



# MARYLAND Department of Health

PT 38-18

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

## MARYLAND MEDICAL ASSISTANCE PROGRAM Nursing Home Transmittal No. 268 June 28, 2018

To: Nursing Facility Administrators  
*Susan J. Tucker*

From: Susan J. Tucker, Executive Director  
Office of Health Services

Re: Nursing Facility Payment Advance Processing

**Note: Please ensure that appropriate staff members in your organization are informed of the contents of this memorandum.**

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Pursuant to Maryland House Bill 1215 of 2018, the Department will implement payment advances for nursing facilities as detailed below. The process for implementing payment advances will remain effective for a period of two years beginning July 1, 2018 and end on June 30, 2020.

Any Long Term Care Application submitted on or after July 1, 2018 that does not have a decision within 90 days from the date the application is filed is subject to a payment advance. Medicaid-enrolled nursing facilities may request the payment advance, adhering to requirements within this transmittal. The amount paid will not exceed 50 percent of the estimated amount due per day for the time period requested.

The Department has determined a process for nursing homes to request payments. Any nursing home can use this process between now and January 1, 2019. Starting January 1, 2019, all nursing facilities interested in continuing advanced payment requests must enroll with the Department during a designated period of time. Further instructions on enrollment will be released prior to January 2019.

The following outlines the process and the required information necessary for all requests for payment:

### **Requesting Payment**

Providers must submit all requests for payment advance using a form provided by the Department. (Please see Attachment 1 Nursing Facility Payment Advance Request Form.)

Prior to submitting the request, the provider must confirm the following:

- The current application has no decision (approved or denied) for the applicant.

- The current application has remained open or pending without a decision for at least 90 days.
- Medical certification has been authorized by the Department's Utilization Control Agent.

A request for payment advance that does not meet the above will be denied.

### **Maryland Department of Health Processing**

The Department reviews the applicant's records and calculates the payment. The Department will return incomplete or invalid requests to the submitter by secure email.

When all requirements are met, the Department will calculate the rate to be paid and the number of days requested. The rate paid is 50 percent of each quarterly facility-specific rate. The number of days for each quarter is determined based on the date of application and the date on the payment advance request form.

The subsequent payment will be paid through MMIS as an adjustment. The remittance will use reason code "DL" for the payment.

### **Ongoing Payments**

Nursing facility providers may submit requests for payment every 30 days after the initial approval if a determination has not been made. The same process as stated in "Requesting Payment" and "MDH Processing" applies; however, the days paid will be calculated from the date of last payment to the date of the most recent payment advance request form.

### **Recoupment of Payments**

When a decision is made for the applicant (approved or denied), the facility must notify the Department on its designated form (Attachment 2 Nursing Facility Payment Advance Case Closure Form) within 30 days of decision. The Department will audit monthly for outstanding payments to ensure timely recoupment is made.

To recoup payment, the next claims payment will be reduced by the amount paid by mass adjustment. Again, the remittance will use reason code "DL" for the takeback. The takeback will include payments made for applicants who are approved or denied. No further action is necessary by the facility.

If eligibility has been approved, the provider may submit a claim for nursing facility service payment through its usual process.

If you have any questions about the process, please contact Eric Saber at [eric.saber@maryland.gov](mailto:eric.saber@maryland.gov).

Attachments (2)  
cc: Nursing Home Liaison Committee



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**Fax Cover Sheet**

TO:	Office of Health Services Nursing Facility Payment Advance Request		
TO FAX #:	410-333-7803		
PLEASE CHECK ONE:	INITIAL REQUEST	<input type="checkbox"/>	30-DAY EXTENSION
FROM:			
FROM FAX #:			
DATE FAX SENT:			



**MARYLAND**  
Department of Health

**Nursing Facility Payment Advance Request Form**

If the following criteria are not met, your request will be denied.

- The current application has no decision (approved or denied) for the applicant.
- The current application has been open or pending without a decision for at least 90 days.
- Medical certification has been authorized by the Department’s Utilization Control Agent.

ALL INFORMATION SPECIFIED BELOW MUST BE PROVIDED:

<b>Facility / Submitter Information</b>			
Name of Facility		Provider Number	
Contact Name		Email Address	
Phone Number			
<b>Applicant Information</b>			
First Name		Last Name	
Date of Birth		Social Security Number	
Medicaid Number (or temporary ID#)			
Date of Long Term Care Medicaid Application		Application ID#	
Utilization Control ID#			
Facility Representative Signature			

**For Department Use Only**

Date Payment Advance Form Received			
Date LTC MA Application Received		Days Pending	
Application Decision Date (if applicable)			
Medical Eligibility Certification	Approved		Denied

Payment Advance Request Decision	Approve		Deny	
Dates Approved		Total Days Approved		
Facility-specific Rate Paid		Total Payment Due:		
<b>Department Representative Signature</b>				



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**Fax Cover Sheet**

TO:	Office of Health Services Nursing Facility Payment Advance CASE CLOSURE FORM
TO FAX #:	410-333-7803
FROM:	
FROM FAX #:	



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Department of Health

**Nursing Facility Payment Case Closure Form**

ALL INFORMATION SPECIFIED BELOW MUST BE PROVIDED:

<b>Facility/ Submitter Information</b>			
Name of Facility		Provider Number	
Contact Name		Email Address	
Phone Number			
<b>Applicant Information</b>			
First Name		Last Name	
Date of Birth		Social Security Number	
Medicaid Number (or temporary ID#)			
Date of Long Term Care Medicaid Application		Application ID#	
Case Decision Date			
Facility Representative Signature			

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**For Department Use Only**

<b>Received Date</b>		
<b>Department Representative Signature</b>		