PT 19-01

STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM

General Provider Transmittal No. 53
Managed Care Organizations Transmittal No. 25

April 27, 2001

All Medicaid Providers

FROM: Joseph Millstone, Executive Director
Office of Health Services

NOTE: Please ensure that the appropriate staff members in your organization are informed of the contents of this transmittal.

Amendment to the HealthChoice Regulations Regarding Automatic Disenrollment of MCO Enrollees at Age 65 or Over.

Effective January 1, 2001, the Maryland Medical Assistance Program has amended Regulation .06 (B) COMAR 10.09.63 entitled Maryland Medicaid Managed Care Program: Eligibility and Enrollment (Disenrollment) by requiring the Medicaid Program to disenroll recipients age 65 and over from a managed care organization within the HealthChoice Program and place them in the Medicaid fee-for-service Program.

Recipients who are 65 or over will receive letters informing them that they will be disenrolled from their MCO either at the end of their birth month or at the end of the month in which the Department receives notice that the recipient is age 65 or over, whichever comes first. The letters also direct enrollees to either contact their local Social Security Administration office or call 1-800-772-1213 to apply for Medicare.

The Department will place the recipient in Medicaid fee-for-service until the recipient becomes Medicare eligible and Medicare becomes the primary health insurer. This means that the recipient receives a red and white Medical Assistance card and can receive all Medicaid covered benefits from a Medicaid provider until the recipient becomes Medicare eligible. You, as a Medicaid provider, can provide the appropriate Medicaid covered services and bill Medicaid directly for the recipient until the recipient becomes Medicare eligible.

Once the recipient is eligible for Medicare and presents a Medicare card, you, as the provider, should bill Medicare first. To receive Medicaid reimbursement for the portion of the bill not paid by Medicare you should be linked to the Medicare crossover file. To be linked to the Medicare crossover file, please contact Ms. Cheryl Gresham in the Office of Operations, Provider Liaison Unit, at (410) 767-6033.

When you are linked to the Medicare crossover file, the Medicare Program will automatically send that portion of the bill that Medicare does not pay directly to Medicaid. If you do not receive communication from Medicaid within 60 days regarding reimbursement, call Medicaid Provider Relations at (410) 767-5503.

In accordance with COMAR 10.09.36, a provider may not balance bill a Medicaid recipient for a covered service. The provider must accept Medicaid payment as payment in full.

If you have questions regarding the contents of this Transmittal, please contact the Division of HealthChoice Management at (410) 767-1482.