TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY POLICY
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

410-767-1463 or 1-800-492-5231 option 2 and request extension 1463

MANUAL: Medical Assistance **EFFECTIVE DATE: March 1, 2006**

RELEASE NO: MR-132 **ISSUED: February 2006**

APPLICABILITY: Chapter 10 updates; long-term care notices and forms; deduction of noncovered medical or remedial services from recipients' available income for the cost of care; prescription drug costs and post-eligibility deductions

Item	**Remove Pages**	**Insert Pages**
Chapter 10 – Eligibility for Institutionalized Persons		
Table of Contents	iii	iii
Appendix B – Table of Contents – Long Term Care Forms and Notices	1000-97 – 1000-99	1000-97 – 1000-99
DHMH 1159D Worksheet for Institutionalized Persons – Cost of Care/ Available Income		DHMH 1159D (after DES 2005)
DHMH 4233 (LTC) Notice of Eligibility		DHMH 4233 (after DHMH 4210)
DHMH 4240 (LTC) Notice of Change in Available Income		DHMH 4240 (after DES 100)
Policy Alert 10-12 "Deduction of Noncovered Medical or Remedial Services from an Institutionalized Person's Available Income for the Cost of Care"		Policy Alert 10-12 (after Policy Alert 10-11)
Policy Alert 10-13 "Prescription Drug Costs and Post-Eligibility for Institutionalized Persons"		Policy Alert 10-13 (after Policy Alert 10-12)

COMMENTS

Chapter 10

- **Appendix B – Long-Term Care (LTC) Forms and Notices**

  Added to Appendix B:
  DHMH 1159D LTC worksheet
  DHMH 4233 LTC Notice of Eligibility
  DHMH 4240 LTC Notice of Change in Available Income

These documents are mentioned in Policy Alert 10-12, issued in this Manual Release. Since these forms are no longer printed by the DHMH Division of Eligibility Policy & MCHP, eligibility caseworkers may copy and use the forms from this Manual Release, create word processing documents, or download these forms from the electronic version of MR-132 on the DHMH Medicaid website www.dhmh.state.md.us/mma/mma/pdf/mr132.pdf.

- **Policy Alert 10-12 Deduction of Noncovered Medical or Remedial Services from an Institutionalized Person's Available Income for the Cost of Care**

Manual Release 126, effective August 1, 2005, issued policy changes for pages 1000-35 – 1000-36, related to the post-eligibility deduction of noncovered medical or remedial services from institutionalized recipients' available income for the cost of care. These policies conform to federal requirements and a Medicaid State Plan amendment. Pages 1000-35 – 1000-36 were revised again in Manual Release 127, effective December 1, 2005.

Policy Alert 10-12, issued in this Manual Release, provides a complete explanation of those policies related to deductions for noncovered medical or remedial services from long-term care or waiver recipients' available income for their cost of care. Also, the procedures are explained for verifying the recipient's unpaid incurred expenses, requesting DHMH's Beneficiary Services Administration to approve the total amount of the allowed deduction, and calculating the recipient's monthly deductions and available income.

- **Policy Alert 10-13 Prescription Drug Costs and Post-Eligibility for Institutionalized Persons**

Policy Alert 10-13 provides information related to Medicare enrollees' expenses for Medicare premiums and prescription drugs, effective with implementation of Medicare Part D prescription drug coverage as of January 1, 2006. The Policy Alert specifies how these changes impact deductions for Medicare premiums and noncovered services from a long-term care recipient's available income for the cost of care.

Contact the DHMH Division of Eligibility Policy at 410-767-1463 if you have any questions about this Manual Release.

TABLE OF CONTENTS (Continued)

Chapter 10 Eligibility for Institutionalized Persons

the representative, agreeing to provide information to the LDSS.

- The second section is completed and signed by the representative, when the applicant/recipient is unable to sign the form, agreeing to provide information to the LDSS.

9. **DES 2005 (LTC)** – Consent for Release of Information to long-term care facility (LTCF)

   Necessary

   - This form is signed by the applicant/recipient to authorize the LDSS to release information to the LTCF.

10. **DHMH 1159D (LTC) –** Worksheet for Institutionalized Persons – Cost of Care/Available Income

    Optional

    - This worksheet is used by the eligibility caseworker to calculate the cost of care, monthly income, deductions, and available income. This worksheet is used for difficult calculations that might not be calculated correctly by CARES, such as deductions for noncovered services over multiple months. The caseworker then enters the correct information on the CARES screens.

11. **DHMH 4210 (LTC)** – Notice of Ineligibility for Non-Financial Reasons

    Necessary

    - This notice is used when the applicant/recipient is not eligible for MA due to non-financial reasons. It advises the applicant/recipient of the reactivation date. When needed, it may indicate that the applicant/recipient is within the income and asset scales but a DHMH 257 with the level of care certification has not been received by the LDSS. This manual notice is to be used until the appropriate LTC notice is available through CARES.

12. **DHMH 4233 (LTC)** – Notice of Eligibility

    Optional

    - This manual eligibility approval notice is used, and the CARES notice is suppressed, when it is difficult to get CARES to put the correct information on the system-generated notice, such as when more than one column is completed for deductions to available income that change (e.g. deductions for noncovered services).

13. **DHMH 4235 (LTC)** – Notice of Ineligibility due to Excess Resources or Disposal of Resources

    Necessary

    - This notice is used to advise the applicant/recipient that the resources exceed the allowable resources standard, or that resources were transferred or otherwise disposed of for less than fair market value. There is space to list the resources and the value of each. This manual notice is to be used until the appropriate LTC notice is available through CARES.

14. **DES 100 (LTC)** – Explanation of Ineligibility due to Excess Resources – Attachment to DHMH 4235

    Necessary

    - This is an **attachment to the DHMH 4235** notice for recipients. It indicates that MA is cancelled due to excess resources, gives the amount of over-scale resources, specifies the effective date of cancellation, and advises the individual that benefits may be restored if the excess amount of the resources is used to reimburse the Medicaid program for its payments (see pages 800-12 – 800-15).

15. **DHMH 4240 (LTC)** – Notice of Change in Available Income

    Optional

    - This manual notice is used to inform the recipient and long-term care facility of a change in the recipient's available income for the cost of care. The CARES notice is suppressed if CARES is unable to put the correct information on the

system-generated notice. For example, suppress the CARES notice when more than one column is completed for changes in deductions that affect the monthly available income for the cost of care (e.g. deductions for noncovered services).

16. **DHMH 4245** – Physician Report

Necessary

- This form is completed by the applicant/recipient's physician to indicate how long the physician anticipates the individual will remain in the LTCF. It is used as part of the consideration of home property and a residential maintenance allowance.

17. **DHMH 4255 (LTC)** – Home Exclusion – Statement of Intent

Necessary

- This form is completed whenever a person has home property, to indicate the institutionalized person's intent to return to the home property (see pages 800-17-800-18). It is used as part of the consideration of home property and a residential maintenance allowance.

18. **DHMH 4343** – Declaration of Joint Bank Account Ownership Interest

Optional

- This form is completed and signed by the applicant/recipient and any co-owners who have a bank account(s) or other liquid assets in common. The owners must also indicate their ownership interest in each account (see pages 800-47 – 800-57).

NOTE: An **optional** form or notice is used at the discretion of the eligibility caseworkers. A necessary form or notice is required to be used for the stated purpose.

MARYLAND MEDICAL ASSISTANCE PROGRAM

Worksheet for Institutionalized Persons

Cost of Care/Available Income

Application Date: _____	Consideration Periods: _____ to _____
Redetermination Date: _____	_____ to _____

Cost of Care Determination

	Effective _____	Effective _____	Effective _____
Private Per Diem	$_____	$_____	$_____
Days Per Month	x _____	x _____	x _____
Monthly C.O.C.	$_____	$_____	$_____

Available Income Determination

	Effective _____	Effective _____	Effective _____
Monthly Income:			
Social Security	$_____	$_____	$_____
V.A.	_____	_____	_____
Pension	_____	_____	_____
Other _____	_____	_____	_____
Other _____	_____	_____	_____
Total Monthly Income	$_____	$_____	$_____
Deductions:			
Personal Needs	$_____	$_____	$_____
Health Insurance	_____	_____	_____
Medicare	_____	_____	_____
Other _____	_____	_____	_____
Total Deductions	-_____	-_____	-_____
Available Income	$_____	$_____	$_____

Eligibility Decision

☐ Available income is less than cost of care. Eligible for MA and cost of care. Issue 206N showing income. Complete 1159C, LIEN WORKSHEET, if the institutionalized person has home property.

☐ Available income is equal to cost of care. Eligible for MA card only. Issue 206N showing available income. Complete 1159C, LIEN WORKSHEET, if the institutionalized person has home property.

☐ Available income is greater than cost of care. For applications, proceed to side 2. For recipients, close case.

Explain decision on 1159 A-1

Spend-Down

Available income is greater than cost of care. Ineligible for cost of care.

Consideration Period _____ to _____

Income:

Total Monthly Income $_____ x _____ = $_____

Allowances:

Personal Needs	$_____ x _____ =	$_____	
Spousal/Dependent	_____ x _____ =	_____	
Residential	_____ x _____ =	_____	
		Total Allowances	**-_____**
		Available Income	$_____

Cost of Care:

Private per diem $_____

Days in period x _____

Projected Cost of Care **-_____**

Excess Available Income $_____

Medical Expenses:

Date	**Amount**
_____	$_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ Spend-down met on _____. Eligible for MA card only. Complete 1159C, LIEN WORKSHEET, if the institutionalized person has home property.

☐ Application preserved for the period _____ to _____. Explain decision on 1159A-1

_____ _____
Case Manager Date

MARYLAND MEDICAL ASSISTANCE PROGRAM
NOTICE OF ELIGIBILITY

Re: _____ Date: _____
Name

Client Identification Number: _____ LTC Facility: _____

Dear _____:

This is to notify you that the individual identified above has been determined **eligible** for Medical Assistance (MA) for the period _____through_____. The MA card will be sent to the Long Term Care Facility. A portion of the patient's income must be paid directly to the Facility, and you must contact the Facility to establish the time and manner of payment.

(NOTE: The Department of Social Services and the LTC facility must be notified of any increase in the patient's current income benefits and/or any new benefits received. The increased amount must be paid to the facility when received, whether or not a notice of increased payment requirement is received from the Department of Social Services or the facility has billed for it.)

The portion of income to be paid to the Long Term Care Facility has been calculated as follows:

	Effective _____	**Effective _____**	**Effective _____**
Social Security	$_____	$_____	$_____
Veterans Benefits	_____	_____	_____
Pension _____	_____	_____	_____
Other _____	_____	_____	_____
Total Income	$_____	$_____	$_____
Personal Needs	_____	_____	_____
Health Insurance	_____	_____	_____
Medicare	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____
Total Deductions	-_____	-_____	-_____
Cost of Care	$_____	$_____	$_____

If these amounts are not correct, you must contact the Department of Social Services immediately and, if necessary, the Department will adjust these amounts.

Any change in income, resources, health insurance premiums, medical expenses, living arrangements, persons living in the home, etc., must be reported within 10 working days to the Department of Social Services. The recipient, representative, and Long Term Care Facility are responsible for reporting such changes. Any of these changes could affect eligibility and income paid for the cost of care. This decision is based on COMAR 10.09.24__. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached.

Sincerely,

_____
Case Manager

_____
Department of Social Services

cc: Representative
Long Term Care Facility

Telephone_____

HOW TO HAVE A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- **Call** the telephone number on the other side of this notice to ask for a conference.
- **Request** a hearing by:
- **Calling** 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- **Visiting** your local department office and requesting a hearing; or
- **Mailing or giving** a request for a hearing in writing to your local department office, or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- **If you don't want to fill out the form** to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than **90 days** after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than **10 days** after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTICE OF CHANGE IN AVAILABLE INCOME

Date: _____

Re: _____
Name

_____ LTC Facility _____
Client Identification Number

Dear _____:

Based on a review of Medical Assistance eligibility for the person named above, the portion of income to be paid to the Long Term Care Facility has been recalculated as follows:

	Effective _____	**Effective _____**	**Effective _____**
Social Security	**$**_____	**$**_____	**$**_____
Veterans Benefits	_____	_____	_____
Pension _____	_____	_____	_____
Other _____	_____	_____	_____
Total Income	**$**_____	**$**_____	**$**_____
Personal Needs	_____	_____	_____
Health Insurance	_____	_____	_____
Medicare	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____
Total Deductions	-_____	-_____	-_____
Cost of Care	**$**_____	**$**_____	**$**_____

If these amounts are not correct, you must contact the Department of Social Services immediately and, if necessary, the Department will adjust these amounts.

Any change in income, resources, health insurance premiums, living arrangements, persons living in the home, etc., must be reported within 10 working days to the Department of Social Services. The recipient, representative, and Long Term Care Facility are responsible for reporting such changes. Any of these changes could affect eligibility and income paid for the cost of care.

This decision is based on COMAR 10.09.24.___. If you do not agree with this decision, you have the right to request a hearing. The procedures for requesting a hearing are attached.

Sincerely,

_____
Case Manager

_____
Department of Social Services

Telephone_____

cc: Representative
Long Term Care Facility

HOW TO HAVE A HEARING IF YOU THINK WE ARE WRONG

What do I do if I think your decision is wrong?

- **Call** the telephone number on the other side of this notice to ask for a conference.
- **Request** a hearing by:
- **Calling** 1-800-332-6347 or the telephone number on the other side of this notice and requesting a hearing; or
- **Visiting** your local department office and requesting a hearing; or
- **Mailing or giving** a request for a hearing in writing to your local department office or to the following address:

DHMH Docketing – Unit A
Office of Administrative Hearings
11101 Gilroy Road
Hunt Valley, Maryland 21031-1301

- **If you don't want to fill out the form** to request the hearing:
- Come to your local department office. We will help you.
- Call your case manager at the telephone number on this notice or call 1-800-332-6347.

How long do I have to request a hearing?

- You must ask for a hearing no later than **90 days** after the date of this notice.

How long can I still get my benefits while I wait for my hearing?

- If you ask for a hearing no later than **10 days** after the date of this notice and you were getting benefits, you can continue to get your benefits while you wait.

Will I owe any money if I get my benefits while I wait?

- If the judge agrees with us and you lose your appeal, you may have to pay back benefits. This might not be required if it is determined that your request for a hearing resulted from a bonafide belief that the department's decision was in error.

When and where will the hearing be?

- The Office of Administrative Hearings will send you a notice telling you the time and place of your hearing.

Do I have to come to the hearing?

- Yes. You will lose if you do not come. If you can't come, tell the Office of Administrative Hearings and they will reschedule your hearing.

Can I bring someone to help me or speak for me?

- Yes. You can bring a lawyer, friend, or relative. If you want free legal help, call your local department or call Legal Aid at 1-800-999-8904. To see if you qualify for free legal representation, call the Maryland Volunteer Lawyer Services at 1-800-510-0050.

How can I prepare for the hearing?

- You can see your file, including your computer file, at your local department and talk with us about this decision. Please call the telephone number on the other page to make an appointment. We will send you our reasons for the decision that you are appealing, at least 6 days before your hearing.

Policy Alert 10-12

Deduction of Noncovered Medical or Remedial Services from an Institutionalized Person's Available Income for the Cost of Care

Certain deductions are allowed when calculating an institutionalized person's available income for the cost of care in a long-term care (LTC) facility or waiver program (see pages 1000-34 – 1000-37 of the Manual). One of the allowable deductions is for the individual's unpaid, incurred expenses for necessary services recognized under State law as medical or remedial care but not covered by the State's Medical Assistance (Medicaid) program.

Under two circumstances, noncovered services may be used as a deduction from a recipient's contribution towards the cost of care (patient resource amount):

A. The individual was enrolled as a Medicaid LTC or waiver recipient for the date of service, but the necessary medical or remedial service is not covered under the Medicaid State Plan.

   For example, services that are only covered by Maryland Medicaid for children younger than 21 years old (e.g., private duty nursing, eyeglasses, dental care, dentures, or hearing aids) may be deducted from an adult LTC or waiver recipient's available income for the cost of care. Deductions for noncovered assisted living services may not include room and board, just expenditures for the types of services covered for waiver enrollees.

B. The recipient is not Medicaid-eligible for the service date, and the service was received:
   - During the three-month retroactive period associated with the date of application; or
   - During any period between the application month and the first month of current eligibility.

   For example, unpaid bills for nursing facility services received by a recipient during ineligible months in the retroactive period (e.g., when the recipient was still resource over scale) may be deducted from the recipient's available income for the cost of care. **Please note that there is no retroactive period associated with a waiver application, just with LTC applications.*

1. If an applicant/recipient (A/R) or representative mentions that the A/R has unpaid medical bills, the eligibility case worker:

a. Verifies that the service:

- Meets one of the two conditions above;
- Is unpaid and remains the A/R's obligation to pay (e.g., has not already been paid and is not subject to payment by a third party), as verified by a current bill, invoice, or contract from the provider;
- Is recognized under Maryland law as a medical or remedial service (see Appendix to Chapter 9 of this Manual for the description of covered and noncovered services); and
- Was necessary (e.g., would be reimbursed by Maryland Medicaid if the individual and/or service were covered).

b. Requests the necessary verifications. The provider's bill, invoice, or contract must:

- Be either a current contract or a bill or invoice that is no more than one month old;
- Specify the date(s) of service;
- Give a detailed description of the services received;
- Specify the provider's charge for each service received (e.g., give separate charges for nursing facility services and for non-medical services such as beauty parlor);
- Specify any payments received or third party liability for the services (e.g., payments from the A/R or others on the A/R's behalf, health insurance, Medicare, LTC insurance, etc.); and
- Give the provider's name, address, and telephone number.

2. To determine the allowable deduction, the eligibility case worker sends a self-addressed envelope, a copy of the cost of care worksheet, and a copy of the detailed current bill, receipt, or contract to:

DHMH Beneficiary Services Administration
Attn: Noncovered Services
201 West Preston Street, Rm. L-9
Baltimore, MD 21201

3. When the caseworker receives DHMH's approval to deduct a specified total amount for the noncovered services, the caseworker manually calculates the A/R's available income for the cost of care, to assure that it is calculated correctly. Use the DHMH 1159D (LTC) Worksheet for Institutionalized Persons - Cost of Care/Available Income. (See this form

in Appendix B to Chapter 10 of this Manual.) Each deduction for noncovered services is entered on a separate line under "Other" deductions on the worksheet.

- If the amount approved by DHMH for the noncovered service deduction *is less than* the A/R's monthly available income without the noncovered service deduction, use the amount approved by DHMH as the deduction.
- If the noncovered service deduction approved by DHMH *exceeds* the A/R's monthly available income, use the A/R's monthly available income without the noncovered service deduction as the monthly deduction for the noncovered services. Then, the available income is reduced to $0. All of the A/R's net countable income, after any other deductions are subtracted (e.g., spousal maintenance allowance, personal needs allowance), is allowed as the deduction for noncovered services, so the recipient may pay off the provider's bill as quickly as possible.
- Complete more than one column on the DHMH 1159D worksheet if there is an anticipated change in income, cost of care, or deductions—e.g., the recipient's income is changing due to a cost of living increase, or the deduction for Medicare premiums is ending in the 3rd month of Medicaid eligibility when Medicare Buy-In begins.
- Estimate for how many months the deduction for noncovered services will continue until the monthly deductions total the deduction approved by DHMH. Establish a way (e.g., CARES "745" alerts, tracking system) to assure that the monthly deductions continue until the total is reached, and that the monthly amount is adjusted as necessary when the recipient's net countable income and/or other deductions change over time.

4. Enter the required information onto the INST screen of CARES. The monthly deduction for noncovered services is entered in the field for "UNCVRD MED AMT". The INST screen is completed for the current month, any ongoing month with a change, and any historic month with a change.

5. Check the MAFI screen of CARES for each impacted month, to assure that it has the correct information and calculations. Make any necessary corrections to assure that the

available income is correct on CARES for each month, and so will transmit correctly to MMIS recipient screen 4 as the "patient resource amount". The line for "Non-covered Med Exp" on the MAFI screen represents the sum of three fields from the INST screen: "UNCVRD MED AMT" for the noncovered services, "MEDB PREM AMT" for noncovered Medicare premiums, and "UNCOVERED INS PREMIUM AMT" for other noncovered insurance premiums.

6. If a change or correction is necessary to MMIS recipient screen 4 that cannot be processed through the CARES-MMIS interface, submit the 206C form to the DHMH LTC Reconciliation Unit (e.g., to change the available income/resource amount for one or more historic months).

7. Suppress the CARES approval notice. Issue the manual DHMH 4233 (LTC) Notice of Eligibility (see Appendix B in Chapter 10) to the recipient, any designated representative, and the LTC facility (if the consent to release of information is signed). Complete as many columns (maximum of three per notice) and as many notices that are necessary to inform the recipient of the allowed deductions and the available income for the current month and for any subsequent months with a change. Under "other," specify each type of deduction not already listed (e.g., nursing facility bill, dental bill, spousal allowance, residential maintenance needs allowance).

8. Set a "745" alert in CARES as a reminder to recalculate the recipient's available income for any anticipated change in the recipient's income (e.g., January 1st COLA increase in Social Security income) or other deductions (e.g., annual increase in a health insurance premium or the community spouse's rent). Also, set a "745" alert for when the deduction for noncovered services is estimated to end once the recipient pays off the approved amount from the provider's bill.

9. Fully narrate in CARES. Include the requested amount of noncovered service deduction, the amount approved by BSA, the type of service, the provider, and the anticipated ending month for the deduction.

10. If the recipient's income or a deduction changes, follow the above procedures for manual calculation of the noncovered service deduction and the available income and for entry into CARES. Suppress the CARES notice and send the manual DHMH 4240 (LTC) Notice of Change in Available Income (see Appendix B in Chapter 10) to the recipient, any designated representative, and the LTC facility.

Time Frame for Deducting Noncovered Services from a Recipient's Available Income for the Cost of Care in a LTC Facility or Waiver

- The deduction may not begin before the month that the expense is incurred by the recipient.
- If the case worker is informed about the expense or determines eligibility after the month of service, the case worker may begin the deduction for the noncovered service in the:

  (a) month of service,
  (b) effective month of eligibility if the service was received during a prior ineligible month, or
  (c) current or ongoing month so that the recipient's contribution towards the cost of care and the provider's Medicaid payment do not need to be revised.

- If there is a contract for regular payments for an item or service, the monthly obligation is allowed for the period specified in the contract.
- If the noncovered service deduction approved by DHMH, in addition to other allowable deductions, exceeds the recipient's net countable income for the month, the excess portion of the deduction for noncovered services may be carried into additional month(s) and, if necessary, may be carried into a subsequent 6-month period(s) under consideration. The deductions continue until the monthly amounts deducted for the noncovered service total the amount approved by DHMH for the deduction.
- If an applicant requests deductions for services received during ineligible month(s) in the retroactive period and/or between the application month and the first month of eligibility, the deduction is authorized to begin in the first month of the certification period, as part of the eligibility approval.
- Unpaid bills for medical services received during a retroactive period associated with an earlier application that was denied due to a technical factor or excess resources or that expired six months after the application month may not be deducted from available income for a subsequent application.

- If a recipient requests deduction for noncovered services received during the current month of eligibility, the deduction begins in the current month.
- If a recipient requests deduction for noncovered services received before the current month of eligibility, the caseworker and the recipient (and the LTC provider if necessary) determine in which month the deduction will begin. If the recipient's available income is reduced for historic months, the LTC provider would have to refund to the recipient the difference in the calculated available income for each adjusted historic month, since the recipient has already paid the provider for the cost of care in those months. Also, the LTC provider would need to submit an adjusted claim for increased Medicaid reimbursement for each impacted month.
- If the LTC provider needs to submit a claim more than 9 months after the service date due to agency delay or a change in the recipient's available income calculated by the agency, the caseworker sends the DHR/IMA 81 Administrative Error Letter to the provider and a copy to the recipient. (See the DHR/IMA 81 on the back of page 1100-7 in Chapter 11.) The provider submits the 81 letter with the claim, so that DHMH will not apply the 9-month billing limitation when processing the claim.

Example 1:
The DHMH Beneficiary Services Administration (BSA) approves a deduction of $450 for dental care received by a recipient. According to the MAFI screen for the current month (based on the case worker's entries on the UINC, ERN1, and ERN2 screens), the recipient's total available income, before deducting these noncovered services, is $1,400. The recipient has no deductions for Medicare premiums or private health insurance. After the deduction for noncovered dental services, the recipient's available income is reduced to $950. The caseworker enters $450 under "UNCVRD MED AMT" on the INST screen for the current month. The caseworker checks the MAFI screen for the current month. The caseworker makes the necessary corrections if MAFI does not have $450 for "Non-covered Med Exp" and $950 for the "Available Income Amt." The caseworker ensures that the noncovered service is only deducted for the current month, not for ongoing months when the available income should return to $1,400. The case worker suppresses the CARES change notice and issues the DHMH 4240 (LTC) change notice to the recipient and the LTC facility, to inform them of the recipient's approved deduction for the dental expense and of the change in the recipient's available income for the cost of care for that one month. The caseworker fully narrates in CARES.

Example 2:
BSA approves a deduction of $9,000 for nursing facility services received by an applicant during two ineligible months in the retroactive period. The eligibility caseworker uses the

DHMH 1159D worksheet to calculate the available income. The applicant has monthly income of $1,400 and deductions for a personal needs allowance of $62, a spousal maintenance allowance of $400, and the Medicare Part B premiums of $78.20 for the first two months of Medicaid eligibility. Therefore, the recipient's available income is $859.80, before deducting the nursing facility noncovered services. This means that, for the 1st and 2nd month of current eligibility, the deduction for noncovered services (the unpaid private-pay nursing facility bills) is $859.80 and the available income is $0. Beginning with the 3rd month of current eligibility, there is no deduction for Medicare premiums. Therefore, the deduction for noncovered services increases to $938.00 and the available income remains at $0. Within 10 months, the deductions for noncovered services will total the recipient's incurred expenses for nursing facility services.

The case worker suppresses the CARES approval notice and issues the DHMH 4233 (LTC) to the recipient, to inform the recipient of the eligibility decision, the approved certification period, the available income of $0, and each approved deduction including the monthly deduction for the unpaid nursing facility bill. Two columns are completed on the notice—one for the first two months of eligibility and the second column for the 3rd and ongoing months. The caseworker fully narrates in CARES.

The case worker sets a "745" alert in CARES to recalculate the recipient's available income for the 10th month of eligibility, the last month of deductions for the recipient's nursing facility bills. Also, "745" alerts are established to adjust the deduction amounts and/or available income for any other month that a change to other deductions or income is anticipated. Beginning with the 11th month of eligibility, there will be no deduction for noncovered services. In the 9th month, the worker records the manual calculations on the DHMH 1159D (LTC) worksheet, enters the necessary information on CARES, and issues the manual DHMH 4240 (LTC) change notice with two columns completed--for the 10th month and for the 11th and ongoing months. The caseworker narrates in CARES.

Example 3:
A recipient is in the 2nd year of the 20 months necessary to pay off a bill of $12,000 for nursing facility services received during ineligible months in the retroactive period. The recipient's monthly Social Security income is $664. Since the recipient has no deductions besides the personal needs allowance of $62 and the noncovered services, the monthly amount deducted for noncovered services is $602 and the available income is $0.

The case worker sets a "745" alert to recalculate the available income when the recipient's Social Security check increases on January 1st. When the caseworker finds out that the COLA will be 4.1% so the recipient's income will increase to $692, the worker recalculates the deduction for noncovered services as $630 to keep the available income as $0. CARES will automatically issue the COLA letter in early December informing the customer that the available income for the cost of care will be $28. The caseworker issues the manual DHMH 4240 (LTC) change notice to the recipient, informing the recipient that the deduction for noncovered services is actually $630 and that the available income for the cost of care is still $0.

Questions regarding this issuance should be directed to the DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231, option 2, extension 1463.

Policy Alert 10-13

Prescription Drug Costs and Post-Eligibility for Institutionalized Persons

Background

Beginning January 1, 2006, individuals enrolled in Medicare may receive prescription drugs through Medicare Part D (see DHR/FIA Action Transmittal 06-06). For the most part, coverage of prescription drugs is no longer available under Medicaid. Pages 1000-22, 1000-33 – 1000-43, 1000-51 – 1000-54, and 1000-90 of this Chapter 10 in the Medicaid Manual address the deduction of a long-term care recipient's incurred expenses for health insurance premiums or for noncovered medical or remedial services from the recipient's available income for the cost of care. See also Policy Alert 10-12, issued in this Manual Release. Following is information about how Medicaid eligibility case workers are to consider pharmacy charges and Medicare Part D costs in the Medicaid post-eligibility calculations for institutionalized persons.

Medicare Part D Premiums

Dual eligibles for full Medicare and Medicaid benefits are entitled to premium-free Medicare Part D enrollment. However, they may choose to enroll in an enhanced prescription drug plan. Those who enroll in an enhanced plan are responsible for the portion of the premium that is attributable to the enhancement. When an institutionalized Medicaid recipient is enrolled in an enhanced Medicare plan, the portion of the premium that remains the individual's responsibility is an allowable deduction in the post-eligibility calculation for the recipient's contribution to the cost of care.

Co-pays, Deductibles, and Coverage Gap

Dual eligibles that are institutionalized and enrolled in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) are not responsible for the payment of Medicare Part D deductibles or co-pays, nor are they subject to a coverage gap in their Medicare Part D benefits. A Medicare Advantage Plan generally

provides all health care, including prescription drug coverage. (These rules do not apply to individuals eligible under a 1915(c) home and community-based services waiver.) Listed below are the various circumstances that may apply to institutionalized persons who are dual eligibles:

1. Individuals who were dual eligibles and institutionalized as of January 1, 2006 were auto-enrolled into a PDP or, if in a Medicare Advantage Plan that offers a drug plan, into the MA-PD. For institutionalized dual eligibles, the drug plans may not require co-pays or deductibles and may not impose any coverage gap.

2. For individuals who were dual eligibles prior to institutionalization, and who were subject to co-pays, the drug plan may continue to charge those co-pays until the plan is notified of the individual's institutionalized status. If the state identifies the individual as an institutionalized dual eligible for past months on the state's monthly file sent to Medicare, the plan will reimburse the individual for any co-pays incurred during those months.

3. For individuals who were enrolled in Medicare Part D, but who were not eligible for Medicaid at the time of institutionalization, the plan may continue to charge co-pays, deductibles, and costs incurred during a coverage gap until the plan is notified by the state of the individual's status as an institutionalized dual eligible. If the state identifies the individual as an institutionalized dual eligible for past months on the state's monthly file sent to Medicare, the plan will reimburse the individual for co-pays, deductibles, and costs incurred during a coverage gap for those months.

4. Individuals who qualify for Medicare Part D but are not enrolled in a drug plan, and are not Medicaid eligible at the time of institutionalization, will be fully responsible for their drug costs until their Medicaid eligibility is determined and their Medicare Part D auto-enrollment is processed as an institutionalized person. The plan will be responsible for drug charges as of the effective date of the enrollment. The plan will not charge deductibles or co-pays, or apply a coverage gap to those persons enrolled as institutionalized dual eligibles.

In the first three circumstances above, when Medicaid post-eligibility is calculated for the individual's cost of care contribution, there should be no deductions for prescription co-pays, deductibles, or coverage gaps. This is because, if these costs are incurred, the individual is not ultimately responsible for these charges.

In the last circumstance above, the individual will remain responsible for Medicare Part D covered drugs purchased prior to the effective date of the Part D enrollment. In this circumstance, the cost of these drugs is allowable as a deduction for noncovered services in the Medicaid post-eligibility calculation.

Creditable Coverage under Part D

Individuals who were dual eligibles, institutionalized, and receiving Medicare benefits may also have health and prescription benefits through a union or employer retirement plan. Most of these plans providing prescription drug coverage to Medicare beneficiaries must disclose whether their coverage is "creditable prescription drug coverage" through a Disclosure Notice.

Because this coverage is considered creditable, these institutionalized individuals may have decided to continue their prescription coverage through their union or employer retirement plan. In these cases, they are deemed to have creditable coverage under Part D and do not have to join a Medicare Prescription Drug Plan. Therefore, any documented out-of-pocket payments for premiums, co-pays, and deductibles associated with their retirement plan prescription benefits must be allowable deductions in the Medicaid post-eligibility calculation for the recipient's cost of care contribution. They must, however, provide documentation of the out-of-pocket payments and a copy of the Disclosure of Creditable Coverage Notice from the employer or union retirement plan for the allowable deduction.

Non-Formulary Part D Drugs

PDPs and MA-PDs are required to develop transition plans for institutionalized individuals. Plans may allow for limited coverage of drugs that are not part of the plan's formulary. Each PDP/MA-PD's transition plan may vary. Plans must issue a periodic (at least monthly) statement to each beneficiary explaining all benefits paid and denied.

Medicare Part D drugs that are not covered by the plan may not be covered by Medicaid and so, absent other drug coverage, would remain the individual's responsibility. These charges may be allowable deductions in the Medicaid post-eligibility calculation for the cost of care contribution. Medicaid eligibility caseworkers should use the following rules to determine whether to deduct prescription charges as noncovered services:

- When a plan denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the plan's decision on any exception requested. If the drug charge appears on the statement as a denial, and the beneficiary did not request an exception, do not allow the charge as a deduction for noncovered services.
- If the drug charge appears on the statement as a denial, and an exception was requested by the beneficiary but was denied, allow the charge as a deduction for noncovered services.

Institutionalized persons should be advised to maintain their statements and other related documentation needed for consideration of pharmacy expenses as noncovered services.

This procedure will help ensure that legitimate costs for drugs not covered by the plan are correctly allowed in post-eligibility. By relying on the plans' statements and exception notices, eligibility case workers do not need to know each plan's formulary, or the non-formulary drugs covered under a transition plan or under the exception process.

Non-Part D Covered Drugs

Certain drugs are not covered under Medicaid Part D. State Medicaid programs have the option of covering these excluded drugs. Maryland Medicaid covers excluded drugs for Medicaid recipients, including institutionalized persons.

Questions regarding this issuance should be directed to the DHMH Division of Eligibility Services at 410-767-1463 or 1-800-492-5231 option 2 and request extension 1463.