STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Nursing Home Transmittal No. 208
November 30, 2007

TO: Nursing Home Administrators
Chronic Hospitals

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

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

RE: Use of DHMH 257 and 259 Forms –
Supplemental Information to DHR-DHMH Action Transmittal 06-30;
Special Instructions for Nursing Facility Residents Receiving Hospice Benefits

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This transmittal describes the appropriate use of two DHMH forms related to medical and financial eligibility for Medical Assistance reimbursement in nursing homes: DHMH 257 Long Term Care Patient Activity Report and DHMH 259 Medical Care Transaction Form. All parties to Medical Assistance nursing home payment – the facilities, the Program's Utilization Control Agent (UCA), and local departments of social services (LDSS) – should adhere to these procedures. The information is to be read and followed in conjunction with Action Transmittal #06-30, issued jointly by the Family Investment Administration of the Department of Human Resources and Medicaid's Office of Systems, Operations, Eligibility, and Pharmacy dated March 3, 2006. A copy of this action transmittal is attached.

In summary, please use the DHMH 257 and 259 forms as follows:

- Use the DHMH 257 upon admission to the nursing home to open a LTC payment span and upon discharge from the nursing home to close the LTC payment span.[1]
- Use the DHMH 259 as described below to move a recipient from Medicare co-pay to "Begin Full MA." In addition, submit the DHMH 3871B to the UCA so that it can determine whether the patient meets the NF level of care.

[1] The AT #06-30 expands upon this directive more fully, explaining how and when to use the DHMH 257 when a person enters a facility directly from the community for an expected stay of 30 or fewer days, with or without existing Community MA, MCO or non-MCO, and/or with Medicaid or QMB (Qualified Medicare Beneficiary) co-pay if applicable.

- For facilities with both chronic and nursing facility levels of care (so-called "dual" facilities) – please continue to use the DHMH 259 to move between these levels, clearly marking the form with "DUAL CHRONIC-NF," until a separate form is established for this process.

INSTRUCTIONS FOR USING THE DHMH 257 AND 259 FORMS

Processing Level of Care Changes Using the DHMH 257 & 259 Forms

To Begin Payment

Initial DHMH 257/Begin Payment must be submitted according to instructions stated in Action Transmittal #06-30.

Medicare Coinsurance DHMH 257/Begin Payment – submit directly to the LDSS office. The UCA does not assign level of care because Medicare payment, by definition, indicates the patient's need for skilled nursing and/or other skilled services, such as rehabilitation.

Straight Medicaid DHMH 257/Begin Payment – submit directly to the UCA with form DHMH 3871B, for medical eligibility determination and assignment of Medicaid payment level (i.e., light, moderate, heavy, or heavy special). The UCA will forward to LDSS after the need for nursing home level of care has been determined.

To Change Reimbursement Levels from Medicare Co-pay to Begin Full MA

Fill out the DHMH 259 Level of Care Transaction Form to indicate Medicare co-pay days are ending and forward to UCA. Also submit the DHMH 3871B form to the UCA for medical eligibility determination and assignment of Medicaid payment level (i.e., light, moderate, heavy, and heavy special). The UCA will forward to the Department after the need for nursing home level of care has been determined.

To Cancel Payment

Submit DHMH 257 Cancel Payment Transaction directly to LDSS in the event of:

Death;
Discharged home, or to another nursing facility; or
Termination of Bed Hold payment to nursing facility after maximum 15-day benefit for Hospital Leave/Bed Hold is exhausted*

***NOTE**: If the patient returns to the facility after a cancel pay due to expiration of the 15-day maximum Hospital Leave/Bed Hold, this process must start again, with the submission of a new initial DHMH 257/Begin Payment.

Dual Facilities: Move Between Chronic and Nursing Facility Levels of Care

- For facilities with both chronic and nursing facility levels of care – please continue to use the DHMH 259 to move between these levels, clearly marking the form with "DUAL CHRONIC-NF," until a separate form is established for this process.
- Facility provider numbers change as levels change between chronic hospital and nursing facility level of care, and LTC payment spans must change as well. Forward your "DUAL CHRONIC-NF" DHMH 259 documents to the following address for processing:

Christina Allen, Supervisor
Medical Assistance Problem Resolution
201 West Preston Street, Rm. SS-5
Baltimore, MD 21201
Attn: Dual Chronic-NF DHMH 259(s)

The Following Transactions Should Not Be Submitted Via DHMH 259:

1. Hospital Leave/Bed Hold days. There is no change in level of care status during this time period.

2. Expiration of Hospital Leave/Bed Hold. This transaction must be handled via a DHMH 257/Cancel Payment, as noted above.

3. Medicare coinsurance. Neither the UCA nor the LDSS have to confirm the need for nursing home level of care or assign a reimbursement level at this point, since the Medicare nursing benefit has been approved for skilled nursing and/or other skilled services. The nursing facility will have a Medicare EOMB in chart for assessment purposes.

SPECIAL INSTRUCTIONS FOR HOSPICE ELECTIONS

When a patient residing in the nursing facility elects the hospice benefit, the facility does not need to submit a DHMH 257/Cancel Payment. The LTC spans for that nursing facility will be end-dated in the MMIS-II system via an internal procedure that takes place during the Hospice election/enrollment process at DHMH.

If at any point after hospice election, the patient decides to discontinue hospice care and benefits and return to nursing facility care, the facility must submit a DHMH 257/Begin Payment and another 3871B, for assignment of reimbursement level.

Because Medicaid operations canceled the recipient's previous LTC span on MMIS-II via an internal process only, the recipient's LTC spans are still open and continuous on the CARES system. Please complete the new DHMH 257/Begin Payment, submit it to KePRO for processing, noting on the form that KePRO should forward this DHMH 257 to the following address:

Christina Allen, Supervisor
Medical Assistance Problem Resolution Division
201 W. Preston Street, Rm. SS-5
Baltimore, MD 21201
Attn: Hospice Revocation DHMH 257(s)

Any questions regarding this transmittal may be directed to the Division of Long Term Care Services at (410) 767-1736.

Attachment
cc: Nursing Home Liaison Committee
Local Departments of Social Services
Utilization Control Agent
Stacy A. Hromanik, MA Problem Resolution Division

Department of Human Resources 311 West Saratoga Street Baltimore MD 21201	**FIA ACTION TRANSMITTAL**
Control Number: #06-30	**Effective Date:** UPON RECEIPT **Issuance Date:** March 3, 2006

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
FAMILY INVESTMENT SUPERVISORS AND ELIGIBILITY STAFF

FROM: KEVIN M. MCGUIRE, EXECUTIVE DIRECTOR, FIA
CHARLES E. LEHMAN, EXECUTIVE DIRECTOR, DHMH, OOEP

RE: STANDARDIZATION OF MEDICAL ASSISTANCE LONG-TERM CARE PROCEDURES FOR JURISDICTION, LESS THAN 30 DAY STAY, AND MEDICARE DAYS

PROGRAMS AFFECTED: MEDICAL ASSISTANCE LONG TERM CARE (MA-LTC) FOR ADULTS

ORIGINATING OFFICE: OFFICES OF OPERATIONS AND PROGRAMS
DHMH OFFICE OF OPERATIONS, ELIGIBILITY AND PHARMACY

SUMMARY:

The Budget and Taxation and Appropriations Committees filed a joint report in November 2000, which required the Departments of Human Resources (DHR) and Health and Mental Hygiene (DHMH) to establish a workgroup with representatives of the Health Facilities Association of Maryland (HFAM) and Mid-Atlantic LifeSpan. The workgroup's main goal was to focus on ways to resolve communications issues between the agencies that provide customer service and develop procedures to expedite Medicaid eligibility determinations for Nursing Home residents.

A subcommittee of that workgroup recommended procedures for the Local Departments of Social Services (LDSSs) and Long-Term Care (LTC) providers that will reduce customer confusion and assist case managers, providers and customers with compliance requirements. While progress has been made, some topics continue to remain unresolved and require standardization on the part of LDSSs and LTC Providers.

To ensure that the recommended procedures will succeed, the subcommittee will take into consideration the impact not only on the nursing home community but also on the State's resources. It is essential that new procedures be adhered to consistently in order to ensure statewide compliance. The Executive Directors of both DHR and DHMH agree with the recommendations and support the actions of the subcommittee.

ACTION REQUIRED:

LDSS and LTC Facilities/Providers must observe the following procedures when processing LTC applications or redeterminations for adults.

STANDARDIZATION OF JURISDICTION OF RECORD FOR MA-LTC APPLICANTS:

Maryland Medicaid regulations address state residency only. An applicant for Maryland Medicaid must reside in a LTC facility in Maryland, and is considered to be a Maryland resident as of the date of admission to the LTC facility, with no waiting period. There are no local residency requirements. To ensure timely processing of Medicaid applications, use the following policies to determine where a customer's application will be processed. Please note, however, that the application must be taken and pended at the LDSS where the customer applies, in order to establish the date of application. An LDSS may not refuse to accept an application if the customer applies in an "incorrect" jurisdiction based on the following policies.

A LTC application is to be processed by the LDSS in the jurisdiction where the applicant resides. A LTC applicant is considered to reside in the Maryland jurisdiction where the customer lived before admission to the LTC facility, not in the jurisdiction where the LTC facility is located. If the LTC applicant did not reside in Maryland before admission to the LTC facility (e.g., the customer lived in a different state or country), the customer is considered to reside in the jurisdiction where the LTC facility is located.

Local Department Case Responsibility

A. Customer is admitted to a LTC facility directly from a community residence, that may be in a different jurisdiction than the LTC facility:

   - ❖ File, process and maintain application in the jurisdiction where the customer resided before admission to the LTC facility.

B. Customer is admitted to a LTC facility from a state institution:

   - ❖ File, process and maintain the application in the jurisdiction where the LTC facility is located.

C. Customer resided with their spouse then entered a LTC facility in another jurisdiction:

   - ❖ File, process and maintain the application in the jurisdiction where the customer resided before admission.

D. Applicant and spouse were separated before admission and lived in different jurisdictions and the excluded home is not in the jurisdiction where the applicant lived:

- ❖ File, process and maintain the application in the jurisdiction where the customer lived prior to admission.

E. Applicant did not live at home before admission (e.g., lived in an assisted living facility or with family) and the countable home is in a different jurisdiction than where the applicant lived:

- ❖ File, process and maintain the application in the jurisdiction where the customer lived prior to admission.

F. Customer is admitted to a LTC facility, and a previous community address either cannot be determined or was in a different state or country:

- ❖ File, process and maintain the application in the jurisdiction where the LTC facility is located.

Note: Under extenuating circumstances, a customer or his representative may request in writing to process the application in a local department other than where the case is currently maintained. Maintain the original copy of the written request in the case record.

MEDICAID COMMUNITY COVERAGE FOR LESS THAN 30 DAYS STAY IN LTC FACILITY

Refer to pages 900-23 – 900-24 in the Medicaid Eligibility Manual, issued in MR-108.

A Long Term Care Facility (LTCF) may admit a person for an anticipated stay of less than 30 days. When such a person is admitted to a LTCF from a community setting (including an acute hospital that admitted the person from the community), has a plan of care for a LTCF stay less than 30 days, and is discharged from the LTCF back to the community within 30 days, determine eligibility for community Medical Assistance under COMAR 10.09.24.09. For persons enrolled in HealthChoice, the Managed Care Organization (MCO) is responsible for the LTCF's charges during the first 30 days in a nursing home, chronic care hospital, or rehabilitation hospital; therefore, the facility must bill the MCO (see Medicaid billing instructions dated July 2005). Since either Medicaid or the MCO pays the provider, the client contribution to the cost of care (patient resource amount) is not assessed.

The LTCF will notify the LDSS LTC Eligibility Caseworker of admission and discharge from the LTCF via the DHMH 257 (Long Term Care Patient Activity Report). The DHMH 257 should be clearly marked "Community MA". The "Begin" and "Cancel" transactions should be included on the same form, so the stay of less than 30 days will be apparent.

A. Medical Assistance Applicant
(Non MA and Non Medicare at admission)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating " Community MA".
- Submits the DHMH 257 to DHMH's utilization control agent (UCA) for Level of Care.
- Refers the applicant to LDSS for an application and Community MA eligibility determination.

The LDSS LTC Eligibility Caseworker:
- Completes a Community MA eligibility determination.
- Completes a DES 501 if applicant is eligible.
- Sends a copy of the 501 to the LTCF.

B. Medical Assistance Applicant – MA Community Spenddown
(Non MA and Non Medicare at admission)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Submits the DHMH 257 to UCA for Level of Care.
- Refers the applicant to LDSS for an application and Community MA eligibility determination.
- Provides an itemized bill showing the cost of care, ancillaries, and other medical expenses on a day-by-day basis, if applicant is ineligible for Community MA due to excess income.

NOTE: A person certified for Medical Assistance under spenddown based on expenses incurred while in LTCF must pay the LTCF the excess income used to meet spenddown.

LDSS LTC Eligibility Caseworker:
- Completes a Community MA spenddown determination.
- Completes a DES 501 entering the applicant's spenddown amount as of the date of eligibility if applicant is eligible through spenddown.
- Sends a copy of the 501 to the LTCF.

C. Community Medical Assistance Recipient Not in MCO
(Non Medicare at admission i.e., SSDI recipients not on Medicare, spenddown)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Submits the DHMH 257 to UCA for Level of Care.

The LDSS LTC Eligibility Caseworker:
- Upon receipt of DHMH 257, updates case record in CARES to indicate recipient was in LTCF for less than 30 days, a DHMH 257 was submitted, and DES 501 was

completed.
- Completes the DES 501 and sends a copy to the LTCF.

D. Community Medical Assistance Recipient in MCO (Non Medicare at admission)

The Long Term Care Facility:
- Must notify MCO as soon as possible that the recipient is in LTCF.
- Must send DHMH 3871B to UCA
- Informs recipient/representative they should contact LDSS within 10 days to report recipient is in LTCF for less than 30 days.
- May contact LDSS regarding Community MA status of recipient.

The LDSS LTC Eligibility Caseworker:
- Upon notification, updates CARES narrative to reflect recipient is in LTCF for less than 30 days.

NOTE: Neither the DHMH 257 nor DES 501 is completed. LDSS LTC Eligibility Caseworker is only required to update the CARES narrative, if informed.

E. Community Medical Assistance Recipient Not in MCO (Medicare at admission – Stay Less Than Skilled so days not covered by Medicare)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Submits the DHMH 257 to UCA for Level of Care.

The LDSS LTC Eligibility Caseworker:
- Upon receipt of DHMH 257, updates case record in CARES to indicate recipient was in LTCF for less than 30 days, a DHMH 257 was submitted, and DES 501 was completed.
- Completes the DES 501 and sends a copy to the LTCF.

MEDICAID OR QMB COVERAGE OF CO-PAYMENTS FOR MEDICARE COVERED LTC STAY

Refer to page 900-24 in the Medicaid Eligibility Manual issued in MR-108, and pages 1000-53 – 1000-54 issued in MR-96.

Medicare covers a Medicare recipient in full for the first 20 days in the LTCF at a skilled or chronic level of care. For the 21st – 100th days in a LTCF at a skilled or chronic level of care, the Medicare recipient is assessed a co-payment. If the individual is a Medicaid or QMB recipient, Medicaid pays the Medicare Part A co-payment under the Medicare Buy-In Program. Medicare and Medicaid pay the provider since the client contribution to the cost of care (patient resource amount) is not assessed. If the individual is

expected to remain in the LTCF for 30 days or longer, it is recommended that the individual apply for LTC Medicaid, so that Medicaid will cover the LTC stay when the Medicare coverage ends.

The LTCF will notify the LDSS LTC Eligibility Caseworker of admission and discharge from the LTCF via the DHMH 257 (Long Term Care Patient Activity Report). The DHMH 257 should be clearly marked "Community MA". The "Begin" and "Cancel" pay dates should be included on the same form The "Begin" payment should be marked "Other: Medicare Coinsurance".

A. Medical Assistance or QMB Applicant
(Medicare covered stay - Skilled/Chronic Level)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Under Action Requested/Begin Payment/Other: specify "Medicare Coinsurance".
- Submits the DHMH 257 directly to LDSS and not to the UCA, since Medicare has already determined Level of Care
- Refers the applicant to LDSS for application and Community MA eligibility determination.

The LDSS LTC Eligibility Caseworker:
- Completes a Community MA eligibility determination.
- Completes a DES 501 to begin Medicare co-pay if applicant is Medicaid or QMB eligible.
- Sends a copy of the 501 to the LTCF.

B. Medical Assistance Applicant – – MA Community Spenddown
(Medicare covered stay – Skilled/Chronic Level)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Under Action Requested/Begin Payment/Other: specify "Medicare Coinsurance".
- Submits the DHMH 257 directly to LDSS.
- Refers the applicant to LDSS for application and Community MA eligibility determination.
- Provides an itemized bill showing the cost of care, ancillaries, and other medical expenses on a day-by-day basis, if applicant is ineligible for Community MA due to excess income.

NOTE: A person certified for Medical Assistance under spenddown based on expenses incurred while in LTCF must pay the LTCF the excess income used to meet spenddown.

LDSS LTC Eligibility Caseworker:
- Completes a Community MA spenddown determination.

- Completes a DES 501 to begin Medicare Co-Pay, entering the applicant's spenddown amount as of the date of eligibility, if applicant is eligible through spenddown.
- Sends a copy of the 501 to the LTCF.

NOTES:
LDSS Eligibility Caseworkers cannot use any Medicare covered service in the spenddown determination, but may use the individual's incurred expenses for Medicare premiums, co-payments, and deductibles.

If applicant is ineligible for Community Medical Assistance through spenddown, the Community Eligibility Caseworker must determine eligibility for Qualified Medicare Beneficiary (QMB).

C. Community Medical Assistance or QMB Recipient (Medicare covered stay – Skilled/Chronic Level)

The Long Term Care Facility:
- Completes the DHMH 257 clearly indicating "Community MA".
- Under Action Requested/Begin Payment/Other: specify "Medicare Coinsurance".
- Submits the DHMH 257 directly to LDSS.

The LDSS LTC Eligibility Caseworker:
- Updates CARES narrative to reflect recipient is in LTCF.
- Completes a DES 501 to begin Medicare Co-Pay.
- Sends a copy of the 501 to the LTCF.

INQUIRIES:
Please direct questions pertaining to these procedures to Patricia Bailey, Bureau of Medical Assistance Operations at 410-767-8907 or at pbailey@dhr.state.md.us, Medical Assistance policy questions to the DHMH Division of Eligibility Services at 410-767-1463, and Medical Assistance CARES questions to Cathy Sturgill at 410-238-1247 or at csturgil@dhr.state.md.us.

cc: DHR Executive Staff
DHMH Executive Staff
FIA Management Staff
DHMH Management Staff
Constituent Services
RESI
DHR Help Desk