



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM**  
**MCO Transmittal No. 249**  
**September 15, 2025**

**TO:** Managed Care Organizations  
 Long-Term Care Facilities  
 Skilled Nursing Facilities  
 Nursing Homes

**FROM:** Monchel Pridget, Acting Director  
 Medical Benefits Management

Jamie Smith, Director  
 Long Term Services and Supports

**RE:** Additional Guidance - HealthChoice Long Term Care Coverage

**NOTE:** Please ensure that the appropriate staff members in your organization are informed of the content of this transmittal.

This transmittal clarifies the HealthChoice long-term care policies regarding eligibility verification, prior authorization, the 90-continuous days requirement when an individual receives acute hospital services in the middle of a long-term care stay, payment, and safe discharge coordination. This transmittal should be read in conjunction with [PT 36-23 Clarification of HealthChoice Coverage for Long Term Care Facilities](#) and [PT 15-17 Roles and Responsibilities of Nursing Facilities, Specialty Pediatric Hospitals and Chronic Hospitals when Admitting HealthChoice MCO Members](#).

### **Eligibility Verification**

Maryland Medicaid has observed a trend of long-term care facilities (LTCF) seeking reimbursement after obtaining retroactive long-term care coverage through the Department of Human Services. However, according to the system of record, the individual was enrolled in a managed care organization (MCO) at the time of the admission. Long-term care facilities must verify eligibility of a Medicaid enrollee through the Eligibility Verification System (EVS) prior to admission, on the day of admission, and continuously throughout the enrollee's stay at the facility via phone or electronically through [eMedicaid](#). If the Medicaid enrollee is enrolled in an MCO at the time of the LTCF admission, seeking retroactive disenrollment into a long-term care

Medicaid coverage group does not negate the facility's responsibility to contact the MCO for authorization to cover the first 90 days of the enrollee's stay in the facility. If Maryland Medicaid investigates a request for reimbursement, and a long-term care coverage span is retroactively applied to a Medicaid enrollee already enrolled in a HealthChoice MCO, the LTCF may not receive reimbursement.

### **Prior Authorization**

The LTCF must seek prior authorization from an MCO to receive payment for the stay. Authorization requests should follow the requirements outlined in COMAR 10.67.09.04. More information about this process is outlined in PT 36-23. To receive payment for the service, the LTCF should make every reasonable effort to obtain the MCO's authorization of the requested admission. If this is not possible due to admission taking place on the weekend or on a holiday, the LTCF should inform the MCO of the admission and seek authorization by the next business day. It is in the best interests of the enrollee, the LTCF, and the MCO for the LTCF to contact and coordinate with the MCO promptly.

If the authorization is denied, LTCFs may assist enrollees with filing an appeal to the MCO using the process outlined in COMAR 10.67.09.05. LTCFs must have written consent from the enrollee or the enrollee's authorized representative to appeal a denied authorization or service day. Only the enrollee or the enrollee's authorized representative may request continuation of benefits during the appeal.

If the denial reason is the LTCF does not participate in the MCO's network, the MCO is responsible for either coordinating a single case agreement with the facility for the enrollee's care or transferring the enrollee to an appropriate setting that meets their healthcare needs.

### **Calculating the 90 Continuous Days**

Pursuant to COMAR 10.67.06.07(B)(4), the days during the enrollee's acute care hospital stay would count toward the MCO's 90 days in the LTCF if the enrollee returns to the LTCF before day 91. If a member is admitted to an acute care hospital during their stay at the LTCF and is discharged back to the LTCF after day 90, the 90-day count for continuous admission to the LTCF restarts.

Additionally, MCOs should not interpret the 90 continuous days of coverage as a benefit limitation. Until the individual is disenrolled into Medicaid fee-for-service, the MCO is responsible for medically necessary care delivered by the LTCF. The MCO shall provide medically necessary LTCF services for any days following the first 90 continuous days of admission until the date the MCO has obtained the Department's determination from the Utilization Control Agent (Telligen) that the admission is medically necessary as specified in COMAR 10.67.06.07(B)(2). As outlined in PT 36-23, LTCFs are required to request a level of care determination from the Department's Utilization Control Agent (UCA) on day 75 of the enrollee's stay to determine if the Department's level of care criteria is met. If day 75 falls on a weekend, the LTCF should submit the request on the next business day. LTCFs should note that

the UCA will not accept requests for a level of care determination before day 75 of an enrollee's stay to prevent duplicative requests.

### **Payment Responsibility for Skilled Nursing Days and Administrative Days**

HealthChoice MCOs remain responsible for payment and monitoring of a member's stay at a LTCF if the member meets the MCO's evidence-based criteria or the Department's level of care (LOC) criteria. If the member meets the MCO's evidence-based criteria, the MCO is responsible for reimbursing the LTCF at the skilled nursing rate. During the enrollee's stay, if the MCO determines the enrollee does not meet an evidence-based skilled nursing LOC, and the enrollee (or LTCF with the enrollee's consent) fails to appeal the MCO's decision, the MCO must then determine if the enrollee meets the Department's LOC criteria.

If the enrollee meets the Department's LOC criteria, the MCO is responsible for reimbursing the LTCF at an administrative day rate provided that the enrollee remains eligible under that criteria. The MCO administrative day rate for the Department's LOC criteria must include any clinical costs, in addition to the costs associated with room and board.

### **Safe Discharge Coordination between the LTCF and MCO**

If the enrollee fails to meet both the evidence-based LOC criteria and the Department's LOC criteria, the MCO is responsible for paying the administrative day rate until the enrollee is safely discharged to the appropriate LOC as per the treatment plan.

The MCO must remain engaged with the LTCF until the member is safely discharged to the appropriate setting. The MCO and the LTCF should maintain accurate and complete documentation to reflect discharge planning coordination efforts. Coordination should include a minimum of twice a week updates, from when the members' discharge is being planned, reflecting efforts of continued engagement until the member is either discharged from the LTCF or disenrolled from the MCO and enrolled into Medicaid Fee-for-Service. Each member should have their own discharge plan with one enrollee per report. Continued engagement includes records of emails, meetings, any evidence of communication between the MCO and LTCF that shows they coordinated discharge efforts for the member.

For managed care policy questions related to this transmittal, please contact [mdh.healthchoiceprovider@maryland.gov](mailto:mdh.healthchoiceprovider@maryland.gov).