TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY POLICY L-9
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201

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

MANUAL: Waiver for Older Adults Eligibility Manual

EFFECTIVE DATE: February 2007

RELEASE NO: MR-12

ISSUED: January 2007

APPLICABILITY: Waiver for Older Adults Applicants and Recipients

Item	Remove Pages	Insert Pages
DHMH/OA1A Form Advisory Approval Letter	DHMH/OA1A	DHMH/OA1A
DHMH/OA 1D Form Advisory Denial Letter	DHMH/OA 1D	DHMH/OA 1D
DHMH/OA 05C Form Advisory Opinion/LTCF Discharge Letter	DHMH/OA 05	DHMH/OA 05
DHMH/OA 07 Form Notice of Ineligibility	DHMH/OA 07	DHMH/OA 07
DHMH/OA 09 Form Notice of Closing	DHMH/OA 09	DHMH/OA 09

Place this transmittal letter in the front of your eligibility manual.

COMMENTS

The main purpose of this manual release is to replace all references to Delmarva in the notices and letters section, with the term "utilization control agent." As of February 1st 2007 the Keystone Peer Review Organization, Inc. (KePRO) is replacing Delmarva as the utilization control agent for the Maryland Department of Health and Mental Hygiene.

As of February 1, 2007, all documentation, copies, faxes and telephone inquires pertinent to the utilization control agent should be directed to:

KePRO
Executive Plaza II
11350 McCormick Road
Suite 102
Hunt Valley, MD 21031
Phone: 866-581-6773
Acute Care Fax: 866-581-6771
Long Term Care/Community Services Fax: 866-581-6769
E-mail: Maryland@KePRO.org
Website: http://dhmh.kepro.org/default.aspx

The latest appeal rights are added to the DHMH/OA 07 and 09 ineligibility and closing notices to reflect current practice.

The increased fee for an assessment of resources, which was raised from $50 to $200, is now updated in the Advisory Approval letter DHMH/OA 1A.

Text is modified in DHMH/OA Advisory Opinion/LTCF Discharge notice, from " If you find a community residence by _____six months from the date that your Medical Assistance waiver application was received" to "…six months from the first day of your application month."

_____

Area Agency on Aging

_____

_____

_____

_____ _____

Name of Potential Applicant *Date of Notice*

_____

Authorized Representative

_____

Address

_____

_____

Dear_____:

You have advised this agency that the above-referenced individual does not wish to apply for Medical Assistance under the Waiver for Older Adults at this time. Also, you have requested documentation regarding this person's present qualifications to participate in the waiver. The purpose of this request is to establish the date upon which a division of spousal assets will be made, under the Medical Assistance "Spousal Impoverishment" provisions, should an application be filed in the future. This information is then used to determine the amount of assets the applicant's spouse may preserve.

Based on an advisory opinion from the utilization control agent and from the evaluation completed by this agency, the potential waiver applicant **meets** the level of care and other non-financial criteria for participation in the Waiver for Older Adults effective _____.

This letter does <u>not</u> assure future eligibility for Medical Assistance or participation in the waiver program. The advisory opinions of this agency and the utilization control agent are not binding and have no bearing on Medical Assistance eligibility in a nursing home or other long-term care facility. This advisory opinion does not substitute for the evaluations that are required upon application for waiver eligibility.

<u>Keep</u> <u>this</u> <u>letter.</u> Prior to application for Medical Assistance, you may request an assessment of resources from the Department of Health and Mental Hygiene. To do this you must call the Eligibility Policy/MCHP Division at (410) 767-1463 or 1-800-492-5231, pay a $200 fee, and complete an assessment form. You will need to include a copy of this letter when you submit the assessment form. If an application for a Medical Assistance waiver is filed in the future, you must submit a copy of this letter with your application form.

Sincerely,

_____

Name

_____

Title

_____

Telephone

Copy: Applicant- 2
Authorized Representative
AAA File
MDoA

_____
Area Agency on Aging

_____
_____
_____

_____ _____
Name of Potential Applicant *Date of Notice*

_____
Authorized Representative

_____
Address

_____
_____

Dear_____:

You have advised this agency that the potential applicant named above does not wish to apply for Medical Assistance under the Waiver for Older Adults at this time. Also, you have requested documentation regarding this person's present qualifications to participate in the waiver. The purpose of this request is to establish the date upon which a division of spousal assets will be made, under the Medical Assistance "Spousal Impoverishment" provisions, should a waiver application be filed in the future. This information is then used to determine the amount of assets the applicant's spouse may preserve.

Based on an advisory opinion from the utilization control agent and from the evaluation completed by this agency, the potential waiver applicant **does not meet** the level of care and other non-financial criteria for participation in the Waiver for Older Adults at this time. Therefore, a date cannot yet be established for the division of spousal resources for a future waiver application. The specific reason(s) for this advisory opinion are specified on the next page of this letter.

Keep this letter. This advisory opinion does not substitute for the evaluations that are required upon application for waiver eligibility and has no bearing on Medical Assistance eligibility in a nursing home or other long-term care facility. You may request another waiver advisory opinion at any time prior to waiver application. **The opinions of this agency and the utilization control agent are not binding and are not subject to appeal.**

Sincerely,

_____
Name

_____
Title

_____
Telephone

Copy: Applicant- 2
Authorized Representative
AAA File
MDoA

Reason(s) for Advisory Denial for the Waiver for Older Adults

As of the date of this notice, the advisory opinion is that the individual named above **does not meet the non-financial eligibility criteria** in COMAR 10.09.54 to participate in the Waiver for Older Adults due to failure to meet the following criteria:

- ❑ 1. You are not medically eligible for the waiver because the Medical Assistance Program's utilization control agent issued an advisory opinion that you do not need a nursing facility level of care. Specifically, you must meet the medical eligibility criteria for Medical Assistance nursing facility benefits in accordance with COMAR 10.09.10 and COMAR 10.09.54.03A.

- ❑ 2. You are younger than the waiver's minimum age of 50.

- ❑ 3. This agency has determined that you are not able to live safely at home or in a facility operated by a licensed assisted living services provider (COMAR 10.09.54.03B(5)(b)).
  Explanation: _____

- ❑ 4. You do not need any waiver services at this time (COMAR 10.09.54.03B(4)).
  Explanation: _____

- ❑ 5. You do not meet the waiver's requirement because, the expected costs to Medical Assistance of caring for you in the community would be more than Medical Assistance's average payments for nursing facility residents (COMAR 10.09.54.03B(5)(c)).
  Explanation: _____

- ❑ 6. Other reason(s) (COMAR 10.09.54.03B): Reason(s):
  _____

WAIVER ADVISORY OPINION

Division of Eligibility Waiver Services (DEWS)
Schaefer Tower
6 St. Paul Street, Suite 306
Baltimore, MD 21202

Date: _____

MA No. _____

Participant
Participant Address
Participant City, State, Zip Code

Dear:

Based on the information provided in your application for the Medicaid Home and Community Based Services Waiver for Older Adults, the Department of Health and Mental Hygiene is issuing you this Waiver Advisory Opinion. At the time this application was filed, you met the technical, medical, and financial eligibility standards for the waiver and Medical Assistance (Medicaid), except you are still in the long-term care facility and do not yet live in the community (COMAR 10.09.54.03B).

If you find a community residence by _____ (six months from the first day of your application month), the Department of Health and Mental Hygiene will issue you an approval letter for participation in the waiver if you continue to meet the waiver's eligibility requirements. Your waiver enrollment will take effect on the day that you move from the long-term care facility to your community home.

The Older Adults Waiver staff at _____ (the local administering agency) will continue to provide referrals for nursing home transition and case management services to assist you during the six-month period after your application.

Please inform your waiver case manager at the local administering agency as soon as you have located a residence. That will act as the trigger to issue you an approval letter for participation in the waiver if you continue to meet eligibility requirements. If you cannot find a community residence within six months of the first day of your application month, you will have to reapply for the waiver.

This advisory opinion is not an approval for waiver services and therefore is not subject to appeal. If you have any questions regarding this advisory opinion, please contact your eligibility case worker at 410-767- _____.

Sincerely,

Eligibility Case Worker,
Division of Eligibility Waiver Services (DEWS)

_____
Telephone

cc: Authorized Representative
Area Agency on Aging
DHMH Division of Waiver Programs
DHMH Office of Access, Quality, and Program Integrity
Utilization Control Agent

Division of Eligibility Waiver Services (DEWS)
Schaefer Tower
6 St. Paul Street, Suite 306
Baltimore, Maryland 21202

Date: _____
MA No._____

Participant
Participant Address
Participant City, State, Zip Code

Dear _____:

The Department has reviewed your application received on _____ and has determined that you **are not eligible** to receive Medical Assistance (Medicaid) services under the **Waiver for Older Adults.** This determination is based on the following reasons as determined by the _____(the local administering agency) and the Medical Assistance Division of Eligibility Waiver Services (DEWS):

Medicaid Eligibility (financial and technical)

❑ 1. You do not meet the Medicaid eligibility requirements under:
- ❑ a. Medicaid eligibility rules at COMAR 10.09.24
- ❑ b. Waiver for Older Adults eligibility rules at COMAR 10.09.54.03C

See the attached notice for the reason(s):
- ❑ Notice of Ineligibility: Transfer Penalty (DHMH/OA 6)
- ❑ Notice of Ineligibility: Financial Reasons (DHMH/OA 8)

- ❑ Other reason(s): _____

❑ 2. You did not provide the information necessary to complete your Medicaid eligibility determination. The information required is:

_____
_____
_____

If you send in this information before _____, you will not have to file another application form. This agency will re-activate your original application and determine your Medicaid eligibility for the Waiver for Older Adults.

Medical Eligibility

❑ 3. You are not medically eligible for the waiver because the Medicaid Program's utilization control agent found that you do not need a nursing facility level of care. Specifically, you must meet the medical eligibility criteria for Medicaid nursing facility benefits in accordance with COMAR 10.09.10 (COMAR 10.09.54.03A).

Client Name on Page One _____

Technical Waiver Eligibility

❑ 4. You are younger than the waiver's minimum age of 50 (COMAR 10.09.54.03B(2)).

❑ 5. The_____, as the local administering agency for the waiver, has determined that you are not able to live safely at home or in a facility operated by a licensed assisted living services provider (COMAR 10.09.54.03B(5)(b)). Reason:

❑ 6. As of the requested date for waiver enrollment, you will not be residing at home or in a licensed facility operated by a Medicaid approved provider of assisted living services (COMAR 10.09.54.03B(1)).

❑ 7. _____could not approve your waiver plan of care. It does not meet all of the requirements of COMAR 10.09.54.03B(4) because:

- ❑ a. the plan of care was not approved by all members of the multidisciplinary team
- ❑ b. the plan of care does not include any waiver services
- ❑ c. other: _____

❑ 8. You are presently enrolled and choose to remain in:

- ❑ a. another Medicaid 1915 (c) home and community-based services waiver:
- ❑ b. Program of All-Inclusive Care for the Elderly (PACE)

If you still wish to participate in the Waiver for Older Adults, you or your authorized representative should contact your case manager about disenrolling from your current program (COMAR 10.09.54.03B(3)).

❑ 9. You do not meet the waiver's requirement for individual cost-neutrality. Specifically, the anticipated costs to Medicaid of caring for you in the community exceed Medicaid's average per capita expenditures for nursing facility residents (COMAR 10.09.54.03B(5)(c)).

❑ 10. You or your authorized representative declined to choose waiver services in the community as an alternative to nursing facility services (COMAR 10.09.54.03B(8)).

❑ 11. Your Medical Assistance application has expired after 6 months from the application date.

12. Other reason(s): _____

Client Name on Page One _____

This decision is based on COMAR 10.09.24 and COMAR 10.09.54.03. Please be advised that this decision does not affect your current or potential eligibility for other Medical Assistance benefits. If you have questions concerning items 1 and 2 in this letter, contact your eligibility case worker at the number below. If you have questions regarding items 3 through 12 in this letter, please call your local administrating agency for the waiver.

You or your authorized representative may appeal this decision to the Office of Administrative Hearings, pursuant to COMAR 10.01.04, within ninety (90) days of the date on this notice. Further details about the appeals process are attached. Mail your request for a hearing to the following address:

Department of Health and Mental Hygiene
Office of Health Services
Attention: Appeals
201 W. Preston Street, 1st Floor
Baltimore, Maryland 21201

Sincerely,

_____
Eligibility Case Worker
Division of Eligibility Waiver Services (DEWS)

_____
Telephone

cc: Authorized Representative
Area Agency on Aging
DHMH Division of Waiver Programs
DHMH Office of Access, Quality, and Program Integrity
Utilization Control Agent

See next page for information about Fair Hearings

Summary of Procedures for Fair Hearings

You have the right to appeal this decision within 90 days from the date of the notice. **Your request must be made in writing. Please include the specific reason(s) for your appeal and a copy of the denial letter that accompanies this notice. If you wish, someone may assist you in filing your appeal.**

Mail your request for a hearing to the following address:
Department of Health and Mental Hygiene
Office of Health Services
Attention: Appeals
201 W. Preston Street, 1st Floor
Baltimore, Maryland 21201

If you are presently receiving benefits, you must request a fair hearing within 10 days from the date of this notice of agency determination or by the effective date of the termination of benefits, whichever is later, to insure continuation of your services until the fair hearing decision is made. However, if the judge agrees with us and you lose your appeal, you may have to pay back benefits received while you waited for the hearing and judge's decision. This recovery might not be required if it is determined that your request for a hearing resulted from a bona fide belief that the Department's decision was in error.

The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot be present, you must notify the Office of Administrative Hearings to reschedule the hearing or you must identify the person who will attend in your place. You may represent yourself, or if you wish, you may be represented by legal counsel or by a relative, friend or other person. It is not necessary, however, that someone represent you. You may bring any witnesses or documents you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of persons from the general public may be admitted to the hearing if you desire.

Prior to the hearing, you may review the documents and records that the Department will use at the time of the hearing and you can ask for the names of the witnesses the Department intends to call. During the time before the hearing, if you have new or additional information you wish the Department to know about, you may request a reconsideration of your case by calling your resource coordinator, service coordinator, case manager or waiver eligibility case worker**.**

Under some circumstances, the Department may pay for transportation and other costs if they are necessary for the proper conduct of the hearing.

All these procedures and a fuller explanation of the fair hearing process can be found in the Code of Maryland Regulations (COMAR), 10.01.04, 10.09.24.12, 10.09.24.13, and 10.09.24.15 and in the Code of Federal Regulations (C.F.R.), 42 C.F.R. § 431.200.

You may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904 or the Maryland Disability Law Center at 1-800-233-7201.

Division of Eligibility Waiver Services (DEWS)
Schaefer Tower
6 St. Paul Street, Suite 306
Baltimore, Maryland 21202

Date: _____
MA No: _____

Participant
Participant Address
Participant City, State, Zip code

Dear _____:

It has been determined that you **<u>are no longer eligible</u>** for the **Waiver for Older Adults**.

Your eligibility for waiver services ends as of _____.

Your eligibility for Medical Assistance (Medicaid):

- ❑ Ends as of _____
- ❑ Remains active

This determination is based on the following reasons as determined by the _____ (the local administering agency) and the Medical Assistance Division of Eligibility Waiver Services (DEWS):

<u>Medicaid Eligibility</u> (financial and technical)

❑ 1. You no longer meet the Medicaid eligibility requirements under:
- ❑ a. Medicaid eligibility rules at COMAR 10.09.24
- ❑ b. Waiver for Older Adults eligibility rules at COMAR 10.09.54.03C

- ❑ See the attached Notice of Closing: Financial Reasons (DHMH/OA 10) for the reason(s).
- ❑ Other reason(s):
  _____

❑ 2. You failed to complete the redetermination process. Your eligibility will be considered and may be re-established without a gap in coverage if you file the redetermination package or a new application with your eligibility caseworker by _____.

❑ 3. You failed to provide the requested information needed to determine your continued Medicaid eligibility. The information required is:
_____
_____

If you send in this information before _____, you will not have to file another redetermination application. This agency will re-activate your original redetermination application and determine your continued Medicaid eligibility for the Waiver for Older Adults.

Client Name on Page One _____

Medical Eligibility

❑ 4. You no longer qualify as medically eligible for the waiver because the Medicaid Program's utilization control agent found that you do not need a nursing facility level of care. Specifically, you must meet the medical eligibility criteria for Medicaid nursing facility benefits in accordance with COMAR 10.09.10 (COMAR 10.09.54.03A).

Technical Waiver Eligibility

❑ 5. The _____, as the local administering agency for the waiver, has determined that you are not able to continue to live safely at home or in a facility operated by a licensed assisted living services provider (COMAR 10.09.54.03B(5)(b)). Reason:

❑ 6. You are no longer residing at home or in a licensed facility operated by a Medicaid provider of assisted living services (COMAR 10.09.54.03B(1)).

❑ 7. You are residing in a long-term care facility such as a nursing home or a chronic care hospital for at least 30 days, or are expected to reside there for at least 30 days (COMAR 10.09.54.03B(1)).

❑ 8. _____ could not approve your revised waiver plan of care. It does not meet all of the requirements of COMAR 10.09.54.03B(4) because:

- ❑ a. The plan of care was not approved by all members of the multidisciplinary team
- ❑ b. The plan of care does not include any waiver services
- ❑ c. Other: _____

❑ 9. You have chosen to enroll in:

- ❑ a. Another Medicaid 1915 (c) home and community-based services waiver:

- ❑ b. Program of All-Inclusive Care for the Elderly (PACE)

If you still wish to participate in the Waiver for Older Adults, you or your authorized representative should contact your case manager about disenrolling from your current program. (COMAR 10.09.54.03B(3)).

❑ 10. You no longer meet the waiver's requirement for individual cost-neutrality. Specifically, the anticipated costs to Medicaid of caring for you in the community exceed Medicaid's average per capita expenditures for nursing facility residents (COMAR 10.09.54.03B(5)(c)).

❑ 11. You or your authorized representative declined for you to continue receiving waiver services in the community as an alternative to nursing facility services (COMAR 10.09.54.03B(8)).

❑ 12.Other reason(s)_____

Client Name on Page One _____

This decision is based on COMAR 10.09.24 and COMAR 10.09.54.03. Please be advised that this decision does not affect your current or potential eligibility for other Medical Assistance benefits. If you have questions concerning items 1 through 3 in this letter, contact your eligibility case worker at the number below. If you have questions regarding items 4 through 12 in this letter, please call your local administrating agency for the waiver.

You or your authorized representative may appeal this decision to the Office of Administrative Hearings, pursuant to COMAR 10.01.04, within ninety (90) days of the date on this notice. **If you are presently receiving benefits, you must request a fair hearing within 10 days from the date of this notice of agency determination or by the effective date of the termination of benefits, whichever is later, to insure continuation of your services until the fair hearing decision is made.**

Further details about the appeals process are attached. Mail your request for a hearing to the following address:

Department of Health and Mental Hygiene
Office of Health Services
Attention: Appeals
201 W. Preston Street, 1st Floor
Baltimore, Maryland 21201

Sincerely,

_____
Eligibility Case Worker
Division of Eligibility Waiver Services (DEWS)

_____
Telephone

cc: Authorized Representative
Area Agency on Aging
DHMH Division of Waiver Programs
DHMH Office of Access, Quality, and Program Integrity
Utilization Control Agent

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Office of Health Services
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201 W. Preston Street, 1st Floor
Baltimore, Maryland 21201

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The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot be present, you must notify the Office of Administrative Hearings to reschedule the hearing or you must identify the person who will attend in your place. You may represent yourself, or if you wish, you may be represented by legal counsel or by a relative, friend or other person. It is not necessary, however, that someone represent you. You may bring any witnesses or documents you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of persons from the general public may be admitted to the hearing if you desire.

Prior to the hearing, you may review the documents and records that the Department will use at the time of the hearing and you can ask for the names of the witnesses the Department intends to call.

During the time before the hearing, if you have new or additional information you wish the Department to know about, you may request a reconsideration of your case by calling your resource coordinator, service coordinator, case manager or waiver eligibility case worker**.**

Under some circumstances, the Department may pay for transportation and other costs if they are necessary for the proper conduct of the hearing.

All these procedures and a fuller explanation of the fair hearing process can be found in the Code of Maryland Regulations (COMAR), 10.01.04, 10.09.24.12, 10.09.24.13, and 10.09.24.15 and in the Code of Federal Regulations (C.F.R.), 42 C.F.R. § 431.200.

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