TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY SERVICES
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MANUAL: Medical Assistance **EFFECTIVE DATE: December 1, 2005**

RELEASE NO: MR-127 **ISSUED: November 2005**

APPLICABILITY: Pickle eligibility standards; QMB/SLMB eligibility and manual notices; Disabled Adult Children; MA application; representative; newborns; citizenship and alien eligibility; disability determination; pre-release MA applications for inmates; resource eligibility; long-term care post-eligibility deductions from cost of care for non-covered services; guaranteed MA eligibility under HealthChoice; recipient fraud or abuse; spousal impoverishment standards

Item	Remove Pages	Insert Pages
Chapter 3 – Coverage Groups		
Pickle Eligibility		
(Social Security Cost-of-Living Adjustments)	Table I, 300-25	Table I, 300-25
(SSI Income Standards)	Table II, 300-26	(page deleted)
Qualified Medicare Beneficiaries (QMBs)	Policy Alert 03-1	Policy Alert 03-1
(SSI Payment Rate)	Appendix A (after page 39)	Appendix A (after page 39)
(QMB/SLMB manual notices)	Appendix C QMB Notices	(pages deleted)
	Appendix D SLMB Notices	(pages deleted)
Disabled Adult Children (DAC)	Policy Alert 03-3	Policy Alert 03-3
Chapter 4 – Application Requirements		
MA application; representative; newborns	400-1 – 400-4	400-1 – 400-4
Chapter 5 – Non-Financial Eligibility Requirements		
Citizenship/alien eligibility policies	500-1 – 500-6	500-1 – 500-6c

Disability determination procedures	500-9 – 500-10	500-9 – 500-10c
Pre-release MA applications for inmates	500-12a – 500-12b	500-12a – 500-12b-2
Chapter 8 – Resources		
Resource eligibility and ineligibility	800-7 – 800-8	800-7 – 800-8
Chapter 10 – Eligibility for Institutionalized Persons		
Deduction for non-covered medical or remedial services	1000-35 – 1000-36	1000-35 – 1000-36
Chapter 11 – Certification Periods		
HealthChoice Six Month Guarantee of Eligibility	Policy Alert 11-01	(pages deleted)
Chapter 14 – Fraud and Abuse		
Recipient fraud and abuse	Table of Contents 1400-1 – 1400-8	Table of Contents 1400-1 – 1400-3
Appendix		
Spousal impoverishment standards	Schedule MA-8	Schedule MA-8

COMMENTS

Manual Release MR-127 contains the following new standards effective 1/1/06:

- Social Security COLA (cost-of-living adjustment) used in determining Pickle eligibility for coverage group S04 - Table I in Chapter 3 (Table II is deleted as unnecessary.) Be sure to test for Pickle eligibility for persons made income overscale for SSI due to the annual Social Security COLA increase in benefits.
- SSI payment rate – Appendix A in Policy Alert 03-1
- Spousal Impoverishment standards - Schedule MA-8 in the Manual's Appendix

Policy Alert 03-1
The manual notices in Appendix C and D of Policy Alert 03-1 are deleted for Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs). These versions are obsolete. The current notices are programmed in CARES.

Policy Alert 03-3
Policy Alert 03-3 is replaced with corrected and clarified policies and procedures for Disabled Adult Children (DACs). Individuals who meet these requirements are entitled to Medical Assistance (MA) as recipients of Supplemental Security Income (SSI), without needing to file a MA application, even though they are eligible for SSI in a no-pay status.

CHAPTER 4
Pages in Chapter 4 are replaced to clarify certain application requirements:

- **DHMH/FIA CARES 9701 and DHR/FIA CARES 9711 Request for Assistance**

A form that is signed and received by the local office as a MA application and which is used to establish the MA application date must be approved by the Department of Health and Mental Hygiene (DHMH). The DHR/FIA CARES 9711 Request for Assistance and the one-page interview summary printed from CARES are not approved by DHMH as MA applications, and so may not be used to establish the application date, even if they are signed and received by the local office. An application form approved by DHMH and signed with an original signature must be received by the local office in order to establish the application date, such as the DHMH/FIA CARES 9701 Application for Assistance or the Eligibility Determination Document (EDD) printed from CARES.

- **Authorized representative**

A section about the representative is added. An applicant or recipient (A/R) may have only one authorized representative at a time. Only the representative is authorized to act in the A/R's behalf in matters related to the A/R's MA application or case (e.g., to file a request for a hearing). Information about the A/R's application or case may only be released to the A/R or the A/R's authorized representative, not to a hospital collection agency or other entity which is not the A/R's authorized representative (see FIA Information Memo 06-08). In order for an individual to be considered as an A/R's MA representative, the individual must be designated as authorized to act in the A/R's behalf in matters related to the MA application and case. This designation must be made in writing on the MA application, another form (e.g., DES 2004 – LTC – Representative's Statement form), or a letter to the local office. For example, a hospital form that designates a representative for matters related to the A/R's care in the hospital does not constitute the designation of a representative for the A/R's MA application or case.

- **Separate Applications; Newborns**

Clarifications are made as to when a separate MA application is not necessary —which categories of public assistance are automatically MA eligible and under what circumstances a newborn is automatically eligible. If a newborn is born to a mother who was MA or MCHP eligible for the date of birth (including in the X-track for aliens) and who continues to be eligible, the newborn is presumptively determined MA eligible in coverage group P03 or P12. The newborn remains eligible for the first year of life, even if the mother subsequently loses eligibility or the child no longer lives with the mother, unless the newborn moves out-of-state, dies, or becomes eligible in a different coverage group.

CHAPTER 5
In Chapter 5, the following clarifications are made:

- **Citizenship and Eligibility**

The citizenship and alien eligibility requirements are clarified, for consistency with federal policies and procedures. In particular, the policies are clarified for when the 5-year bar to eligibility for federal benefits is applied and when the bar is not applied. Also, the Child Citizenship Act of 2000 is explained, which permits certain children born overseas to

be automatically considered as U.S. citizens when they enter the United States legally for permanent residence, without the need to apply for a certificate of citizenship.

- **SRT/Disability Determinations**

The disability determination procedures are clarified in Chapter 5, in accordance with the requirements at COMAR 10.09.24.05. Policies are explained for when a disability determination package does and does not need to be sent to the State Review Team (SRT) for a disability determination (see also FIA Information Memo 06-18).

- **Certain Prison Inmates**

The policies and procedures are updated related to MA applications for certain prison inmates prior to release, to be consistent with FIA Action Transmittal 05-33 Revised, issued on June 9, 2005.

CHAPTER 8

In Chapter 8, the basic policy for resource eligibility is corrected and clarified. Resource eligibility is determined as of the 1st moment of the 1st day of the month, not for an entire month. If an individual is resource eligible at that point in time, the individual remains resource eligible for the entire month, even if resources increase during the month. If the individual is resource overscale at that point in time, the individual is resource ineligible for the entire month, even if resources decrease during the month. See also the policies and procedures on pages 800-9 – 800-15 related to the reduction of resources by long-term care (LTC) applicants and recipients.

CHAPTER 10

In Chapter 10, the policies are corrected and clarified related to the deduction of a long-term care recipient's unpaid bills for non-covered medical or remedial services from the recipient's available income for the current cost of care. Previously, it was incorrectly stated on page 1000-35 that a retroactive period is associated with the effective date of MA eligibility. In fact, as stated elsewhere in the Manual, a retroactive period is associated with the month of MA application. Also, it is clarified that any months for which a long-term care recipient was ineligible between the month of application and the effective date of MA eligibility are considered to be months that the recipient was not covered by MA for services covered under the MA State Plan, such as nursing facility services. Therefore, the recipient's unpaid bills for medical and remedial services received during those ineligible months may be deducted from the recipient's available income for the current cost of care in the long-term care facility. However, deductions may not be made for unpaid bills for services rendered before the retroactive period associated with the recipient's month of MA application.

Policy Alert 11-01

Policy Alert 11-01 is deleted related to a six-month guarantee of MA eligibility for HealthChoice enrollees. This guarantee was eliminated effective July 1, 2004.

Chapter 14

Chapter 14 is updated related to recipient fraud and abuse. Referrals for investigations are to be directed to the Division of Medicaid Quality Control in the newly created Program Integrity Unit.

Table I.

Social Security Cost of Living Adjustments, 1977-2006

Date of Increase	Increase	COLA Factor
July, 1977	5.9%	1.059
July, 1978	6.5%	1.065
July, 1979	9.9%	1.099
July, 1980	14.3%	1.143
July, 1981	11.2%	1.112
July, 1982	7.4%	1.074
Jan., 1984	3.5%	1.035
Jan., 1985	3.5%	1.035
Jan., 1986	3.1%	1.031
Jan., 1987	1.3%	1.013
Jan., 1988	4.2%	1.042
Jan., 1989	4.0%	1.040
Jan., 1990	4.7%	1.047
Jan., 1991	5.4%	1.054
Jan., 1992	3.7%	1.037
Jan., 1993	3.0%	1.030
Jan., 1994	2.6%	1.026
Jan., 1995	2.8%	1.028
Jan., 1996	2.6%	1.026
Jan., 1997	2.9%	1.029
Jan., 1998	2.1%	1.021
Jan., 1999	1.3%	1.013
Jan., 2000	2.4%	1.024
Jan., 2001	3.5%	1.035
Jan., 2002	2.6%	1.026
Jan., 2003	1.4%	1.014
Jan., 2004	2.1%	1.021
Jan., 2005	2.7%	1.027
Jan., 2006	4.1%	1.041

Note: July 1977 through July 1981, round product up nearest 10 to obtain actual benefit paid. Effective July 1982, round product down to nearest $1.00 to obtain actual benefit paid.

APPENDIX A

MARYLAND MEDICAL ASSISTANCE PROGRAM

Table 1

QMB INCOME STANDARDS

Effective 4/1/05	Individual	Couple
Annual	$9,570.00	$12,830.00
Monthly	$ 818.00*	$ 1,090.00*

*Gross income before applying the $20 disregard

Table 2

SSI PAYMENT RATE

Effective 1/1/06	Individual	Couple
Monthly	$603.00	$904.00

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January 2006

APPENDIX A

MARYLAND MEDICAL ASSISTANCE PROGRAM

Table 3

SLMB INCOME STANDARDS

Effective 4/1/05	Individual	Couple
Monthly	$819 - $977*	$1,091 - $1,303*

*Gross income before applying the $20 disregard

Table 4

SLMB II INCOME STANDARDS

Effective 4/1/05	Individual	Couple
Monthly	$978 - $1,097*	$1,304- $1,464*

*Gross income before applying the $20 disregard

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Policy Alert 03-3
Disabled Adult Children
(DAC)

If the Social Security Administration (SSA) considers an individual eligible for Supplemental Security Income (SSI), the individual is eligible for Medical Assistance (MA) as an SSI recipient, even if the individual does not receive SSI cash benefits due to receipt or increase of Social Security benefits. An SSI-eligible person who is at least 18 years old is MA-eligible as a Disabled Adult Child (DAC) if the parent, on whom the individual is dependent, dies or receives Social Security benefits as an elderly or disabled person, and the SSI recipient files a claim for Social Security benefits based on the parent's Social Security account. If the individual's Social Security cash benefit exceeds the SSI benefit, the individual no longer receives SSI cash payments. The individual is still deemed SSI-eligible by SSA, but in a "no-pay" status. This sequence of events makes the individual a DAC. Since the individual is still SSI-eligible, he/she remains MA-eligible as such. The DAC does not need to file a MA application in order to obtain and retain MA coverage. The MA eligibility case worker must assure that the DAC's MA eligibility remains active without a break after the SSI payments end, and SSI eligibility continues in a no-pay status.

For an individual to be MA-eligible as a DAC, the individual must be "deemed" by SSA as SSI-eligible in a no-pay status. This occurs when the individual becomes income-overscale for SSI cash benefits due to receipt or increase of Social Security Childhood Disability Benefits under the parent's Social Security account. The following criteria must be met for Childhood Disability Benefits:

- The individual is at least 18 years old, unmarried, not the head of a household, and dependent on a parent because the individual is blind or disabled;
- The individual has blindness or a disability that began before age 22; and
- The individual's parent either died or became eligible for Social Security because the parent is elderly or disabled.

The State Data Exchange System (SDX) or State Verification and Exchange System (SVES) should indicate that the SSI recipient is MA-eligible as a DAC when SSI cash

payments end or when SSI eligibility is initiated in a no-pay status. SDX/SVES should have the following information in order for an individual to be considered a DAC:

1. The individual is at least 18 years old;
2. The individual has "D" (deemed) as the SSI status for Medicaid eligibility;
3. The individual has "NC1" (no payment) as the SSI payment status;
4. The individual's SSA claim number differs from the individual's Social Security number, because he/she is eligible under the parent's SSA claim number; and
5. The individual's SSA claim number ends with a "C" suffix (Beneficiary Identification Code – BIC), followed by a number (e.g., "212-22-1212 C1").

This information is not always transmitted accurately or timely by SSA. Upon discovering that a DAC was denied or terminated for MA eligibility due to an SDX or worker error, the eligibility case worker must certify the individual as MA-eligible retroactive to the date that MA eligibility was erroneously denied or terminated.

Anyone who meets the DAC criteria must be certified as eligible for MA without a lapse in coverage from the time that SSI cash payments ended. Even though a DAC may have income in excess of the MA medically needy income limit (MNIL), the individual is eligible for MA as categorically needy. Their MA eligibility is determined based on whether they are technically eligible as a DAC. They are not required to complete a MA application form. A financial eligibility determination is not conducted.

If a DAC becomes employed, the earned income or accumulated resources may make the individual financially ineligible for the deemed status of SSI eligibility. When SSA's database indicates that a DAC is no longer SSI-eligible, the individual is no longer categorically eligible for MA as an SSI recipient. The MA eligibility case worker must then redetermine the individual's eligibility for the most appropriate coverage group. The policies and procedures must be followed in Policy Alert 12-03 and its CARES Supplement for "Redeterminations for Former SSI Recipients." Eligibility must be redetermined before MA coverage may be terminated, with a notice of adverse action issued at least 10 days before any case closure.

Although a DAC may have received SSI benefits as a child, this is not a requirement. An individual is eligible for SSI payments as a child if the individual:

- Qualifies for SSI based on disability and financial eligibility;
- Is either:
    - under 18 years old, or
    - under 22 years old and regularly attending school, college, or training that was designed to prepare the individual for a paying job;
- Is not married; and
- Is not the head of a household.

CARES Procedures

The following procedures are used to certify a DAC as eligible in coverage group S02 on CARES:

- Delete the SSI income from the **UINC** screen effective the month that the SSI payments ended. Enter the SSA income effective the month that the Social Security payments began. (These months should be the same.)
- At the bottom of the **UINC** screen, enter "SI" in the "Appl type" field, and enter "S" in the "Stat" field. Enter the date that SSI cash payments were terminated.
- If SSI eligibility has not been closed yet, these changes may be entered as interim changes. If SSI eligibility has already been terminated, the case will need to be rescreened, and these changes entered before finalization.

INTRODUCTION

The local department of social services (LDSS), local health department (LHD), or other entity designated by the Department of Health and Mental Hygiene (DHMH) ("Department") is responsible for determining initial and continuing eligibility for Medical Assistance (MA or Medicaid). Policies and procedures used are supported by Maryland's MA State Plan approved by the Centers for Medicare and Medicaid Services (CMS) and by the Code of Maryland Regulations (COMAR) 10.09.24. Every reference to "LDSS" in this chapter includes any other entity designated by the Department to determine MA eligibility, such as the local health departments or DHMH's Division of Eligibility Waiver Services.

GENERAL APPLICATION REQUIREMENTS AND PROCEDURES

The general MA application requirements apply to both non-institutionalized and institutionalized persons. However, due to the special circumstances of institutionalized persons, certain aspects of the application process may be handled differently. These are addressed under the section "Application Procedures Specific to Institutionalized Persons" in this chapter.

Provision of Public Information

If anyone requests public information about MA policies and procedures, DHMH or the entity determining MA eligibility must provide the information either orally or in writing. Information must be provided about the:

- MA eligibility requirements, including the income and resource limits and the policies related to spend-down of over-scale income and reduction of over-scale resources;
- Available MA services; and
- The applicant's or recipient's (A/R's) and representative's rights and responsibilities.

DHMH publishes fact sheets and brochures and a website about MA at: www.dhmh.state.md.us/mma. Information about MA eligibility is also available by calling the DHMH Division of Eligibility Services: 410-767-1463 or 1-800-492-5231 ext 1463.

Representative

A representative may assist the A/R in the application and redetermination process

and in other matters related to the A/R's MA eligibility. Only one designated representative at a time may be recognized as authorized to act on the A/R's behalf. Designation of a representative is indicated in writing on the MA application form, another form, or a letter submitted to the Department or its designee.

- An A/R who is at least 18 years old and mentally competent to provide information required by the Department is not required to have a representative, but may choose to designate a representative to provide assistance or act on the A/R's behalf in matters related to MA eligibility.
- A pregnant woman of any age is not required to have a representative and may sign the application and attend the interview on her own behalf, even if she is younger than 18 years old.
- A child younger than 18 years old (unmarried and not pregnant), or an individual who is not mentally competent to provide required information, must have a representative designated in writing to act on the individual's behalf in matters related to MA eligibility.
- A representative may be one of the following individuals who is at least 18 years old:
    - An individual who is related to the A/R by birth or marriage;
    - The A/R's legally recognized guardian or representative with power-of-attorney;
    - The caregiver with whom an A/R younger than 18 years old lives, if the child does not live with the child's parent or other caregiver relative;
    - An individual designated by the A/R if the A/R is at least 18 years old;
    - A provider's representative;
    - The A/R's legal counsel;
    - A governmental representative who is not involved with determining the A/R's MA eligibility (e.g., social services social worker); or
    - Any other individual who can provide the information required for MA eligibility.

Application Form and Application Date

An individual interested in applying for MA, or a representative, must contact the LDSS or other designated entity to complete the appropriate written application form, based on the type of coverage requested. Identified below are specific categories of A/R's that are not required to complete a separate MA application in order to have their eligibility determined.

The MA application form is the instrument through which information pertinent to the determination of eligibility is gathered from the A/R or the A/R's representative. DHMH designates which forms may be used as MA applications and which forms establish the application date. Screening forms, such as the DHR/FIA CARES 9711 Request for Assistance, are **not** approved by DHMH as MA application forms.

The MA application date is the date that the LDSS or other designated entity receives a MA application with an appropriate original signature on a form approved by DHMH. The local office should date-stamp the application to document the receipt date.

For an initial application, the applicant and/or representative usually participate in a face-to-face interview with the eligibility case worker or designee. For a redetermination of continuing eligibility, however, a face-to-face interview is only required if the eligibility case worker decides that it is necessary for a particular case, in order to obtain the necessary verifications or resolve certain issues.

Following the initial eligibility determination, communication between the LDSS and the recipient or representative is usually by mail or telephone. Faxes and emails are not used to request or provide information. Redeterminations are conducted through a mail-in process. A redetermination package, including an application form and a notice with the due date, is mailed to the recipient or representative, who completes and returns the package with any required verifications to the LDSS by mail.

Persons Eligible for MA Without Filing a Separate Application

Recipients of Public Cash Assistance

Recipients determined eligible for the following types of public cash assistance (even if they are in a no-pay status) are eligible for MA without filing a separate MA application:

- Supplemental Security Income (SSI) (coverage groups L01 and S02);
- Temporary Cash Assistance (TCA) (coverage groups F01-F03);
- Public Assistance to Adults (PAA) (coverage group S01);
- Foster care or subsidized adoption under Title IV-E of the Social Security Act (coverage group E01); and
- Refugee Cash Assistance (RCA) (coverage groups G01 and G02).

Child Born To a MA-Enrolled Mother

Newborns are presumptively eligible for MA for a period of up to 12 months if the mother is enrolled as a Maryland MA recipient on the date of the newborn's birth. The newborn's MA coverage is tied to the mother's MA enrollment for the date of birth. Therefore, an application and determination of the newborn's eligibility are not required in order to add the newborn to the mother's currently eligible assistance unit (AU). Coverage of the newborn under this policy applies irrespective of any ineligibility factor that may pertain to the newborn, except that the newborn must be a Maryland resident.

If the mother is determined eligible for MA or the Maryland Children's Health Program (MCHP) for a certification period including the newborn's birth, the child is certified in coverage group P03, unless the mother was eligible in coverage group P11. Then, the newborn is certified in coverage group P12. This presumptive eligibility for the newborn applies even if:

- The mother is determined eligible for the date of birth after the fact; or
- The mother is eligible in the X-track for ineligible or illegal aliens.

The newborn continues to be presumptively eligible in coverage group P03 or P12 for one year from the month of birth, unless the newborn moves from Maryland, dies, or becomes eligible in a different MA coverage group (e.g., T-track for long-term care or E-track for foster care or subsidized adoption). Therefore, the newborn retains eligibility in P03 or P12 even if the mother loses MA eligibility or the baby moves out of the mother's household during the baby's 12-month certification period.

If the newborn is added to a TCA AU (coverage groups F01 – F03), the newborn's eligibility may be affected by a change in circumstances of any family member, including the newborn, which makes the TCA AU ineligible. Then, each AU member, including the newborn, must have their MA eligibility redetermined for the most appropriate coverage group. The newborn's automatic eligibility in the TCA AU is also lost if the newborn ceases living with the mother

Upon expiration of the newborn's presumptive eligibility period, a

redetermination must be conducted to determine the child's continued eligibility, applying regular policies and procedures. Timely redeterminations are required to assure that coverage is not continued inappropriately. Eligibility factors pertaining to the newborn, which could not be considered during the 12-month presumptive eligibility period, must be considered at this time. A MA ineligible child must be considered for possible coverage under MCHP.

1184 Certification Procedure for the Newborns

Certification of a newborn on the MA Master File is initiated by the DHMH Office of Operations, Eligibility and Pharmacy (OOEP). This procedure expedites certifications of newborns and must be followed by both hospitals and local departments. The procedure is as follows:

- OOEP is notified by the hospital, via the DHMH 1184 (Hospital Report of Newborns), that a child has been born to a mother who is a MA or MCHP recipient. OOEP certifies the newborn on the MA Master File using the mother's case number to establish a temporary case number until the CARES interface assigns a permanent case number for the child. Therefore, the child will not have a CARES IRN at this point.
- OOEP sends a completed 1184 to the LDSS or LHD, as appropriate, for eligibility processing.
- Upon receipt of an 1184, the LDSS/LHD takes the following actions:
    - Review the case record to make certain that the mother was eligible for the date of the newborn's birth and that the mother's eligibility currently exists;
    - Record certification of the newborn in the case record and on CARES (Add-a-Person);
    - Review the 1184 for any errors or inconsistencies (name, address, eligibility dates, category codes, etc.) and take necessary corrective action as needed; and:
    - If there is a discrepancy between CARES and MMIS as to whether the mother was MA/MCHP eligible for the date of the child's birth, the LDSS/LHD

reviews the case record to determine the correct eligibility status and then takes the appropriate action.

If an LDSS or LHD is informed of a newborn's birth but the hospital or clinic failed to initiate the DHMH 1184 process, the LDSS/LHD must take action on its own to determine if the infant is automatically eligible for MA. The LDSS/LHD must determine if the mother was eligible for the date of the newborn's birth and if that eligibility currently exists. If the mother continues to be eligible, the LDSS/LHD adds the newborn to the mother's unit.

No application is required to certify the newborn. The newborn's certification must begin no earlier than the date of birth and terminate 12 months following the birth. The newborn's presumptive eligibility should not terminate when the mother is no longer eligible for MA or the child ceases to live with the mother. The newborn's eligibility should terminate, however, if the child moves out-of-state. Then, terminate eligibility in accordance with timely and adequate notice requirements.

If the mother gave up legal custody of the newborn at birth and the child does not go home from the hospital with the mother (does not physically remain in the mother's custody), the newborn does not automatically qualify for MA/MCHP as part of the mother's AU.

Certification Procedure for the Newborn of a TCA Recipient

The TCA policy in regard to adding a newborn to the TCA grant is outlined in the TCA Manual. The client will be given a copy of the DHMH 1184 by the hospital. The DHMH 1184 can be used for birth verification so that the newborn may, if otherwise eligible, be added to the TCA assistance unit. If a child is born to a TCA applicant in the month of application and the mother is found eligible in that month, certification of the newborn's MA and certification for the mother and other eligible members of the TCA unit begins the first day of the month in which they were found eligible for TCA. If the child was born prior to the month of the applicant/mother's eligibility for TCA and there are outstanding medical bills, refer to the policies for non-Public Assistance (NPA) MA or MCHP for determination of retroactive eligibility.

A. Citizenship.

1. Federal Medical Assistance Coverage.

Note: Refer to the following Internet site for the current federal Medical Assistance (MA or Medicaid) eligibility requirements related to aliens: www.cms.gov/immigrants

To be eligible for federal coverage of full Medical Assistance benefits, an individual must be one of the following:

1. A citizen of the United States by birth or naturalization, including:
   - An individual who was born in one of the 50 states, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, or the Virgin Islands;
   - An individual who is naturalized as a United States citizen;
   - An individual who was born in American Samoa or Swain's Island and is considered a United States national; or
   - A child younger than 18 years old who was born outside the United States and its outlying possessions (see the section below about a child born overseas to a citizen parent) and who automatically acquires U.S. citizenship upon the child's legal entry to the U.S. for permanent residency if the child is living in the legal and physical custody of a parent or parents meeting the following requirements:
     - Before implementation of the Child Citizenship Act of 2000 on February 27, 2001: both of the child's natural or adoptive parents were United States citizens by birth or naturalization at the time of the child's birth, and at least one parent was physically present in the United States or its possessions prior to the child's birth for a period or periods totaling at least 5 years, at least 2 of which were after the parent's 14th birthday. If the child's parents are divorced or one parent is deceased, the parent with whom the child lives must meet the physical presence requirements.

- On or after February 27, 2001: at least one of the child's parents was a U.S. citizen by birth or naturalization at the time of the child's birth and that parent was physically present in the United States or its possessions prior to the child's birth for a period or periods totaling at least 5 years, at least 2 of which were after the parent's 14th birthday.

2. A qualified alien who has been continuously present in the United States since the most recent date of entry to the United States which was before August 22, 1996, regardless of the date of qualified alien status;
3. A qualified alien who either most recently entered the United States on or after August 22, 1996 or has not been continuously present in the United States since the most recent date of entry before August 22, 1996, and who:
   - Meets the federally required 5-year bar to public benefits; or
   - Is in an immigration category that is not subject to the 5-year bar; or
4. An alien who is:
   - An honorably discharged veteran of the armed forces of the United States, including veterans of the following foreign armed forces:
     - Individuals who served in the Philippine Commonwealth Army during World War II or as Philippine scouts following World War II; and
     - Hmong and other Highland Lao veterans who fought under United States command during the Vietnam War and who were lawfully admitted to the United States for permanent residence;
   - On active duty in the armed forces of the United States;
   - The spouse, including a surviving spouse who has not remarried, or an unmarried dependent child (younger than 21 years old) of an honorably discharged veteran or alien on active duty in the armed forces of the United States;
   - A recipient of Supplemental Security Income (SSI) benefits;
   - A member of a federally-recognized Indian tribe, as defined in 25 U.S.C. §450b(e); or
   - An American Indian born in Canada to whom §289 of the Immigration and Nationality Act (INA) applies.

requirements, they do not need to file an application for citizenship. Therefore, there may be no documentation to verify the child's citizenship, unless an application was filed with the Bureau of Citizenship and Immigration Services in the Department of Homeland Security, and a certificate of citizenship was issued. The child will have either a permanent resident card or an I-551 stamp on the child's passport. Because the child is considered a citizen, the 5-year bar to MA eligibility for certain qualified aliens does not apply.

Qualified Aliens

An "alien" is an individual who was not born in the U.S. and is not considered a U.S. citizen by birth or naturalization. The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 (PRWORA) was signed into law on August 22, 1996. This Act significantly changed aliens' eligibility for Medical Assistance (MA) and other federal needs-based benefits. The Act restricts the eligibility of certain legal aliens for the federal MA Program. Illegal aliens have never been eligible for full MA benefits in a federal category, just for coverage of emergency medical services (coverage group X02).

MA eligibility for aliens is based on whether the alien is a "qualified" or "non-qualified" alien **and** whether the alien most recently entered the United States before or after August 22, 1996, and has been continuously present since then.

Aliens Subject to the 5-Year Bar

(a) Qualified aliens who most recently entered the United States on or after August 22, 1996, and who are now in one of the immigration categories specified below (unless they were previously in an immigration category exempt from the 5-year bar, such as an asylee or refugee) are not eligible for federally-funded Medical Assistance for a period of 5 continuous years from their:

- Most recent U.S. entry date, if the individual entered the United Status with the status of a qualified alien; or
- Effective date of qualified alien status approved by the Department of Homeland Security, if the individual did not enter the United States as a qualified alien (e.g., entered as a temporary visitor).

(b) The 5-year bar to federal benefits also applies to qualified aliens who most recently entered the United States before August 22, 1996 but who were not continuously present since then in the United States, and whose current immigration status is subject to the 5-year bar (and who were not previously in an exempt immigration category). Then, the 5-year bar is applied to either their U.S. entry date as a qualified alien or their effective date of qualified alien status.

The following types of qualified aliens are subject to the 5-year bar for federal benefits, if condition (a.) or (b.) above is met:

- An alien who was lawfully admitted to the United States for permanent residence or whose immigration status was changed to that of a lawful permanent resident, in accordance with the INA;
- An alien granted parole for at least 1 year under §212(d)(5) of the INA; and
- A documented or undocumented immigrant who has been battered or subjected to extreme cruelty by the individual's U.S. citizen or lawful permanent resident spouse or parent, or by a member of the spouse's or parent's family residing in the same household as the immigrant, if:
    - The spouse or parent consented to, or acquiesced in, the battery or cruelty;
    - The abusive act or acts occurred in the United States;
    - The individual responsible for the battery or cruelty no longer lives in the same household as the victim;
    - A Violence Against Women Act immigration case or a family-based visa petition has been filed; and
    - There is a substantial connection between the battery or cruelty and the need for Medical Assistance benefits.

Aliens Not Subject to the 5-Year Bar

The following types of qualified aliens are not subject to the 5-year bar for federal benefits, even if they were not a qualified alien when they entered the U.S. (e.g., entered as a temporary visitor before August 22, 1996 and status was later changed to a legal permanent resident):

- A qualified alien who most recently entered the United States prior to August 22, 1996, and who has been continuously present since then;
- An alien who most recently entered the U.S. in an immigration status listed below that is exempt from the 5-year bar (e.g., an asylee) and later converted to an immigration status listed above that is subject to the 5-year bar (e.g., legal permanent resident);
- An alien granted asylum under §208 of the INA;
- A refugee admitted into the United States under §207 of the INA;
- A child receiving federal payments for foster care or adoption assistance under Part B or E of Title IV of the Social Security Act, if the child's foster or adoptive parent is considered a citizen or qualified alien (Note for E-track eligibility);
- An alien whose deportation is being withheld under §243(h) of the INA in effect prior to April 1, 1997 or §241(b)(3) of the INA as amended;
- A Cuban or Haitian entrant, as defined at §501(e) of the Refugee Education Assistance Act of 1980;
- An alien granted conditional entry under §203(a)(7) of the INA in effect before April 1, 1980;
- An alien who was lawfully admitted to the United States for permanent residence and was:
    - Receiving SSI benefits on August 22, 1996 and is lawfully residing in the United States;
    - Lawfully residing in the United States on August 22, 1996 and is blind or disabled; or

- Admitted to the United States as an Amerasian immigrant under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988; and

- A victim of a severe form of trafficking, in accordance with §107(b)(1) of the Trafficking Victims Protection Act of 2000, who was subjected to:
  - Involuntary servitude; or
  - Sex trafficking if the act is induced by force, fraud, or coercion, or the individual who was induced to perform the act was younger than 18 years old on the date that the visa application was filed.

The following types of aliens are also not subject to the 5-year bar, regardless of their immigration category:

- A child receiving federal payments for foster care or adoption assistance under Part B or E of Title IV of the Social Security Act, if the child's foster or adoptive parent is considered a citizen or qualified alien (Note for E-track eligibility); and
- An alien who is:
  - An honorably discharged veteran of the armed forces of the United States;
  - On active duty in the armed forces of the United States; or
  - The spouse, including a surviving spouse who has not remarried, or an unmarried dependent child (younger than 21 years old) of an honorably discharged veteran or alien on active duty in the armed forces of the United States.

Meaning of "Continuously Present"

An alien is not considered to be continuously present in the United States if, before the date of qualified alien status, the alien had:

- A single absence from the United States of more than 30 days; or
- Absences from the United States totaling more than 90 days.

Procedures for Verification of Alien or Immigration Status

The primary way to verify alien/immigration status for a legal alien is by the *Systematic Alien Verification for Entitlement (SAVE)* system of the Department of Homeland Security. See the DHR/FIA Action Transmittal 04-34, issued in April 2004, for how an authorized user at the LDSS or other designated entity is to access and use the on-line screens of the SAVE system. Inquiry to SAVE may not be made by an alien's name, Social Security number, etc. Only the identification number on an alien's immigration document may be used for SAVE inquiry. Therefore, SAVE cannot be used if the eligibility case worker does not have a valid "INS" number for the alien, because the individual is now a naturalized citizen, is an illegal alien, or gave the eligibility case worker an invalid number or someone else's number.

Refer to the following transmittals issued by the Department of Human Resources about how to verify immigration status for certain categories of aliens or immigrants:

- Action Transmittal 05-16: Eligibility for Family Members of Victims of Severe Trafficking in Persons
- CARES Bulletin 05-16: Legal Immigrants in F-Track Medical Assistance
- FIA Information Memo 05-47: Mexico's Matricula Consular Identification Card
- CARES Bulletin 04-07: 5 Year Bar for Federal Benefits for Qualified Aliens
- Action Transmittal 03-34: Restoration of Food Stamps to Immigrants Who Have Lived in the United States for Five or More Years
- FIA Information Memo 99-51: Guidance for Verification of Immigration Status

Form numbers and the types of immigration documentation change over time. For the most current information about immigration documents issued by the federal government, consult federal web sites, such as:

- www.cms.hhs.gov/immigrants/
- http://uscis.gov/

If qualified alien status cannot be verified through the SAVE system or if additional information is needed to resolve a discrepancy, the following documentation may be used:

Documentation That An Applicant Is A Qualified Alien

Acceptable documentation of qualified alien status consists of the following:

° Lawful Permanent Resident - INS Form I-551 ("green card"), or for recent arrivals a temporary I-551 stamp in a foreign passport or on form I-94.

NOTE: If a lawful permanent resident presents an old INS form (I-151, AR-3, or AR-3a) as evidence of status, contact the Department of Homeland Security to verify the alien's status by filing a G-845 and attaching a copy of the old form. Also, refer the applicant/beneficiary to the Department of Homeland Security to apply for a replacement card.

° Refugees - INS Form I-94 endorsed to show entry as a refugee under §207 of the INA and date of entry to the United States; or INS Form I-688B, I-766 annotated "274a 12(a)(3)," or Form 1571.

° Asylees - INS form I-94 annotated with stamp showing grant of asylum under §208 of the INA; a grant letter from the Asylum Office of the Department of Homeland Security; Form I-688B or I-766 annotated "274a 12(a)(5); or an order of an Immigration Judge granting asylum. If the applicant/beneficiary presents a court order, contact the Department of Homeland Security to verify that the order was not overturned on appeal by filing a G-845 with the local Department of Homeland Security district office,

c) The report shall be reviewed by an ophthalmologist, contracted by the Department or its designee, who determines on behalf of the local department of social services or other designated entity determining Medical Assistance (MA) eligibility:

(i) Whether the person meets the definition of blindness; and

(ii) The need and frequency of re-examination for periodic redetermination of blindness.

When processing applications involving determination of blindness, it is important for the eligibility case worker to keep in mind the period under consideration. If the applicant is requesting assistance for the retroactive period under consideration and indicates the existence of the impairment during that period, the required medical and social information must be collected for the retroactive period.

The blindness medical form must be completed and used to report information to the State Review Team and the State's reviewing ophthalmologist. This form may be supplemented by any additional medical statements or reports submitted by the examining practitioner. The social summary must be completed and submitted with the medical information to the State Review Team at the Department of Human Resources. Payment may be made to the customer's ophthalmologist or optometrist, through issuance of a vendor payment, for completion of the medical form at the time of the customer's MA application and at a scheduled review.

3. Re-examinations for periodic redeterminations of blindness will be conducted according to #2 of this section.

4. The local department of social services or other entity determining MA eligibility shall accept the Social Security Administration's determination of blindness for a person receiving a Social Security benefit based on blindness.

E. Disability.

Chapter 5, Section E, Disability, which was contained on Pages 500-10 through 500-10c of MR-127, has been rescinded.

Replacement pages will be issued in a subsequent Manual Release.

F. Caretaker Relative.

In order to be eligible for a MA Families and Children (FAC) coverage group as a caretaker relative, an individual must meet the definition of "caretaker relative" as being the parent or other adult who is:

- related to a child by blood, marriage, or adoption; and
- living with and caring for the child.

For this purpose, a child is defined as unmarried and less than 21 years old. The required verification of an applicant's or recipient's status as a caretaker relative is addressed under Chapter 6 of this Manual.

G. Inmate of a Public Institution.

In order to be eligible for Medical Assistance, a person may not be an inmate of a public institution. This is defined as an individual who is incarcerated and serving a court's sentence for a criminal offense or is otherwise confined involuntarily in a public correctional facility, including a State-owned and operated juvenile services facility.

- The DHR Office of the Inspector General (OIG) receives a quarterly report from the Department of Public Safety and Correctional Services (DPSCS), listing the inmates in DPSCS and Baltimore City Jails. The OIG checks the CARES database to match individuals on the DPSCS report. When a match is found, they send a report on the inmate with a cover letter to the FIP Assistant Director at the local department of social services (LDSS). The documents are then given to the appropriate supervisor to distribute to the Case Manager. When the Case Manager receives the match report from the OIG, the case must be reviewed and appropriate action taken to determine whether the information on the report requires the case to be closed and timely notice sent. The OIG allows 90 days for the LDSS to take appropriate action on the case and return the completed DPSCS match report. If the report is not returned, an overdue notice is sent to the LDSS.

- When the Case Manager receives a "Conflicting Data Report" (DHMH 4541) from DHMH (e.g., because the Department of Health and Mental Hygiene (DHMH) learned of an incarceration), the case must be reviewed to resolve the conflicting information, and determine whether the individual is still entitled to Medicaid eligibility. The green copy of the DHMH 4541 should be returned to DHMH (the address is on the back of each page of the document), advising DHMH of the resolution.

Medicaid Applications for Prison Inmates Prior to Release

FIA Action Transmittal (AT) 05-33 Revised (issued June 9, 2005) presents policies and procedures to facilitate applications by certain inmates for Medicaid and/or the Family Investment Administration (FIA) programs and services they will need upon release from incarceration-- Medicaid, Food Stamps, Temporary Cash Assistance, or Temporary Disability Assistance Program. This AT replaced AT 98-46. These enhanced procedures are intended to assure that eligibility will begin on the date the customer is released from incarceration. The special population for this pre-release assistance is limited to terminally ill or chronically physically or mentally ill inmates requiring treatment upon release. The Department of Human Resources and DPSCS reached an agreement for interaction between staff from the LDSSs and DPSCS, particularly as related to expedited Medicaid.

- To be eligible for a pre-release Medicaid application, an inmate must:
  - Reside in Maryland upon release;
  - Be serving a sentence and have a projected release date of at least 6 weeks in the future;
  - Have no detainers that would result in incarceration in another jurisdiction; and
  - Either be terminally ill or have a chronic physical or mental illness requiring treatment upon release.

- DPSCS staff is responsible for:
  1) Identifying all inmates who appear to meet the criteria;
  2) Completing a needs assessment to determine if the inmate is a candidate for the pre-release application process for Medicaid and/or FIA benefits;
  3) Developing a release plan indicating whether the inmate will reside in the community or an institution;
  4) Conducting the required face-to-face interview for benefits, assisting the inmate with completing the DHR/FIA application form for Medicaid and FIA benefits, and forwarding the application and accompanying information to the LDSS at least 60 days before the inmate's expected release date including a release plan, an application for benefits, DHR/FIA 402B and DHMH 4204 completed by the DPSCS medical department, DHR/FIA 161 Authorization to Release Information form signed by the customer or representative, and all the verifications and documentation necessary for the LDSS to determine eligibility for benefits (e.g., address and living arrangement upon release, Social Security number, income, resources, verification that application has been made for all potential benefits);
  5) Contacting the Social Security Administration about the status of the customer's application for SSDI/SSI, if needed;
  6) Telephoning the LDSS Inmate Liaison in the jurisdiction where the customer will reside to alert them that the application and information are being forwarded and to provide contact information for the DPSCS Inmate Liaison;
  7) Telephoning the LDSS Inmate Liaison as soon as a release date is set; and

8) On the release date:
   - For inmates released to the community, informing the inmate of the status of the application for Medicaid and/or FIA benefits and the LDSS's address; or
   - For inmates released to an institution, making arrangements for the transfer and notifying the LDSS Inmate Liaison of the transfer.

- The LDSS is responsible for:
  - Reviewing and processing the DHR/FIA application and accompanying materials, requesting any additional information from the DPSCS Inmate Liaison (sending a 1st reminder notice, a 2nd reminder, and then denying the application if the information is not received by the due date given in the 2nd reminder notice), and completing a referral to the State Review Team for a disability determination, if necessary; and
  - Upon notification by DPSCS of the inmate's release:
    - Finalizing the eligibility determination if all of the required information is received;
    - Sending the appropriate notice to the applicant in care of the DPSCS Inmate Liaison; and
    - If the customer is determined eligible, faxing information on a C-TAD to DHMH on the day of discharge, so that DHMH will activate the case on MMIS to assure that the next day the Medicaid card is issued and the Eligibility Verification System (EVS) will verify for providers that the customer is Medicaid-eligible. The LDSS should print MMIS Recipient Screen 1 the next day for verification.

H. Institution for Mental Disease (IMD).

A person between **22 and 64** years old who is institutionalized in an IMD is not Medicaid-eligible until the individual is discharged from the IMD to the community or to another type of medical institution, such as a general hospital or nursing facility. An IMD includes such long-term care facilities as:

- Psychiatric hospital, residential treatment center (RTC) for children, or Regional Institute for Children and Adolescents (RICA),

- Intermediate care facility-alcoholic (ICF-A), and
- Residential drug-free treatment program.

If an individual enters an IMD before age 21, the recipient may remain Medicaid-eligible as an institutionalized person in the IMD up to the 22nd birthday. If the recipient is discharged from the IMD and then is readmitted and institutionalized at age 21 or older, the recipient loses Medicaid eligibility. Therefore, Medicaid covers a recipient's services in an IMD for individuals under age 21 until the **earlier** of the following dates, that the recipient:

- Is determined to no longer require the IMD services;
- Is unconditionally discharged from the IMD;
- Reaches age 22; or
- Loses Medicaid eligibility for other reasons.

In Chapter 10 of this Manual, see page 1000-2 for the definition of an institutionalized adult and page 1000-4 for an institutionalized child. See Policy Alert 10-7 for more information about Medicaid policies and procedures related to institutionalization in an IMD. See pages 900-20 – 900-24 in Chapter 9 for a description of the eligibility policy for an admission to a long-term care facility (e.g., IMD) for a stay that is not considered to be an institutionalization because it is short-term or Medicare-covered. Since the individual is not institutionalized, this is a MA community case, not a long-term care case.

I. Conditional Release or Convalescent Leave from an Institution for Mental Disease.

A person on conditional release or convalescent leave from an IMD is not considered to be institutionalized in the IMD, with one exception. An individual younger than age 22 who is receiving inpatient psychiatric services for individuals under 21 is considered institutionalized in an IMD until the earlier of the date that the individual is unconditionally released from the IMD or reaches age 22. For an individual under age 22, conditional release or convalescent leave must involve a change of residence to community residence, not to a licensed and certified long-term-care facility, in order to alter the individual's status as institutionalized in an IMD. Conditional release includes a child's placement in foster care. An individual under age 22 is considered a community resident beginning with the first full month of deinstitutionalization.

than excess resources, those reasons should also be included in the letter.

It is necessary that each interview include an in-depth discussion of the resource situation of each assistance unit member. The interview should not be limited to the questions and answers on the application form, which serve as triggers for an in-depth discussion. For example, if an applicant was on private pay in a long-term care (LTC) facility prior to applying for Medicaid, the simple verification of that fact does not satisfy the resource evaluation requirements. It is necessary to discuss and verify the original amount and source of the funds used for private pay, how and when payments were made to the facility, the amount, etc. The case record and CARES narrative should contain sufficient verifications and documentation to assure that resources were properly reduced to the applicable resource standard. For a LTC or waiver case, there should also be sufficient evidence that there was no disposal or transfer of resources for less than fair market value. Reaching correct conclusions requires extensive knowledge about resources as well as good interviewing skills.

Every effort should be made to accurately evaluate total resources, even if the value of one resource is sufficient to render a decision of ineligibility. If an applicant/recipient (A/R) fails to provide the information needed to determine the exact amount of excess resources, include a statement to that effect in the notice of ineligibility, along with a list of resources for which the values were not determined. Include complete details in the case record and the CARES narrative.

Federal income tax returns may be requested to substantiate that all income and resources have been reported. Some types of income (e.g., interest, dividends, rents) indicate the existence of resources. Therefore, there should be reasonable consistency between the A/R's reported income and resources. Once all resources are identified, the eligibility case worker must determine whether each resource is countable or excludable.

Then, the total of the countable amounts is compared to the appropriate resource limit in Schedule MA-2, MA-2A, or MA-2B in the Appendix of this Manual.

Resource Eligibility

Resource eligibility exists when the assistance unit's total countable resources are within the applicable resource limit as of the **1st moment of the 1st day of the month.** The appropriate resource standards are used in Schedule MA-2, MA-2A, and MA-2B of the Appendix, based on number of assistance unit members, whether the coverage group is for a medically needy or categorically needy category, and whether a categorically needy category is for an ABD or FAC coverage group. Resources are not a factor of eligibility for certain coverage groups, such as low-income children who are determined eligible in the P-track for the Maryland Children's Health Program (MCHP) or D-track for MCHP Premium, or pregnant women who are determined eligible for MCHP in the P02 or P11 coverage group.

Resource Ineligibility

An A/R is not eligible for any month in which the assistance unit's total countable resources exceed the applicable resource standard as of the **1st moment of the 1st day of the month**. If resources increase or are reduced during a month, the A/R's eligibility is not affected until the following month. Then the A/R's resources are evaluated based on their countable value as of the 1st moment of the 1st day of the month. Any disposals of income or resources for less than fair market value during the month, however, may result in a penalty period being imposed for a LTC or waiver A/R.

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 Medicaid applications filed as of April 1, 2004 or later, 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, pharmacy) but not covered for the recipient because the **recipient was not Medicaid eligible as of the service date**. The recipient's incurred expenses may only be deducted if the services were **received during any months in the three-month retroactive period** associated with the **month of Medicaid application**, that 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 retroactive period may not be deducted** from the recipient's available income for the cost of care.

If the recipient was under a penalty period on the service date(s), the total monthly deduction for medical or remedial services is for the amount of the allowable fees exceeding $4,300. For example, if the Medicaid fee for the recipient's nursing facility services is $5,300 for a month that the recipient was under penalty for disposal of assets, $1,000 may be deducted from the recipient's available income for the cost of care ($5,300-$4,300=$1,000).

For services received during ineligible months, the provider's charge is deducted. For noncovered 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 self-addressed envelope, a copy of the cost of care worksheet, and a copy of the detailed current

bill, receipt, or contract to:

DHMH Beneficiary Services Administration
201 West Preston Street, Rm. L-9, Attn: Noncovered Services
Baltimore, MD 21201

The bill, receipt, or contract must contain a service date, charge, and detailed description of the item or service. BSA will send the eligibility case worker a memo with the allowable amount noted.

- These deductible expenses cannot be covered by Medicaid, Medicare, 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 made for medical or remedial services received before the 3-month retroactive period.

- Since the deduction is only made for 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, were not authorized, were 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 expense 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, may be carried forward into a subsequent 6-month period under consideration.

- **The eligibility case worker should 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 countable 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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Chapter 14 Fraud and Abuse

Release No: MR-127
December 2005

See COMAR 10.09.24.14 and .14-1 for the definitions, policies, and procedures related to recipient fraud and abuse of the Medicaid program. There have been organizational and procedural changes since the regulations were promulgated.

The Corrective Managed Care Program, described in Regulation .14-1, was discontinued when the HealthChoice managed care program was implemented in 1996. The Department of Health and Mental Hygiene, however, retains the option to re-institute the program. A HealthChoice managed care organization (MCO), in accordance with COMAR 10.09.75, has the option to implement corrective managed care for enrollees who abused the MCO's benefits.

In July 2004, the Division of Medicaid Quality Control was transferred through a Departmental reorganization to the Medical Care Programs Office of Planning and Finance (OPF). The Division is part of a newly created Program Integrity (PI) Unit. The PI Unit is charged to control fraud, waste, and abuse within the Maryland Medicaid program. The focus is statewide. All persons involved with the Medicaid program have a responsibility to work towards an error-free program.

- The Division of Medicaid Quality Control investigates allegations of possible Medicaid recipient fraud.
- If suspected fraud is discovered by personnel of a local department of social services or local health department, the case must be promptly reported to the PI Unit via the DHMH Form 4243. A completed DHMH Form 4243 should be sent to the following address:

  Department of Health and Mental Hygiene
  Division of Medicaid Quality Control
  Fraud, Waste and Abuse Unit
  201 West Preston St., Rm. 216
  Baltimore, MD 21201

- The DHMH Form 4243 may be obtained from the PI Unit by sending a written request to the address above, by calling 1-866-654-4421, or by visiting the website at: www.dhmh.state.md.us/mma/programintegrity/index/htm

- Referrals for investigation of suspected recipient fraud are also generated from providers, police departments, the Social Security Administration, and citizens. They should call or write the PI Unit to provide information and request an investigation.

Medicaid fraud is defined as:

- Knowingly and willfully making or causing to be made any false statement or false representation of a material fact (whether or not the individual is found eligible):
    - In an application for a Medicaid benefit or payment; or
    - For use in determining rights to a Medicaid benefit or payment;
- Having knowledge of the occurrence of any event affecting the initial or continued right to Medicaid benefits or payments for the individual who filed the application or on whose behalf the application was filed, and concealing or failing to disclose that event with an intent to secure fraudulently those benefits or payments either in a greater amount or quantity than is due or when benefits or payments are not authorized;
- Applying to receive or receiving Medicaid benefits or payments for the use and benefit of someone else, and knowingly and willfully converting any part of the Medicaid benefit or payment to a use other than for benefit of that other person;
- Fraudulently obtaining, attempting to obtain, or aiding another person in obtaining or attempting to obtain a Medicaid covered service by the use of:
    - Fraud, deceit, misrepresentation, or subterfuge;
    - Forgery or alternation of a Medicaid prescription;
    - Concealment of a material fact; or
    - Use of false names or addresses;
- Unauthorized possession of a blank provider prescription form;
- Possession of a Medical Care Program recipient identification card without authorization from the individual to whom the card was issued; or
- Manufacture, distribution, or possession of a counterfeit Medical Care Program

recipient identification card or a provider prescription form.

Following are examples of the most frequent types of recipient fraud:

- Intentionally under-reporting or not reporting income and resources;
- Falsely reporting household composition – e.g., omitting wage earners from the Medicaid application;
- Failing to report changes in income, resources, or other circumstances within 10 working days as required – e.g., moving out of state, receipt of cash lump sums;
- Failing to report third party insurance coverage;
- Lending a Medical Care Program recipient identification card another person; and
- Forging or altering prescriptions.

Schedule MA-8

Spousal Impoverishment Standards

	Resources	Effective
Maximum Spousal Share	$99,540	1/1/06
Minimum Spousal Share	$19,908	1/1/06

	Income	Effective
Basic Maintenance and Shelter Allowance	$1,604	7/1/05
Excess Shelter Standard	$ 481	7/1/05
Maximum Maintenance and Shelter Allowance (sum of Basic Maintenance and Shelter Allowance and Excess Shelter Allowance)	$2,489	1/1/06
Utility Standards: (used to compute the community spouse's excess shelter allowance)		
Heat included in rent (LUA) (Food Stamps limited utility allowance)	$ 183	1/1/06
Heat paid separately from housing (SUA) (Food Stamps standard utility allowance)	$ 304	1/1/06