeth Pickell, Benefits Advocate
Fernando Aguayo-Garcia, Director of Quality Assurance
Iara Ried, Legal Assistant
Jason Cinq-Mars, Supervising Attorney
Kalli Leal, Legal Assistant
Kelly Watkins, Supervising Attorney
Negin Mohajeri, Paralegal
Ron Kurlaender, Senior Supervising Attorney
Ryan Leong, Supervising Attorney
Sierra Varano, Legal Assistant
Tricia Frost, Legal Assistant

Executive Team

Brett Andrews, Chief Executive Officer
Christopher Brown, Chief of Policy and Government Affairs
Chuan Teng, Chief of Programs/Confidentiality Officer
James Wegman, Chief Information Officer
Joseph Tuohy, Chief Operating Officer
Katherine Bella, Chief Strategy Officer
Micah Thomas, Executive Administrator
Robert Pascual, Chief Financial Officer

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