

Accessing Services for Adults with Developmental Disabilities through Maryland Medical Assistance/Medicaid

A Guide from the
Maryland Disability Law Center



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

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

1. What healthcare services should Medicaid cover for adults?

Any service should be covered if it is:

- recommended as medically necessary by the person's doctor or another licensed health care practitioner; and
- included in Maryland's Medicaid State Plan.

Additional services, discussed on pages 5 - 7 of this booklet, will be covered if the individual is enrolled in a Medicaid waiver program such as Community Pathways or New Directions.

Services covered for adults include:

Doctor visits including visits to specialists
Family Planning
Home Health
Hospice
Hospital Services, including psychiatric, emergency room and outpatient
Laboratory and x-ray
Medical Day Care
Medical Equipment and Supplies
Medicare Premiums
Mental Health
Nursing Facilities
Personal Care
Prescription Drugs
Physical Therapy
Primary Care
Substance Abuse Treatment
Transportation to Medicaid-covered Services
Vision/Eye Exams

*Adults may also be able to get some dental care depending on the Managed Care Organization (MCO) they choose. See Q&A on page 2.

Some of the above services now covered by Medicaid (such as dental care and medical day care) may be changing. Check with MDLC for updates.

Services that are NOT covered for adults:

Community Residential (for example, a group home)
Environmental Modifications
Habilitation (learning new skills)
In-home Support Services
In-home Behavioral Aides
Respite Care
Vocational Training

However, many of these services ARE covered for adults with developmental disabilities in a Medicaid waiver program. See pages 5-6 for information on the Community Pathways Waiver.

2.. What is a Managed Care Organization (MCO)?

A **managed care organization** or MCO is a health plan that provides most healthcare services to people who have Medicaid. Under its HealthChoice Program, Maryland requires most recipients to receive their healthcare through an MCO. When an individual enrolls in Medicaid, he chooses an MCO. The MCO is the first stop for information and services. There is a customer services number for the MCO on the back of each Medicaid card. However, some services Medicaid covers are provided differently, and the MCO isn't responsible (for example, mental health services, personal care, and physical therapy). Each MCO has its own primary care doctors and the individual must choose one. If a person needs any specialty care, home health services, or equipment or supplies, they should talk to their primary care doctor for a referral.

3. What is the “fee-for-service” Medicaid program?

Some people are on Medicaid but are not in a MCO. For example, people in the Rare and Expensive Case Management Program (REM) and people who are eligible for both Medicare and Medicaid do not join an MCO. They are in the “fee-for-service” Medicaid program and can go to any participating Medicaid provider.

4. What dental services are available for adults on Medicaid?

MCOs provide coverage for cleanings, x-rays and fillings. Call your MCO customer service number for more information. See pamphlet at <http://www.dhmf.state.md.us> by clicking on Medical Care Programs, then on HealthChoice Managed Care, and then on MCO Comparison Chart. “Fee-for-service” Medicaid does not cover routine dental care for adults.

5. Can adults get coverage for eye glasses and eye exams?

MCOs cover eyeglasses and eye exams every one or two years. Call your MCO customer service number for more information. See pamphlet at <http://www.dhmf.state.md.us> by clicking on Medical Care Programs, then on HealthChoice Managed Care, and then on MCO Comparison Chart. Subject to limitations, “fee-for-service” Medicaid also covers eye exams and eyeglasses.

6. How can adults get medical equipment and supplies?

Individuals on Medicaid are eligible for all medically necessary durable medical equipment and disposable medical supplies. For example, wheelchairs, diabetic supplies, diapers, incontinency pants and disposable underpads, prosthetics, and much more.

To receive equipment and supplies, get a referral from the primary care doctor. For individuals in an MCO, the MCO must approve the referral. The MCO should decide within 72 hours if the equipment or supplies are approved. If approved, the individual should receive the equipment or supplies within 7 days. If there is an emergency need, the individual should receive the equipment or supplies within 24 hours. Be sure to let the primary care doctor know if there is an emergency need.

For individuals not in an MCO who are in the fee-for-service program, the doctor must get approval from the Department of Health and Mental Hygiene (DHMH) and the timetables for MCO approval do not apply. However, individuals in the fee-for-service program are still entitled to have equipment and supplies delivered without unreasonable delay. If such delays occur, contact MDLC's intake office. If DHMH approves a specific piece of equipment but an equipment or supply company tells you that they cannot provide it because the reimbursement rate is too low, contact MDLC's intake office.

7. How can a person with a developmental disability obtain mental health services?

To obtain mental health services, contact any mental health provider participating in Medicaid to schedule an assessment to see if the individual qualifies for specialty mental health services through the Public Mental Health System. For help finding a mental health provider, contact the local Core Service Agency for the county where the person lives (see the list at <http://www.dhmh.state.md.us/mha/csa.htm> or call MDLC).

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

However, if a person with a developmental disability also has a covered mental illness diagnosis, a wide range of services such as individual therapy, psychiatric rehabilitation, and mobile treatment, can be accessed through MAPS-MD, a private organization that approves mental health care delivered by a network of private providers. For the first twelve outpatient visits, the person can go to any participating mental health provider. For additional visits or to obtain other services in the Public Mental Health System, a licensed mental health clinician treating the person should make a referral to MAPS-MD to seek approval for the specific services needed. Anyone can contact MAPS-MD to obtain services by calling 1(800)888-1965. However, for best results, MDLC recommends that you ask the treating professional to request services through MAPS-MD.

8. What is personal care?

A personal care aide assists in the home with activities of daily living such as feeding, toileting, bathing, dressing and mobility if it is medically necessary.

- **How can adults access personal care services and find a provider?**

Anyone can ask for an assessment for this service. To do this, contact the county health department's personal care program and request personal care services. If the individual has trouble getting an assessment and an aide or does not receive enough hours of aide services, ask the individual's doctor to write a letter stating why the service is needed and how many hours are needed. Contact MDLC's intake office if services are denied or approved but the health department cannot locate an aide, or the individual is not receiving the number of hours of personal care the doctor recommends.

9. What services are available under "home health?"

The home health benefit covers services provided in a recipient's home, including skilled nursing and home health aides. Home health physical therapy, occupational therapy, speech-language pathology, and mental health services should be covered if it is medically necessary and not just convenient to receive them in the home. Nursing services under home health are provided only on a **part-time or intermittent basis**. Full-time home health nursing services are not covered by Medicaid. However, full-time in-home nursing services are still available to adults in some Medicaid waiver programs or on REM (see below).

- **How can adults access home health services?**

The individual's primary care doctor or other treating health professional should contact the individual's MCO (or DHMH for people in the fee-for-service program) to make a referral and to seek approval for home health services. A private home health agency will be contacted to deliver these services. Call MDLC if services are denied or delayed by the MCO or DHMH.

10. How can adults access transportation to medical appointments?

When a recipient does not have transportation to get to a healthcare provider, transportation assistance is a covered service. Contact the county health department. Find the phone number in the blue government section of your phone book. Some healthcare providers have their own transportation systems for patients. Also, individual MCOs have various transportation services available. Contact your MCO for more information. See pamphlet at <http://www.dhmf.state.md.us> by clicking on Medical Care Programs, then on HealthChoice Managed Care, and then on MCO Comparison Chart.

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

Rare and Expensive Case Management or REM is a special part of the Medicaid program for people who have certain medical conditions or diagnoses. For a list of qualifying conditions see: <http://www.dsd.state.md.us/comar/10/10.09.69.17.htm> or contact MDLC.

The individual must also qualify for HealthChoice (to be in a MCO) to be eligible for REM. Instead of joining an MCO, the individual is in the “fee-for-service” program and can see any healthcare provider who accepts Medicaid. The individual is assigned a REM case manager who should be contacted for help in obtaining healthcare services. An important benefit of REM is that adults over 21 can continue to receive all medically necessary in-home nursing services, while most adults on Medicaid can only get more limited home health nursing services. If an individual in REM becomes eligible for Social Security Disability Benefits (SSDI) and Medicare, they will no longer be eligible for REM. Contact MDLC for assistance in this situation if the individual depends on in-home nursing to live in the community.

12. *What residential services are adults eligible for under Medicaid?*

The regular Medicaid program covers only institutional care, such as placement in a nursing home or intermediate care facility for persons with developmental disabilities (ICF-MR, that could be located outside Maryland) for those who meet the eligibility criteria. Institutional care is considered the most restrictive placement for individuals and may only be approved if there is no less restrictive setting in which services can be provided within a reasonable time. The Community Pathways or New Directions waivers, which are Medicaid waiver programs for individuals with developmental disabilities (discussed below), do cover residential placement in community homes based on individual need.

Individuals residing in the community who seek community residential services should contact MDLC. Also contact MDLC about the legal rights of individuals with developmental disabilities who want to leave nursing homes. Nursing facility residents may be eligible to enter a waiver to be placed in a community residential program.

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

13. *What is the Community Pathways Waiver?*

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

- ***How do adults apply for the Community Pathways Waiver?***

To apply for the waiver, contact your local DDA regional office or go to <http://www.ddamaryland.org> and click on “How to Apply for Services” on the left to find the application and instructions. Call MDLC for help.

If an individual already receives some services from DDA and has a resource or service coordinator, the coordinator can request admission for the individual to the waiver. Call MDLC for help.

- ***What services are available under the waiver?***

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

Resource/ Service Coordination
Community Residential Placement
Supported Employment
Day Habilitation
Personal Support
Family and Individual Support Services
Respite Care
Behavioral Support
Environmental Modifications
Assistive Technology and Adaptive Equipment
In-home nursing
Transportation
Transition Services

- ***What if an individual in the waiver has a budget that is too low to get needed services?***

Service/Resource coordinators or service providers should convene a team meeting and if the team approves the individual’s need for an increase in services, a written request should be submitted to DDA with the supporting documentation (such as medical or professional assessments or behavioral data). In emergency situations, the provider will need to submit a written request to DDA before the team meeting. Contact MDLC if the request is denied or not acted upon in a timely manner, as waiver participants have the right to appeal. See below.

- ***Can services be denied under the waiver?***

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

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

14. What is the New Directions Waiver?

The New Directions Waiver is administered by DDA for individuals with developmental disabilities. New Directions allows recipients the opportunity to self-direct services and supports in their own home or family home by managing their own staffing and budget. It allows people 21 and over to pay family members, even parents, to provide services such as direct supports for them at home or in the community. Individuals are given help by a support broker and a fiscal manager. Financial and medical eligibility, and available services are similar to those for the Community Pathways Waiver.

- **How do adults apply for the New Directions Waiver?**

To apply for the waiver, contact your local DDA regional office:
<http://www.ddamaryland.org/offices.htm>. Call MDLC for help.

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

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

- ✓ The State should not put recipients on waitlists for Medicaid services.
- ✓ Services should be available throughout the State.
- ✓ Services should be approved or denied and provided with “reasonable promptness”.
- ✓ The State should ensure that providers are available to deliver needed services.
- ✓ Recipients should have the freedom to choose their provider.
- ✓ Service denials and delays can be appealed.

16. What does “medically necessary” mean?

“Medically necessary” means that the service or benefit is related to diagnosing, preventing, curing, or reducing the symptoms of an illness, injury, disability, or health condition. The service or benefit must be consistent with good medical practice, the most cost effective method of

treatment, not primarily for convenience, and not experimental. In order to show medical necessity, it is important to have the support of the individual’s doctor or treating professional. In many instances, the professional should write a letter outlining the individual’s condition, service or benefit needs and the reason for those needs. The letter should be as detailed as possible. The letter should clearly say why the professional believes that the service is medically necessary for that particular individual. If the individual has more than one doctor or treating professional, it is best to have letters from each one.

- ***What if an individual's treating professional recommends a service or benefit as medically necessary, but an MCO or DHMH denies the benefit anyway, saying it is not medically necessary?***

This is a common practice, but the individual has the right to file an appeal. In a hearing on an appeal, the treating health care professional's opinion is very important. The law gives more weight to the opinion of treating professionals than to the opinion of professionals who work for the State or health plans and who have never met the patient. If the treating professional believes that the service is medically necessary, it will be helpful to winning an appeal hearing. Contact MDLC for assistance in filing an appeal.

17. What if the needed service isn't available close to a Medicaid recipient's home?

Medicaid recipients have the right to receive certain health care services within a reasonable distance from their home. These services include primary care, pharmacy, obstetrics/gynecology, and diagnostic laboratory and x-ray services. "Reasonable distance" is defined as within 10 minutes travel time for pharmacy and 30 minutes travel time for the other services. For assistance locating a health care provider close to home, first contact the customer service number on the back of your Medicaid card and ask for help locating a provider in your area. If customer service does not help, contact MDLC for assistance.

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

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

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

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

In addition to the regular Medicaid services listed in this booklet that are provided through MCOs or under fee-for-service Medicaid from providers, the **Developmental Disabilities Administration (DDA)** also funds additional services for people with developmental disabilities. These services fall into two categories: Medicaid waiver services for individuals in a waiver (see above), and support services for people not in a waiver. Individuals are likely to be placed on a waiting list to receive both types of services. But once in a waiver, people have very important rights: they are entitled to receive all waiver services that are necessary for their health or safety and to appeal any service denials. In contrast, people who receive services through DDA funding but who are not in a waiver do not have a legal right to receive the services they need from DDA.

You can't tell if an individual receiving services from DDA has any entitlement to services unless you know whether they are in a waiver. Ask the individual's resource/service coordinator or DDA whether the person is in a waiver to understand what rights to services they have.

20. What is the eligibility determination process used by DDA?

If you believe an individual has a developmental disability, apply to DDA now for an eligibility determination regardless of whether the individual currently needs services from DDA or is eligible for Medicaid. See <http://ddamaryland.org/howtoapply.htm> for a copy of the application. Apply before the individual turns 22 or as soon as possible and provide DDA with all available records about the person's disability prior to age 22 including psychological testing data if available. DDA may find a person ineligible, eligible for **Individual Support Services (ISS)** only, or fully eligible as an individual with a **Developmental Disability (DD)** (the category that provides the most services). To be eligible at any future point in their life for a day program, a residential program, or placement in one of the two waiver programs discussed above, DDA must find that the individual is **Developmentally Disabled (DD)** and not just to be **ISS** eligible. Individuals found eligible either as **ISS** or **DD** are also placed in a priority category, such as crisis resolution (the highest category), and will likely be placed on a waiting list for services. Contact MDLC for further information about the specific criteria DDA uses in this process and how to request a change or appeal eligibility or priority decisions by DDA.

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

If a needed Medicaid or waiver service is denied or there is a delay in getting the service, individuals have the legal right to take further action. Contact MDLC's intake office by calling 410-727-6352 or 1-800-233-7201 between 10am and 12 noon. We recommend you contact MDLC before taking any of the steps below to appeal if time permits.

In some cases, MDLC may be able to provide legal representation. Representation by MDLC is free. In other cases, we may refer individuals to pro bono attorneys who can represent them for free. We will try to find a lawyer for every case that has merit.

If a Managed Care Organization (MCO) denies a covered service, call the Health Enrollee Action Line (HEAL Line) to file a complaint or an appeal: 1-800-284-4510. If you would like MDLC assistance and plan to call the HEAL line, please contact MDLC first.

If DHMH denies a service covered in the fee-for-service program, call 1-800-492-5231 to file a complaint or appeal. If you have fee-for-service Medicaid and want to call to file a complaint and you would like MDLC assistance, please contact MDLC first.

If MAPS-MD denies a mental health service, you may file an appeal with MAPS-MD. Contact MDLC first for assistance.

Individuals denied covered Medicaid or waiver services, or who experience a delay in getting services also have the right to request a Medicaid fair hearing, which is a hearing before an Administrative Law Judge. Contact MDLC for more information on how to appeal. A lawyer's assistance is not required, but is highly recommended.

Maryland Disability Law Center

Maryland Disability Law Center (MDLC) is a private, non-profit organization staffed by attorneys and paralegals. MDLC is the Protection and Advocacy organization for the rights of individuals with disabilities in Maryland. MDLC's mission is to ensure that people with disabilities are accorded the full rights and entitlements afforded to them by state and federal law. Among those rights are:

- The right to self-determination
- The right to be free from harm
- The right to be provided with due process
- The right to develop physically, emotionally, and intellectually
- The right to be included in community life with opportunities and choices.

Our goal is to create a more integrated and just society by advancing the legal rights of people with disabilities and ensuring equal opportunities to participate in community life.



1800 N. Charles Street; Suite 400; Baltimore, MD 21201
410.727.6352 1.800.233.7201 www.mdclaw.org