

TRANSMITTAL LETTER FOR MANUAL RELEASES

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF ELIGIBILITY 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:** August 10, 2010

RELEASE NO: MR-154 **ISSUED:** July 19, 2010

APPLICABILITY: Changes in Long Term Care Eligibility for Post Eligibility Medical Deductions under the Class Action Settlement of *Smith vs. Colmers*.

<u>Item</u>	<u>Remove Pages</u>	<u>Insert Pages</u>
<u>Chapter 10-Eligibility for Institutionalized Persons</u>	1000-35 – 1000-36	1000-35 – 1000-36
<u>Deduction of Non-covered Medical or Remedial Services from an Institutionalized Person's Available Income for the Cost of Care</u>	Policy Alert 10-12	Policy Alert 10-12
<u>Chapter 10 – Appendix B</u>	1000-101	1000-101 & 1000-102
<u>OES 001 Revised 7/10 - Request for Non-Covered Services Post-Eligibility Deductions</u>		After the C-Tad
<u>OES 010 (LTC) - Declaration of Unpaid Medical Expenses</u>		After the OES 001
<u>OES 011 (LTC) – Notice of Eligibility for the Post-Eligibility Medical Expense Deduction</u>		After the OES 010

(continued next page)

COMMENTS

Non-Covered Services

Effective August 10, 2010 as a result of the *Smith v. Colmers* class action settlement, the policies are revised for the deduction from a recipient's contribution to the cost of care for non-covered medical or remedial services received by the recipient. This Manual Release (MR-153) revises:

- Policy Alert 10-12
- Medical Assistance Manual Chapter 10, section on non-covered services
- Appendix B of Chapter 10
- Form OES 001.

The OES 010 (LTC) was created to solicit from the applicant and/or their representative a declaration of unpaid medical expenses at the time of application. The OES 011 (LTC) must be completed by the case manager when a decision is received from DHMH regarding the deductions allowed as a non-covered service deduction.

If you have any questions about these policies or procedures, contact the DHMH Division of Eligibility Policy at 410-767-1463 or 1-800-492-5231 (select option 2 and request extension 1463).

devices. Refer to Pages 900-31 and 900-32 in Appendix II of Chapter 9 for a more complete list of items and services not covered by the Medicaid State Plan. These expenses are usually documented by a bill or a paid receipt.

A person may be in need of an item such as dentures or eyeglasses, but unable to obtain it without a guarantee of payment to the provider. A written and signed contract with the provider that obligates the person to pay in a lump-sum or installments is acceptable documentation to allow the deduction from the recipient's available income.

For a Medicaid application, a deduction from available income for cost of care may also be made for medical or remedial services covered by Medicaid (e.g., nursing facility) but not covered for the recipient because the **recipient was not Medicaid eligible as of the service date**. The recipient's incurred expenses may be deducted only if the services were **received during any months in the three-month period prior to the month of Medicaid application**, in which the recipient was not Medicaid eligible. **Incurred expenses may also be deducted for any months that the recipient was ineligible between the month of application and the effective date of Medicaid eligibility**. The bill must still be unpaid and remain the recipient's obligation to pay, as verified by a current detailed bill from the provider. Unpaid bills for medical or remedial services **received before the 3 month prior period may not be deducted** from the recipient's available income for the cost of care.

There is no deduction for non-covered services received during a penalty period; therefore, the amount deducted is \$0.

For services received during ineligible months, the provider's charge is deducted. For non-covered services received **when the recipient is MA eligible, the lesser** of the provider's charge or the Medicaid fee is deducted. If a Medicaid fee is not established, the provider's charge is deducted. The deduction, when added to all other deductions, may not exceed the recipient's total countable income for the month.

To determine the allowable deduction, the eligibility case worker sends a completed OES 001, a self-addressed envelope, and a copy of the detailed current bill, receipt, or contract to:

DHMH
201 West Preston Street, Rm. SS-10
Baltimore, Md. 21201
Attn: Non-Covered Services

The bill, receipt, or contract must contain a service date, charge, and detailed description of the item or service, and applicable service code. DHMH will send the eligibility case worker a memo with the allowable amount noted along with the A/R's Non-Covered Service Report.

- These deductible expenses cannot be covered by Medicaid, Medicare, or any other health insurance, or 3rd party payment (e.g., long-term care insurance, disability insurance).
- This allowance may not be given to reimburse a relative or someone else who has already paid the bill.
- A deduction is not allowed for medical or remedial services received before the 3-month period prior to the month of application.
- Since the deduction is only made for certain medical or remedial services, any extraneous charges must be deleted such as for the beauty parlor, TV rental or personal items.
- The deduction may not include services covered by Medicaid that were received when the recipient was Medicaid-eligible, but for which the Program denied payment because the services were not medically necessary, not authorized, not provided by an enrolled and qualified provider, or were billed after the 9-month billing limitation.
- This deduction is allowed effective the month in which the expenses was incurred. However, for expenses incurred before the certification period, the deduction is allowed effective the month of eligibility or as of the current month.
- 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 amount of the medical expense, in addition to other allowable deductions, exceeds the recipient's total countable income for the month, the excess portion of the deduction for the medical expenses may be carried forward to the ongoing month or months and, if necessary will be carried forward into a subsequent 6-month period under consideration.
- **The eligibility case worker must set a "745" alert in CARES to recalculate the recipient's available income as of the month that the deduction is scheduled to end.**

There are no deductions from total income except those listed above. If total deductions for a month are greater than or equal to the recipient's total monthly income, the person's available income is \$0. With the exception of medical care or remedial services, as specified above, deductions in excess of total countable income are not carried

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Policy Alert 10-12

Deduction of Non-covered 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.

In two circumstances, non-covered 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 services are 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 non-covered 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 period prior to the month 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 three month period prior to the month of application (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 although there is no retroactive period associated with a waiver application, waiver applicants residing in Assisted Living facilities are entitled to have unpaid medical bills incurred during the three months prior to the month of application deducted from their available income for the cost of care.*

1. The eligibility case manager has the applicant or authorized representative complete the OES 010 (LTC) Declaration of Unpaid Medical Expenses. If the applicant/authorized representative indicates they have unpaid medical bills, the case manager requests and/or collects from the applicant/authorized representative, unpaid medical bills and then:
 - 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., had 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 non-covered 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, itemized bill, or invoice that is no more than 30 days 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);
 - For hearing aids - request acquisition cost from the manufacturer (this is the cost to the provider from the manufacturer)
 - 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. Once the applicant's eligibility for long term care (LTC) has been determined, a request must be made to DHMH to determine any post eligibility medical expense deduction.

3. To determine the allowable deduction, the eligibility case manager completes the OES 001, sends a self-addressed envelope, and a copy of the itemized current bill, invoice, or contract to:

DHMH
Attn: Non-covered Services
201 West Preston Street, Room SS-10
Baltimore, MD 21201

4. When the case manager receives DHMH's approval to deduct a specified total amount for the non-covered services, the case manager 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). Enter the allowable deduction for non-covered services as "Other" under deductions on the worksheet.
 - If the amount approved by DHMH for the non-covered service deduction *is less than* the A/R's monthly available income without the non-covered service deduction, use the amount approved by DHMH as the deduction.
 - If the non-covered service deduction approved by DHMH *exceeds* the A/R's monthly available income, use the A/R's monthly available income without the non-covered 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 non-covered services, so the recipient may pay the provider's bill in full 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 non-covered 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.

5. Enter the required information onto the INST screen of CARES. The monthly deduction for non-covered 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.
6. 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 non-covered services, "MEDB PREM AMT" for non-covered Medicare premiums, and "UNCOVERED INS PREMIUM AMT" for other non-covered insurance premiums.
7. 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).
8. Suppress the CARES notice. Issue the manual DHMH 4240 (LTC) Notice of Change in Available Income and OES 011 (LTC) Notice of Eligibility for the Post-Eligibility Medical Expense Deduction (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 of the DHMH 4240 (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 the allowable deduction. Attach to the OES 011 (LTC) Notice of Eligibility for the Post-Eligibility Medical Expense Deduction, a copy of the A/R's Non-Covered Service Report sent by DHMH.
9. 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 health insurance premium or

the community spouse's rent). Also, set a "745" alert for when the deduction for non-covered services is estimated to end once the recipient pays the provider's bill in full from the amount approved by DHMH.

10. Fully narrate in CARES. Include the requested amount of non-covered service deduction, the amount approved by DHMH, the type of service, the provider, and the anticipated ending month for the deduction.
11. If the recipient's income or a deduction changes, follow the above procedures for manual calculation of the non-covered 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 to the recipient, any designated representative, and the LTC facility.

Time Frame for Deducting Non-covered 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 manager is informed about the expense or determines eligibility after the month of service, the case manager may begin the deduction for the non-covered 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 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 non-covered 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 non-covered 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 non-covered service total the amount approved by DHMH for the deduction.
- If an applicant requests deductions for services received during ineligible month(s) in the three month period prior to the month of application 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 the 3 months prior to the month of application may be considered for a Non-Covered Service deduction if the bills are for services received during the consideration period associated with an earlier application—
 - that was denied due to a technical factor;
 - that was denied due to excess resources; or
 - that expired more than six months after the application month.

The 3 month period prior to the month of application is not to be considered for retroactive coverage.

Example 1:

Customer files a LTC application January 3, 2010. No information is returned to determine eligibility. On the 30th day the application is denied and notice is sent to all required parties. The application is placed in a preserved status for the remainder of the 6 month consideration period, which ends June 30, 2010. On July 6, 2010, the customer submits a new application for LTC coverage. The customer states that they have unpaid medical bills for 3 months prior to the month of the new application. Since these bills were incurred during a prior expired consideration period, they cannot be considered for retro-active coverage. However, the bills must be submitted to DHMH for a determination as a deduction of non-covered medical or remedial services.

- If a recipient requests a deduction for non-covered services received during the current month of eligibility, the deduction begins in the current month.
- If a recipient requests deduction for non-covered services received before the current month of eligibility, the case manager and the recipient (and the LTC provider if necessary) determine 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 case manager 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 DHR/IMA 81 letter with the claim, so that DHMH will not apply the 9-month billing limitation when processing the claim.

Example 2:

DHMH 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 manager's entries on UINC, ERN1, and ERN2 screens), the recipient's total available income, before deducting these non-covered services, is \$1,400. The recipient has no deductions for Medicare premiums or private health insurance. After the deduction for non-covered dental services, the recipient's available income is reduced to \$950. The case manager enters \$450 under "UNCVRD MED AMT" on the INST screen for the current month. The case manager checks the MAFI screen for the current month. The case manager makes the necessary corrections if MAFI does not have \$450 for "Non-covered Med Exp" and \$950 for the "Available Income Amt." The case manager ensures that the non-covered service is only deducted for the current month, not for ongoing months when the available income should return to \$1,400. The case manager suppresses the CARES change notice and issues the DHMH 4240 (LTC) change notice and the OES 011 (LTC) and DHMH Non-Covered Service Report to the recipient, representative (if applicable), 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 case manager fully narrates in CARES.

Example 3:

DHMH approves a deduction of \$9,000 for nursing facility services received by a newly approved recipient during two ineligible months prior to the month of application. The case manager uses the DHMH 1159D work sheet to re-calculate the available income. The recipient has monthly income of \$1,400 and deductions for a personal needs allowance of \$71, a spousal maintenance allowance of \$400, and the Medicare Part B premiums of \$96.40 for the first two months of Medicaid eligibility. Therefore, the recipient's available income is \$832.60, before deducting nursing facility non-covered services. This means that, for the 1st and 2nd month of current eligibility, the deduction for non-covered services (the unpaid private-pay nursing facility bills) is \$832.60 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 non-covered services increases to \$929.00 and the available income remains at \$0. The case manager determines that it will take 10 months of non-covered services deductions to total the recipient's incurred expenses for nursing facility services.

The case manager enters the information in CARES and suppresses all CARES approval notice and issues the DHMH 4240 (LTC), the OES 011 (LTC) and a copy of the DHMH Non-covered Service Report to the recipient, representative (if applicable) and the LTC facility to inform them of the eligibility decision, the number of months the non-covered services deduction will be in

effect, 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 case manager fully narrates in CARES.

The case manager 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 non-covered services. In the 9th month, the case manager 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 to the recipient, representative (if applicable) and the LTC facility. The case manager narrates in CARES.

Example 4:

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 \$71 and the non-covered services, the monthly amount deducted for non-covered services is \$593 and the available income is \$0.

The case manager sets a “745” alert to recalculate the available income when the recipient’s Social Security check increases on January 1st. When the case manager finds out what the COLA will be (in this example the COLA will be 4.1%, so the recipient’s income will increase to \$692), they recalculate the deduction for non-covered services as \$621 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 case manager issues the manual DHMH 4240 (LTC) change notice to the recipient, informing them that the deduction for non-covered services is actually \$621 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.

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

- a. 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 MA Manual pages 800-47 – 800-57).

35. **DHMH 4354 (Revised 3/07)** – Resource Evaluation for Married Applicants Institutionalized on or after 9/30/89

- The worksheet is used to assess the resources of a married applicant and the spouse for: the month of institutionalization, the month of application, and the post eligibility transfer period.

36. **DHR/FIA 1052-LTC (7/02)** – Long Term Care Request for Information to Verify Eligibility (**SAMPLE**)

- This form is used by the Medical Assistance LTC case manager to request information necessary to determine Medical Assistance eligibility for the applicant or recipient.

37. **206-C** – Interface Correction Report

- This form is sent to the Division of Recipient Eligibility Programs (DREP) to: correct changes on MMIS that were unable to be transmitted from CARES; for multiple transactions; for changes to income or resources; to report a death; when an individual is discharged from a LTCF or is transferred from one facility to another; to report provider changes; to document multiple spans for MMIS screen 4 (Long-Term Care Spans), etc.

38. **C-TAD** – Certification / Turnabout Document

- This form is sent to the Division of Recipient Eligibility Programs (DREP) to establish MA eligibility on MMIS screen 1 or to change the eligibility data on screen 1.

39. **OES 001 (Revised 06/10)** – Request for Non-Covered Services Post-Eligibility Deductions

- This form is completed by the case manager and sent to the Division of Eligibility Policy to request a post-eligibility deduction and/or a non-covered service deduction.

40. OES 010 (LTC) - Declaration of Unpaid Medical Expenses

- This form is completed by the applicant/representative when they file an application for LTC-MA. It is used to allow the applicant an opportunity to claim unpaid medical bills that may be used as a deduction of non-covered medical or remedial services from an institutionalized persons available income for the cost of care.

41. OES 011 (LTC) – Notice of Eligibility for the Post-Eligibility Medical Expense Deduction

- This manual notice is used to advise the recipient, representative, and nursing facility of the amounts that have been approved and disapproved. The case manager will receive a printout with the decision from the Office of Eligibility Services stating each medical service, the amount approved, and the amount disapproved (if any). This printout needs to be attached to this letter and sent to the recipient, representative, and nursing facility. In addition, this letter also informs the recipient, representative, and nursing facility how long the deduction will continue to be subtracted from the cost of care.

Request for Non-Covered Services Post-Eligibility Deductions

To: Office of Eligibility Services
Department of Health and Mental Hygiene
201 West Preston St, Room SS-10
Baltimore, Maryland 21201-2399

From: _____ County Department of Social Services

D.O. # _____

Date _____

Please include the following information:

New Request Resubmission

Case Manager _____

Contact Number _____

Case Name _____

Client ID Number _____

Application Date _____

Current Certification Period _____

Retro Period (if applicable) _____

Type of Expense (place a check mark next to appropriate type)

Dental Bill Nursing Home Bill

Hearing Aid Bill Months being requested:

Vision Bill _____

Podiatry Bill Other (please specify):

Pharmacy Bill _____

**Maryland Medical Assistance Program
Declaration of Unpaid Medical Expenses**

Date _____

Applicant Name _____

Customer Id# _____

Please complete and sign this form and return it with your application for Long Term Care Medicaid. If you have unpaid medical bills, you may be eligible for deductions from your income.

Please check one of the choices below:

If you answer yes, please sign below, provide a newly dated, itemized, unpaid medical bill(s) that you incurred up to three months prior to this application. The bill must contain a service date, charge, and a detailed description of the service(s) provided. Attach copies of the bill(s) to the form and submit them with your Long Term Care Medicaid application. (If you do not have the bills at the time you submit the application, the bills may be submitted at a later date during this application process.)

Yes, I Have unpaid medical bills and am sending copies of the bills with this form and my application.

Signed: _____ Applicant

Date: _____

Signed: _____ Authorized Representative

Date: _____

No, I Do Not Have unpaid medical bills at this time.

Signed: _____ Applicant

Date: _____

Signed: _____ Authorized Representative

Date: _____

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTICE OF ELIGIBILITY FOR THE POST-ELIGIBILITY MEDICAL EXPENSE DEDUCTION

Date: _____

Re: _____
(Name)

(Client ID #)

Dear _____:

This is to notify you that based on the medical bills, totaling \$ _____, that you submitted on _____, you are determined eligible for the Post-Eligibility Medical Expense Deduction in the amount of \$ _____. You are determined ineligible in the amount of \$ _____. The attached report shows every expense item, if you are eligible for the deduction, and the amount of the deduction that you are eligible to receive. If you were not eligible for the service, it will indicate the reason for your ineligibility.

- The amount of \$ _____ will be deducted from the amount you are responsible to pay the nursing home for the month of _____. The amount of the deduction is less than your monthly contribution to the nursing home cost of care. This is a one time only deduction.
- The amount of \$ _____ will be deducted from your nursing home cost of care contribution beginning the month of _____ and will continue until the month of _____. If there are no changes to your countable monthly income, we anticipate \$ _____ of the allowable deduction will remain at the end of your current consideration period. The remaining amount will be applied to the consideration period that immediately follows.

This decision is based on the requirements found in COMAR 10.09.24.10. If you do not agree with this decision, you have the right to request a hearing within 90 days of the date on this notice. The procedures for requesting a hearing are attached. If you have any questions about this letter, please call your case manager at the number below.

Case Manager

Department of Social Services

Telephone Number

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.