

Accessing Services for Adults Age 21 and Older with Developmental Disabilities through Maryland Medical Assistance/Medicaid

A Guide from
Maryland Disability Law Center



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This booklet provides information about the right to healthcare services for adults with developmental disabilities age 21 or older on Maryland Medical Assistance. Medical Assistance is also called Medicaid.

For children and young adults under the age of 21, please refer to MDLC's Children's Medicaid Booklet, "Accessing Services for Children with Developmental Disabilities through Maryland Medical Assistance/Medicaid and MCHP."

What is Maryland Disability Law Center?

Maryland Disability Law Center (MDLC), the designated protection and advocacy agency for the State of Maryland, protects and advocates for the civil rights of people with disabilities. Our goal is to create a more integrated and just society by advancing the legal rights of people with disabilities and ensuring equal opportunities to participate in community life. We are a non-profit law firm. We provide information and referral, legal representation, abuse and neglect investigations, technical assistance, and community outreach and training.

What is Maryland Medicaid /Medical Assistance?

Medicaid, also called the Maryland Medical Assistance Program, is a joint state and federal health insurance program that offers access to a broad array of healthcare services to low-income and other qualifying individuals. It is under the control of the Maryland Department of Health and Mental Hygiene (DHMH), but to apply for Medical Assistance contact your local Department of Social Services. For more information, visit the Maryland Department of Human Resources' website:

<http://dhr.maryland.gov/fiaprograms/medical.php> or the Maryland Department of Health and Mental Hygiene's website: <http://mmcp.dhmh.maryland.gov/chp/SitePages/Home.aspx>.

What healthcare services should Medicaid cover for adults?

Any service should be covered if it is recommended as medically necessary by the person's doctor or another licensed health care practitioner, and included in Maryland's Medicaid State Plan.

Additional services, discussed on pages 11-13 of this booklet, will be covered if the individual is enrolled in a Medicaid waiver program such as Community Pathways or New Directions. Call MDLC if you want to receive a separate publication about the Developmental Disability Administration Medicaid waiver programs.

Services covered for adults include:

- Doctor visits, including visits to specialists
- Family planning
- Home health
- Hospice care
- Hospital services, including psychiatric, emergency room and outpatient
- Laboratory and x-ray
- Medical equipment and supplies
- Medicare premiums
- Mental health
- Nursing facilities
- Personal care
- Physical therapy
- Prescription drugs
- Primary care
- Substance abuse treatment
- Transportation to Medicaid-covered services
- Eye exams

Adults enrolled in a Managed Care Organization (MCO) may also have access to limited dental care depending on the MCO they choose. Adults in the Rare and Expensive Case Management (REM) program receive full coverage for dental care. See page 9.

Change in service coverage is likely so check back with MDLC for updates.

Services that are NOT covered for adults:

- Full-time in-home shift nurses or shift home health aides
- Most dental care
- Community residential (for example, a group home)
- Environmental modifications
- Habilitation (learning new skills)
- In-home support services
- In-home behavioral aides
- Respite care
- Vocational training
- Occupational therapy unless in a hospital or through home health
- Speech therapy unless in a hospital or through home health

However, some of these services are covered for adults with developmental disabilities in a Medicaid waiver program. See pages 11-13. Some of these services, such as shift nurses and home health aides and full dental care, are covered for adults in REM. See page 9.

What is HealthChoice?

HealthChoice is the name of Maryland's statewide mandatory managed care program. The HealthChoice Program provides health care to most Medicaid recipients. Eligible Medicaid recipients choose and enroll in a Managed Care Organization (MCO) or health plan. They select a Primary Care Provider (PCP) who is a doctor to oversee their medical care. When participating in HealthChoice, the Medicaid recipient must select a PCP who is a member of the MCO's provider network. The PCP is a key party, and is responsible for making referrals to specialists and other services, such as durable medical equipment assessments. Some referrals require the PCP to obtain prior approval from the MCO. People in HealthChoice are also entitled to receive other carved-out healthcare services under Medicaid that are discussed next.

What are carved-out services?

For individuals in HealthChoice, some services are covered by Medicaid, but are not covered by the MCO. Individuals do not need MCO approval or MCO doctor referrals to access these services. This can be confusing because the individual must apply to other agencies for access to these "carved-out services" and the MCO may not be helpful in guiding you to these agencies. These services are:

- Mental health services
- Personal care
- Communication devices
- Initial substance abuse assessment (also covered by the MCO)
- Nursing home and any long-term care facility stay longer than 30 days
- Limited residential care for persons with developmental disabilities

What is the fee-for-service Medicaid program?

Some people are not enrolled in a MCO but are enrolled in the fee-for-service system. The Medicaid recipient can go to any doctor or other provider who accepts Medicaid. However DHMH still must approve or authorize some services in advance. For example, people in the REM program and people who are eligible for both Medicare and Medicaid do not join an MCO and are in the fee-for-service system.

Can adults be charged for the healthcare services they receive under Medicaid?

Most services and benefits will be free but recipients may be asked to pay a very small part of the cost for some services, called a co-payment. For example, an MCO may charge a \$1 or \$3 co-payment for prescription drugs. Other than a small co-payment, providers should not bill you for the services you receive when you are on Medicaid even if DHMH or the MCO has denied coverage and payment for your services. If you receive a bill, you should call MDLC.

What dental services are available for adults on Medicaid?

Some MCOs provide limited coverage for some preventive dental care. These services could be discontinued at any time because they are optional and not required by law. Call your MCO customer service number for more information or see the pamphlet at

http://mmcp.dhmf.maryland.gov/healthchoice/Documents/120306_HC_cc_Mar012012_v1-PREP.pdf

Fee-for-service Medicaid does not cover dental care for adults except for pregnant women and adults in the REM Program, who have access to full dental care. Contact DentaQuest for information and participating dentists at 1.888.696.9598 or www.dentaquestgov.com.

Can adults get coverage for eye glasses and eye exams?

MCOs provide limited coverage for eyeglasses and/or eye exams every one or two years. Other than eye exams every two years, these services could be discontinued at any time because they are optional and not required by law. Call your MCO customer service number for more information or see the pamphlet at http://mmcp.dhmf.maryland.gov/healthchoice/Documents/120306_HC_cc_Mar012012_v1-PREP.pdf

Fee-for-service Medicaid including the REM Program covers eye exams but not eyeglasses.

What are durable medical equipment and disposable medical supplies?

Individuals on Medicaid are eligible for all medically necessary durable medical equipment (DME) and disposable medical supplies. Some examples include:

Durable medical equipment:

wheelchairs
seating and positioning devices
transfer equipment
specialized beds.

Disposable medical supplies:

adult diapers
diabetic supplies
enteral/ parenteral nutritional formula
formula for PKU/ other feeding disorders.

How can I get medical equipment and supplies for an adult?

To get equipment and supplies, you should get a referral from the individual's doctor. In some cases, a specialized assessment may be needed to determine the appropriate equipment needs of the individual. A DME vendor, a company that supplies equipment, will need to submit a request for Medicaid approval with the necessary paperwork.

Individuals in HealthChoice need approval from the MCO or health plan. The health plan should let you and the vendor know within 72 hours if the equipment or supplies are approved or denied. If approved, the individual should receive the equipment or supplies within 7 days. If there is an emergency need, the individual should receive the equipment or supplies within 24 hours.

Individuals in a fee-for-service program need DHMH approval for the equipment, and these timetables are not applicable. However, individuals in fee-for-service programs are still entitled to have equipment and supplies approved or denied without unreasonable delay. If the services or equipment is approved, the individuals have the right to have it delivered without unreasonable delay.

How can I get communication devices?

Under the DME benefit, adults can receive assessments for augmentative communication devices and the devices themselves where recommended following an assessment. Ask the primary care doctor for a referral to a speech and language pathologist able to perform such assessments. If the speech and language pathologist recommends a communication device, whether the individual is in an MCO or fee-for-service Medicaid, DHMH must review the request and approve it first. The speech and language pathologist who does the assessment will work with DHMH, and possibly the vendor of the communication device, to submit the proper documentation needed for approval to DHMH. The primary care physician should review the assessment and submit a letter agreeing that the individual needs the device. For more information, see:

<http://www.mdclaw.org/wp-content/uploads/2011/01/Communication-devices-from-MA-January-2011.pdf>

Contact MDLC if an individual cannot obtain either the assessment for a communication device or the device itself.

Maryland Medicaid may not cover non-traditional communication devices. For example, DHMH has not approved coverage of an iPad even though an individual may use it as a communication device. Contact MDLC about possible Developmental Disabilities Administration (DDA) funding of non-traditional communication devices.

How can I gain access to mental health services?

Individuals diagnosed with a mental illness can access mental health services. Other than the first 12 outpatient therapy visits or emergency room care, services must generally be pre-approved by a private agency working for the state called ValueOptions and will require a professional's referral. Mental health services include, but are not limited to:

- Diagnostic evaluation and assessment
- Medication management
- Individual therapy
- Group therapy
- Family therapy
- Outpatient services
- Mental health targeted case management
- Inpatient hospitalization
- Partial hospitalization/ day treatment
- Mobile treatment
- Psychiatric rehabilitation program

If the individual does not have a mental illness diagnosis covered by the public mental health system, they will not be eligible for specialty mental health services. The MCO is still responsible for providing primary mental health care.

Individuals, families and professionals may also contact ValueOptions 24 hours a day for individuals with a developmental disability who do not have a mental illness diagnosis if they need a psychiatric assessment, medication monitoring, or other related services.

Professionals: Contact ValueOptions with the specific services requested. It is also recommended that the referral be confirmed in writing, be signed by a licensed professional, document all the specifics of the service request, and document the medical necessity of the service. If possible, the referring professional should use the ProviderConnect website:

<https://www.valueoptions.com/pc/eProvider/providerLogin.do>.

The professional can also call 1-800-888-1965 or contact ValueOptions by fax (1-877-502-1044) (keep a copy of your fax confirmation) or mail:

Jaime Miller, LCSW-C
Director of Clinical Operations
ValueOptions Maryland
P.O. Box 166
Linthicum, MD 21090
410-691-4091

Professionals can review Maryland's public mental health system provider manual for further details. It is available upon request from the Mental Hygiene Administration, ValueOptions, or on-line at http://maryland.valueoptions.com/provider/prv_man.htm.

Individuals and Families: Although an individual or family member may call ValueOptions to request mental health services at 1-800-888-1965, we recommend that you obtain the assistance of a mental health professional to make the referral for services. Be sure to provide the professional with this booklet for assistance in the referral process.

ValueOptions should comply with strict timelines found in state regulations for approving services and arranging for a provider to deliver the services.

What is personal care?

Under the Medical Assistance Personal Care (MAPC) program, a personal care aide provides hands on direct support and assistance to a recipient with activities of daily living such as eating, toileting, bathing, dressing, reminding, and mobility if it is medically necessary. MAPC can be provided both inside and outside the individual's home including at work or in job skills programs. No waiting list can be maintained for this service. Personal care, in contrast to private duty nursing or home health care, is for individuals who do not require skilled care.

Anyone, including a family member, case manager, or other person can make a referral for this service by contacting the county personal care program within each county health department. If you contact the health department but have trouble getting an assessment or approval for personal care services, or getting an aide to provide sufficient hours, contact MDLC.

Even after approval for services, local health departments may have trouble finding someone to provide personal care services at the current payment rate, which is a low flat rate per day. If there is a friend, neighbor or relative willing to provide personal care, that person can apply to become an approved personal care provider. Approved providers cannot be the spouse or an individual who has full and unrestricted powers of guardianship of the person requiring personal care.

If the individual is in a Medicaid waiver program and is receiving or wants to receive personal care, the rules may make it difficult to get enough hours to meet the individual's needs. Call MDLC if you have this problem.

What is Community First Choice Medicaid state plan option?

Community First Choice Medicaid state plan option will be available in 2013 to provide long term services and supports through personal and attendant care services with a better payment rate and more hours of service than under Maryland's current personal care program. To qualify, an adult need not be in a nursing home but must meet the medical eligibility criteria for "nursing facility level of care". DHMH updates about this planned program are at:

<http://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Long%20Term%20Care%20Reform.aspx>.

What is home health care?

Home health care agencies can provide skilled nursing services and/or home health aides to provide skilled care and assist with activities of daily living. Home health services are typically provided in the Medicaid recipient's home. Some individuals can get physical, occupational and speech therapy at home, mental health services at home, and medical supplies to be used at home. Home health services are available on a part-time, intermittent basis to individuals who have a medical need for them, and cannot be accessed just because it is more convenient than bringing the individual to a provider. However, there is no requirement that the individual be housebound to receive home health services.

In order to receive home health services you should get a referral from your doctor, and the doctor will need to get approval from the MCO. If you are in fee-for-service Medical Assistance, your doctor will need to get approval from DHMH. Your doctor should work in conjunction with a home health provider to obtain the services.

Shift or full-time nursing and home health aide services are available under the REM Program for eligible individuals but are not covered by the regular state Medicaid program for adults. Adults in some Medicaid waiver programs also have access to shift/full-time home health aides and nurses.

How can adults access transportation to medical appointments?

When a recipient does not have transportation to get to a healthcare provider, transportation assistance is a covered service. Contact the county health department and ask for the Medical Assistance transportation program. Find the health department's phone number in the blue government section of your phone book. Some healthcare providers have their own transportation systems for patients. Also, your MCO may provide bus tokens, taxi service or van service if it is medically necessary. Contact your MCO for more information. See pamphlet:

http://mmcp.dhmh.maryland.gov/healthchoice/Documents/120306_HC_cc_Mar012012_v1-PREP.pdf

What is the Rare and Expensive Case Management (REM) program?

REM is a special part of the Medicaid program for people who have certain medical conditions or diagnoses and meet other eligibility criteria. For a list of qualifying conditions see:

<http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.69.17.htm> or contact MDLC.

Apply for REM either before or after joining an MCO. Once accepted by REM, the individual is in the fee-for-service program and can see any healthcare provider who accepts Medicaid. The individual is assigned a REM case manager who should be contacted for help in obtaining healthcare services. An important benefit of REM is that adults over 21, like persons under 21, can continue to receive all medically necessary in-home nursing services or certified nursing assistant services, while most adults on Medicaid can only get very limited home health nursing or aide services. Other benefits for adults over 21 include the following additional services that other adult Medicaid recipients do not receive: full dental services, occupational therapy in the community, speech, hearing and language services in the community, nutritional counseling and supplements, and chiropractic care.

If an individual in REM becomes eligible for Social Security Disability Insurance (SSDI) and Medicare, they may still remain eligible for REM.

What residential services are adults eligible for under Medicaid?

The Medicaid program covers institutional placements in hospitals, nursing homes, and Intermediate Care Facilities for the Intellectually Disabled (ICF-ID) for those who meet the eligibility criteria. Institutional care is considered the most restrictive placement for individuals and may only be approved if there is no less restrictive setting in which services can be provided within a reasonable time. For adults in the Community Pathways or New Directions waivers, which are Medicaid waiver programs for individuals with developmental disabilities (discussed below), residential services in community homes are covered based on individual need. For more information contact the individual's service or resource coordinator or MDLC.

If an adult is not already in one of these Medicaid waiver programs, and has a health or safety need for residential services, contact the service/ resource coordinator or MDLC.

Contact MDLC about the legal rights of individuals with developmental disabilities who want to leave nursing homes. Nursing facility residents may be eligible to enter Medicaid waiver programs – even programs with waiting lists -- to be placed in a community residential program or to receive other community-based services that will enable a discharge from the nursing facility.

MDLC focuses on getting individuals community-based services so they can continue to live at home, or in the community.

What eligibility determination process is used by Developmental Disabilities Administration (DDA)?

If you believe an individual has a developmental disability, apply to DDA now for an eligibility determination regardless of whether the individual currently needs services from DDA or is eligible for Medicaid. See <http://dda.dhmh.maryland.gov/SitePages/howtoapply.aspx> for a copy of the application. Apply before the individual turns 22 (or as soon as possible afterwards) and provide DDA with all available records about the person's disability prior to age 22 including psychological testing data if available.

DDA may determine that a person is (1) ineligible for services, (2) eligible for Individual Support Services (ISS) only -- also called Supports Only (SO), or (3) fully eligible as an individual with a developmental disability (DD) -- the category that provides the most services. To be eligible in the future for a day program, a residential program, or placement in one of the two waiver programs discussed below, DDA must find that the individual has a developmental disability. Individuals found eligible either as ISS/SO or DD are also given a priority category, such as crisis resolution (the highest category), and will likely be placed on a waiting list for services. Contact MDLC for further information about the specific criteria DDA uses in this process and how to request a change or appeal eligibility or priority decisions by DDA. You may also request a copy of our booklet, *Maryland's Developmental Disabilities Administration Medicaid Waivers: A Practical Guide*.

What is the relationship between Medicaid services and services from Developmental Disabilities Administration (DDA)?

DDA provides additional services not covered by the regular Medicaid program. These DDA services primarily consist of staff support to help people live more independently. The services include supported employment, respite care, staff support in the home, environmental modifications, behavior supports, assistive technology and day and residential services. Because funding for new applicants is limited, DDA assigns each applicant an eligibility and priority category. DDA can usually provide new services

only to people found eligible in its crisis resolution priority category – people who are in crisis. One important exception is that for many years, DDA has had funding to serve eligible young adults as they transition from school after they turn 21 years old. Youth with developmental disabilities who leave or complete school before age 21 will not be included in DDA's definition of transition aged youth until their 21st birthday. Families should re-contact DDA at that time.

DDA provides most of its services through a Community Pathways Medicaid waiver program that accepts a limited number of new participants each year. DDA can enroll individuals in its Medicaid waivers even if they are not eligible for community Medical Assistance. The eligibility criteria for Medicaid waivers allow the monthly income of individuals over 18 years old to be 300% of the maximum monthly Supplemental Security Income (SSI) benefit. All people enrolled in DDA Medicaid waivers are entitled to receive Medical Assistance for health care as well as the DDA Medicaid waiver services they need.

MDLC advises transition aged youth and their families to work with a DDA service or resource coordinator and accept DDA services at age 21 or 22 when leaving school. If services are declined or delayed when transitioning from school, DDA will place the young adult on its waiting list and the individual may need to be in crisis to receive DDA services and enter a Medicaid waiver program in the future.

Because priority categories can change when family or individual circumstances change, for adults not in a DDA Medicaid waiver program, be sure to notify DDA or the resource coordinator immediately if you believe the individual should be in a higher priority category.

If you believe DDA made a wrong decision about eligibility or priority category, you should request reconsideration or file an appeal.

DDA has some limited funding for Low Intensity Support Services (LISS) to address a wide range of individual needs for up to \$3,000/year on a first come, first served basis. Depending on the availability of funds, DDA can approve additional LISS funding beyond \$3,000. If you do not know if a needed service is funded by DDA through Medicaid or by state only funds or whether an individual is in the waiver, contact MDLC for assistance.

What is the Community Pathways waiver?

The Community Pathways waiver is administered by DDA. Community Pathways provides services and supports in the community for individuals with developmental disabilities. There are a limited number of open slots available in this waiver each year and applicants can be placed on a waiting list if the waiver is full. Waiver participants qualify for Medicaid services, and also receive additional services specific to the waiver. In order to qualify for the Community Pathways waiver, individuals must meet the level of care requirements necessary for admission to an Intermediate Care Facility (ICF-ID). This means the person must meet the criteria for developmental disability in Health General section 7-101 of the Maryland Code and also meet financial eligibility requirements. If you don't know whether an individual is in the waiver, but they get some support from DDA, ask their service or resource coordinator or the regional DDA office. Individuals who are in a day program or receive a significant number of hours of supports in the home may already be in the waiver. If the person doesn't receive any services funded by DDA, they are probably not in the waiver and need to apply.

How do adults apply for the Community Pathways Waiver?

To apply for the waiver, contact your local DDA regional office or go to:
<http://dda.dhmf.maryland.gov/SitePages/howtoapply.aspx>. Call MDLC for help.

If an individual already receives some services from DDA and has a resource or service coordinator, the coordinator can request admission for the individual to the waiver. Call MDLC if the coordinator cannot help.

What services are available under the waiver?

In addition to all the regular Medicaid services listed above, individuals in the waiver may also be eligible to receive:

- Service/ resource coordination
- In-home staff support (community supported living arrangement)
- Community residential placement
- Supported employment
- Day habilitation
- Family and individual support services
- Respite care
- Behavioral support
- Environmental modifications
- Assistive technology and adaptive equipment
- Transportation
- Transition services
- Medical daycare

Contact MDLC about in-home nursing services for adults who are not eligible for REM.

What if an individual in the waiver needs additional services?

Service/resource coordinators should convene a team meeting to discuss additional services. If the team agrees that the individual needs an increase in services, the service/resource coordinator will submit a written request to DDA with the supporting documentation (such as medical or professional assessments or behavioral data). In emergency situations, the service/resource coordinator should make a telephone request to DDA. Contact MDLC if the request is denied or not acted upon in a timely manner, as waiver participants have the right to appeal. See below.

Can services be denied under the waiver?

The waiver services listed above, subject to any limits in the waiver itself, should not be denied if the individual needs the requested services.

However, every person in the waiver is not automatically entitled to receive every service listed. Instead, individuals are eligible for covered services that the individual's team decides are necessary to meet their needs to increase independent living skills or to protect their health and safety. DDA cannot deny services to individuals in the waiver because of a lack of available funds. When DDA denies services, it must send a denial letter explaining its decision and the right to appeal. Contact MDLC for help if DDA denies waiver services or does not act in a timely manner when considering requests for services.

What is the New Directions Waiver?

The New Directions waiver is administered by DDA for individuals with developmental disabilities. New Directions allows recipients the opportunity to self-direct services and supports in their own home or family home by managing their own staffing and budget. It allows people over age 21 to pay family members, even parents, to provide services such as direct supports at home or in the community. Individuals are supported by a service/resource coordinator, a support broker and a fiscal

manager. Financial and medical eligibility and available services are similar to those for the Community Pathways waiver.

How do adults apply for the New Directions waiver?

To apply for the waiver, contact your local DDA regional office:

<http://dda.dhmf.maryland.gov/SitePages/aboutdda.aspx>.

If an individual already receives some services from DDA or is in the Community Pathways Waiver, and has a resource/service coordinator, the coordinator can help with the admission process to the New Directions waiver.

What is the Living at Home waiver?

The Living at Home waiver (LAHW) is administered by DHMH and allows recipients the opportunity to self-direct community services and supports in their own home or family home by managing their own staffing. It enables people to pay family members, even parents of adults, to provide services such as direct supports at home or in the community. Individuals are given help by a comprehensive case manager and a fiscal manager. To qualify, an individual does not need to be in a nursing home but must meet the medical eligibility criteria for “nursing facility level of care” and be age 18 to 64 when they enter the waiver.

How do adults apply for the Living at Home waiver?

To apply for the waiver if you are in a nursing facility, contact DHMH at 410-767-7479.

People living in the community cannot apply for the waiver, but can get on a waiting list by calling the waiver services registry at 1-866-417-3480. For more information see:

http://mmcp.dhmf.maryland.gov/docs/Living_Home_Waiver_Fact_Sheet_October_2010.pdf

What is the Older Adults waiver?

The Older Adults waiver (OAW) is administered by The Department of Aging and serves people who need long term services and supports. OAW provides services in an assisted living facility or in the person’s own home or family home by managing their staffing and services. Individuals are given help by a comprehensive case manager and a medical team. To qualify an individual does not need to be in a nursing home but must meet the medical eligibility criteria for “nursing facility level of care” and be age 50 or older.

How do adults apply for the Older Adults waiver?

To apply for the waiver if you are in a nursing facility, call your local area office on aging.

For contact information:

<http://www.msa.md.gov/msa/mdmanual/10da/html/dalocal.html>

People living in the community cannot apply for the waiver, but can get on a waiting list by calling the waiver services registry at 1-866-417-3480. For more information see:

http://mmcp.dhmf.maryland.gov/docs/Older_Adults_Fact_Sheet_October_2010.pdf

What are some of the legal rights of all Medicaid recipients?

- The State should not put recipients on waitlists for regular Medicaid services but may maintain a waiting list for a waiver program when the slots are full.
- Services should be available throughout the State.
- Services should be approved or denied and provided with “reasonable promptness”.
- The State should ensure that providers are available to deliver needed services.
- Recipients should have the freedom to choose their provider.
- Service denials and delays can be appealed.

What does “medically necessary” mean?

“Medically necessary” means that the service or benefit is related to diagnosing, preventing, curing, or reducing the symptoms of an illness, injury, disability, or health condition. The service or benefit must be consistent with good medical practice, the most cost effective method of treatment, not primarily for convenience, and not experimental. In order to show medical necessity, it is important to have the support of the individual’s doctor or treating professional. The doctor should write a letter outlining the individual’s condition, service or benefit needs and the reason for those needs. The letter should be as detailed as possible. The letter should clearly say why the doctor believes that the service is medically necessary for that particular individual. If the individual has more than one doctor or treating professional, it is best to have letters from each one.

What if an individual’s treating professional recommends a service or benefit as medically necessary, but an MCO or DHMH denies the benefit?

This is a common practice, but the individual has the right to file an appeal. In a hearing on an appeal, the treating health care professional’s opinion is very important. The law gives more weight to the opinion of treating professionals than to the opinion of professionals who work for the State or health plans and who have never met the patient. The treating professional’s willingness to testify (sometimes by telephone) and explain why the service is medically necessary is essential to success in an appeal hearing. Contact MDLC for assistance in filing an appeal.

What if the needed service is not available close to a Medicaid recipient’s home?

Medicaid recipients have the right to receive certain health care services within a reasonable distance from their home. These services include primary care, pharmacy, obstetrics/gynecology, and diagnostic laboratory and x-ray services. “Reasonable distance” is defined as within 10 minutes travel time for pharmacy and 30 minutes travel time for the other services. For assistance locating a health care provider close to home, contact the customer service number on the back of your Medicaid card and ask for help locating a provider in your area.

What if an individual has private insurance in addition to Medicaid?

Medicaid is the payer of last resort. This means that Medicaid will only pay if the other insurance will not cover the service. Try to find a provider who participates in both the private health insurance plan and Medicaid. If the private insurance does cover a service, Medicaid may pay the co-pay if the provider is a Medicaid provider. Be sure to let the provider know that the individual has Medical Assistance in addition to the private insurance.

If there is a co-pay for prescription drugs under an individual’s private insurance plan, Medicaid should pay the co-pay, with some exceptions. Tell the pharmacy to bill the primary insurance for the drug, and Medicaid for the co-pay. If you have questions or problems with prescription drug coverage, contact the Pharmacy Program Recipient Access Hotline at 1-800-492-5231, or MDLC.

What are the next steps if an individual cannot obtain needed Medicaid services?

If a Medicaid or waiver service is denied or there is an unreasonable delay in getting the service, individuals have the legal right to take further action. When a service is denied, terminated or reduced, the MCO or DHMH must notify the recipient in writing in a letter explaining the reason for the denial and providing information about how to appeal. We recommend you contact MDLC before taking any of the appeal steps explained in the letter (or below) if time permits. Contact MDLC’s intake office Monday through Friday by calling 410-727-6352 or 1-800-233-7201.

In cases where the MCO or DHMH terminates or reduces any service a recipient is receiving, it is important for the recipient to ask for a fair hearing in writing immediately and to get that appeal letter to the MCO or DHMH within 10 days of the date on the denial letter. If this is done, services must continue until the hearing decision.

In some cases, MDLC may be able to provide legal representation. Representation by MDLC is free. In other cases, we may refer individuals to other attorneys who can represent them for free. MDLC has a list of private attorneys who are willing to represent individuals with a low income on a pro bono basis. However, there is no guarantee that a pro bono attorney will be available at the time you contact MDLC.

If an individual is denied a service by their MCO under the HealthChoice Program, call the Health Enrollee Action Line (HEAL Line) to file a complaint or an appeal: 1-800-284-4510. You should contact MDLC for advice first. A local ombudsman may also be assigned to help access needed benefits and services. If an individual is denied a service that should be covered in the fee-for-service program, call 1-800-492-5231 to file a complaint or appeal. All complaints and appeals should be made in writing.

If ValueOptions denies a mental health service, you may file a written appeal with ValueOptions.

If a Medicaid or waiver service is denied, or there is an unreasonable delay in getting the service, the recipient has the right to request a Medicaid fair hearing. This is a hearing before an Administrative Law Judge. A lawyer's assistance is not required, but is highly recommended. There may also be other, more informal appeal options that vary depending on the circumstances. Contact MDLC for more information on your appeal rights and options.

GLOSSARY

DD – Developmental Disability

DDA – Developmental Disabilities Administration

DHMH – Department of Health and Mental Hygiene

DME – Durable Medical Equipment

HEAL – Health Enrollee Action Line

ICF-ID - Intermediate Care Facility for the Intellectually Disabled

ISS/SO – Individual Support Services or Supports Only

LAHW – Living At Home Waiver

LISS – Low Intensity Support Services

MA – Medical Assistance

MAPC – Medical Assistance Personal Care

MCO – Managed Care Organization

MDLC - Maryland Disability Law Center

OAW – Older Adults Waiver

PCP – Primary Care Physician or Provider

REM – Rare and Expensive Case Management

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

RESOURCES

Community First Choice Medicaid State Plan Option

Web: <http://mmcp.dhmf.maryland.gov/longtermcare/SitePages/Long%20Term%20Care%20Reform.aspx>

Developmental Disabilities Administration

Phone: 410-767-5600

Web: <http://dda.dhmf.maryland.gov/SitePages/howtoapply.aspx>

DentaQuest dental services

Phone: 1-888-696-9598

Web: www.dentaquestgov.com

HealthChoice

Phone: 1-800-977-7388

Web: http://mmcp.dhmf.maryland.gov/healthchoice/Documents/120306_HC_cc_Mar012012_v1-PREP.pdf

Living At Home Waiver

Web: http://mmcp.dhmf.maryland.gov/docs/Living_Home_Waiver_Fact_Sheet_October_2010.pdf

Maryland Department of Health and Mental Hygiene

Phone: 1-800-456-8900

Phone: 1-800-284-4510 *Health Enrollee Action Line*

Web: <http://mmcp.dhmf.maryland.gov/chp/SitePages/Home.aspx>. *Medicaid information*

Maryland Department of Human Resources

Web: <http://dhr.maryland.gov/fiaprograms/medical.php> *Medicaid information*

Maryland Developmental Disabilities Administration

Phone: 410-767-5600

Web: www.dda.dhmf.maryland.gov

Maryland Disability Law Center

Phone: 410-727-6352 or 1-800-727-6352

Web: www.mdclaw.org

Maryland Medical Assistance and Pharmacy Access Hotline

Phone: 1-800-492-5231

Older Adults Waiver

Web: http://mmcp.dhmf.maryland.gov/docs/Older_Adults_Fact_Sheet_October_2010.pdf

Public Mental Health System Providers' Manual

Web: http://maryland.valueoptions.com/provider/prv_man.htm

REM Program List of Qualifying Conditions

Web: <http://www.dsd.state.md.us/comar/getfile.aspx?file=10.09.69.17.htm>

ValueOptions

Phone: 1-800-888-1965 Fax: 1-877-502-1044

Web: <https://www.valueoptions.com/pc/eProvider/providerLogin.do> (*For treating professionals*)

NOTES

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**Maryland Disability Law Center
1500 Union Avenue
Suite 2000
Baltimore, Maryland 21211-1982**

Phone: 410.727.6352 Toll Free: 1.800.233.7201
www.mdclaw.org