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**

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APPLICABILITY: Chapter 9 updates: Medicaid covered services; prescription drug costs for spend-down

Item	**Remove Pages**	**Insert Pages**
Chapter 9 – Determining Financial Eligibility for Non-Institutionalized Persons		
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Covered Services	Appendix III 900-33 – 900-34	Appendix III 900-33 – 900-35
Policy Alert 09-1 "Prescription Drug Costs under Spend-Down"		Policy Alert 09-1 (after page 900-35)

COMMENTS

Chapter 9

- **Covered Services**

Appendix III is updated with information about the medical or remedial services covered by the Maryland Medicaid Program. A general list of covered services is included. Questions about covered services should be referred to DHMH's Medicaid recipient hotline at 410-767-5800 or 1-800-492-5231.

- **Policy Alert 09-1 Prescription Drug Costs under Spend-Down**

Policy Alert 09-1 provides information about the impact of Medicare Part D prescription drug coverage on Medicare enrollees' spend-down for Medicaid eligibility.

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APPENDIX

Appendix III. - Covered Services

Attached is a general list of medical and remedial services covered by Maryland's Medical Assistance (Medicaid or MA) Program. Questions about Medicaid covered services may be referred to DHMH's Medicaid recipient hotline at 410-767-5800 or 1-800-492-5231.

COMAR describes the services covered, provider requirements, eligibility requirements, and provider reimbursement. Many of these services are covered under the HealthChoice benefits package for managed care enrollees. Services are covered on a fee-for-service basis if the services are carved out of the HealthChoice benefits package or if the recipient is not enrolled in HealthChoice (e.g., recipients before enrollment in managed care, spenddown eligibles, Medicare recipients, institutionalized persons, enrollees in Rare and Expensive Case Management, enrollees in the Model Waiver for Disabled Children).

Transportation Costs for Spend-Down

While transportation to and from medical appointments is a Medicaid covered service through grants to local health departments, the service is not always available to recipients throughout the State. If an applicant incurred the cost of transportation to obtain medical care, this cost may be applied to the applicant's excess income for spend-down. These costs may not be projected, but only counted when incurred. The actual incurred amount must be documented by odometer readings; receipts for taxi, rail, ambulance, or wheelchair van fares; or the worker's knowledge of current MTA fares for bus, subway, or light rail. The applicant must provide a bill or receipt for medical care (including to purchase prescription or over-the counter drugs), with a service date identical to the date for which the cost of medical transportation is claimed. The applicant must provide a signed statement affirming that the sole purpose of the trip was to obtain medical care.

Payment Contracts for Spend-Down

Expenses considered for establishing spend-down eligibility may include certain projected payments for medical care already received. For these expenses to be considered, the person claiming the expense must prove that the service was received, the applicant owes a balance to the provider, and the applicant signed a payment contract or similar document with the provider to pay the debt. If all of those conditions are met, the amount of each expense and the date incurred are determined as stated below. The amount and the frequency of payments specified in the contract are used to help determine when spend-down is met.

- If the projected payment is for a medical or remedial service that was received prior to the first day of the period under consideration, the amount of incurred expense is the total amount due during the period under consideration. Only amounts due during that period should be considered. The expense is considered as of the first day of the period under consideration.
- If the projected payment is for a medical or remedial service that was received during the period under consideration and is under a payment contract, the amount of incurred expense is the total amount due during the period under consideration. The expense is considered as of the date on which the contract or other document establishing the schedule of payment was signed.

SERVICES COVERED BY MARYLAND MEDICAL ASSISTANCE (MEDICAID)

The following services are covered by Maryland's Medicaid Program, if the services are not covered by Medicare or other insurance and if the Maryland Medicaid Program's specific requirements for the service are met. If you have questions, call the Maryland Medicaid Hotline at 410-767-5800 or 1-800-492-5231.

- Ambulance and wheelchair van services and emergency medical transportation
- Ambulatory surgical center services
- Clinic services
- Dental services and dentures (for beneficiaries under 21)
- Diabetes care services (covered under HealthChoice)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (for beneficiaries under 21)
- Eye glasses (for beneficiaries under 21)
- Family planning services and supplies
- Hearing aids (for beneficiaries under 21)
- Home and community-based waiver services for targeted populations of developmentally disabled or mentally retarded individuals, older adults, physically disabled adults, medically fragile children, children with autism spectrum disorder, and adults with traumatic brain injury
- Home health agency services
- Hospice care
- Hospital inpatient and outpatient services (acute, chronic, psychiatric, rehabilitation, specialty)
- Kidney dialysis services
- Laboratory and x-ray services
- Medical day care services
- Medical equipment and supplies
- Medicare premiums, co-payments, and deductibles
- Mental health treatment, case management, and rehabilitation services
- Nurse anesthetist, nurse midwife, and nurse practitioner services
- Nursing facility services (nursing homes)
- Oxygen services and related respiratory equipment services
- Personal care services
- Pharmacy services (for beneficiaries not eligible for Medicare Part D)
- Physical therapy
- Physician services (some dental surgery may be included)
- Podiatry services
- Private duty nursing (for beneficiaries under 21)
- School-based health-related services (for beneficiaries under 21)
- Statewide Evaluation and Planning Services (STEPS) (through local health departments)
- Substance abuse treatment services
- Targeted case management for HIV-infected individuals and other targeted populations
- Transportation services to Medicaid covered services (through local health departments)
- Vision care services (eye examination every two years)

Policy Alert 09-1

Prescription Drug Costs under Spend-Down

Beginning January 1, 2006, individuals enrolled in Medicare may receive prescription drugs through Medicare Part D. For the most part, coverage of prescription drugs is no longer available under Medicaid. See DHR/FIA Action Transmittal 06-06 about the implementation of Medicare Part D.

For Medicaid spend-down, an applicant's incurred Medicare Part D pharmacy costs are treated in the same manner as any other costs incurred for medical care. All of the usual rules in Chapter 9 of the Manual are applicable for determination of a Medicaid applicant's liability, insurance coverage, and spend-down eligibility (see pages 900-8 – 900-16, 900-22 - 24, and 900-29 – 900-35 in Chapter 9 of the Medicaid Manual). Any medical expenses that are incurred by the applicant may only be used for spend-down of the assistance unit's excess income. The expenses must be the applicant's obligation to pay and may not be subject to third-party payment or reimbursement, such as premiums or prescriptions not covered by the individual's Medicare Part D pharmacy plan, Medicaid, or other coverage. Any expenses that Medicaid will cover once spend-down is met may not be used for spend-down. However, costs paid in whole or in part by a State-only or local governmental program with no federal funds may be counted as the beneficiary's incurred medical expenses to establish eligibility under Medicaid spend-down, if Medicaid will not subsequently cover any of those costs.

Since enrollment in Medicare Part D is voluntary, some Medicare beneficiaries will not be enrolled in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD). A Medicare Advantage Plan generally provides all health care, including prescription drug coverage. For those Medicare beneficiaries enrolled in a PDP or MA-PD, some drugs might not be covered in the plan's formulary. Also, each plan may have a different combination of deductibles, co-pays, and gaps in coverage. Medicaid eligibility case workers should use the following rules to determine if drug costs incurred by Medicare beneficiaries may be used for Medicaid spend-down:

- If the Medicare beneficiary was not enrolled in a PDP or MA-PD on the date of service, allow the prescription drug cost for Medicaid spend-down.

- If the Medicare beneficiary was enrolled in a PDP or MA-PD on the date of service, the plan must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied, and amounts attributed to cost sharing. If the drug charge is identified on this statement as a beneficiary liability (i.e., part of a deductible, co-pay, or coverage gap), allow the expense for Medicaid spend-down.
- 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 for Medicaid spend-down.
- 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 for Medicaid spend-down.

Applicants should be advised to maintain their statements and other related documentation needed for consideration of pharmacy expenses for Medicaid spend-down.

These procedures will help ensure that legitimate Medicare Part D cost-sharing expenses are allowed under Medicaid spend-down, as well as expenditures for drugs not covered by the PDP or MA-PD. By relying on the plans' statements and exception notices, eligibility case workers do not need to know the cost-sharing rules for each plan, each plan's formulary, or the non-formulary drugs covered under a transition plan or under the exception process.