

# TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
BENEFICIARY SERVICES ADMINISTRATION  
DIVISION OF ELIGIBILITY SERVICES  
300 WEST PRESTON STREET  
BALTIMORE, MARYLAND 21201

**MANUAL: Medical Assistance**      **EFFECTIVE DATE: Upon Receipt**

**RELEASE NO: MR-108**

**APPLICABILITY: Application process**

**ISSUED: February, 2003**

**E-track foster care/subsidized adoption**

**Long-term care facility short and long term stays**

**Women's Breast and Cervical Cancer**

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Chapter 3 - Policy Alert 03-9 (Children Discharged from Out-of-Home Placements – Unscheduled Redetermination)		Policy Alert 03-9 (after Policy Alert 03-8)
Chapter 4 (Application Requirements)	pp. 400-1 – 400-10	pp. 400-1 – 400-6
Chapter 9 (LTCF admissions for community MA/QMB)	pp. 900-23 – 900-24	pp. 900-23 – 900-24
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COMAR 10.09.24.14-1 (Corrective Managed Care)	pp. 127-128	pp. 127-128

## COMMENTS

Manual Release MR-108 contains two policy alerts, effective upon receipt, with policies and procedures for the E-track--children in State out-of-home placements in foster care or subsidized adoptions:

- Policy Alert 03-8, “Children in State Out-of-Home Placements – Medicaid Eligibility Determination - Eligibility Policies and CARES Procedures”
- Policy Alert 03-9, “Children Discharged from Out-of-Home Placements – Unscheduled Redetermination - Eligibility Policies and CARES Procedures”

Manual Release MR-108 also contains updated text to reflect the current policies and procedures for the following sections of the Maryland Medical Assistance Program Eligibility Manual:

- Chapter 4, Application Requirements, pages 400-1 – 400-6. The text is updated related to general application requirements and procedures, expedited enrollment for newborns, and application filing.
- Chapter 9, Financial Eligibility for Non-Institutionalized Persons, pages 900-23 – 900-24. The revised pages clarify the policies and procedures to be followed when a community MA or QMB recipient is admitted to a long-term care facility (LTCF) for an anticipated stay of less than 30 days. It also contains a new section about requirements for community MA or QMB recipients in a LTCF for skilled care covered by Medicare.
- Chapter 10, Eligibility for Institutionalized Person, pages 1000-53 – 1000-54-1. Pages 1000-53 – 1000-54 from MR-96 are reissued (some manuals are missing them) with policies and procedures for a change in level of care and about Medicare coverage for MA LTC recipients. Also included is updated text for page 1000-54-1 with eligibility policies and CARES procedures for an institutionalized person transferring from one LTCF to another.

Manual Release MR-108 contains two revisions to the text for COMAR 10.09.24, Medical Assistance Eligibility, which is included in the Manual.

- Regulation .03-2 eliminates MA payment of Medicare premiums, co-payments, and deductibles for the women in breast or cervical cancer coverage group. The proposed amendment, which reflects federal requirements, became final on January 6, 2003.
- A note is added to the text for COMAR 10.09.24.14-1, Abuse, that the Corrective Managed Care Program was discontinued when HealthChoice was implemented in 1996.

**Policy Alert 03-8**  
**Children in State Out-of-Home Placements – Medicaid Eligibility Determination**  
**Eligibility Policies and CARES Procedures**

**Effective:      Upon Receipt for New E-Track Applications**  
**At Redetermination for Existing E-Track Cases**

Summary:

The Centers for Medicare and Medicaid Services approved changes in Medical Assistance (Medicaid or MA) eligibility requirements for E-track children in out-of-home placements (OHP). **Income and resources are no longer a factor of MA eligibility for foster care children or other OHP children in the E-track.** Therefore, the only reason for a foster care child to be MA eligible in the State-only coverage group of E03 is if the child fails a technical factor of MA eligibility, such as citizenship or Social Security number (SSN). Non-IV-E eligible children in State subsidized adoptions are eligible in the federal category of E02 if they meet MA technical eligibility requirements and have special needs for medical, mental health, or rehabilitative care. E01 is for IV-E or SSI eligible foster care or subsidized adoption children. E02 is for non-IV-E foster care children or special needs subsidized adoption children who are not IV-E or SSI eligible, but meet the MA technical eligibility requirements. The State-only category of E03 is for all other children in State foster care; and the State-only category of E04 is for all other children in State subsidized adoptions.

When the State places a child in foster care or subsidized adoption, it is imperative that the MA certification process is timely so that the child has immediate access to health care coverage. Good communication between the OHP service worker, FIA MA case manager, and IV-E specialist (who determines IV-E eligibility) at the local department of social services (LDSS) is necessary to ensure prompt and correct MA coverage.

This Policy Alert provides uniform procedures to be followed by all local offices when processing E-track MA applications filed on behalf of a child in OHP (IV-E or State foster care and subsidized adoptions) when:

- The child is filing an initial MA application and is not already active or pending in CARES for MA and/or other eligibility; or
- The child applicant is already a recipient in an active or pending assistance unit (AU), such as Temporary Cash Assistance (TCA), Food Stamps (FS), Supplemental Security Income (SSI), MA, or the Maryland Children's Health Program (MCHP).

Eligibility for OHP is established by the Department of Human Resources' regulations found in COMAR 07.02.11. Federal funding of OHP services is governed by Title IV-E of the Social Security Act.

The E-track is only for children committed by the courts to the custody of the Department of Human Resources (DHR) and who are receiving foster care or subsidized adoption services from DHR. The MA application for a foster care child must clearly indicate that parental rights are terminated, which triggers a for child support referral. The procedures in this Policy Alert are not applicable to children placed in foster care or adoption by private agencies or individuals, who should have their eligibility determined under the appropriate MA or MCHP coverage group other than the E-track. They are not eligible in the E-track. However, the E-track may include children who are dually committed to the custody

of DHR and the Department of Juvenile Services, so long as the child is receiving foster care or subsidized services from DHR.

As long as children in the Kinship Care Subsidized Guardianship Waiver Program remain under the State's custody, they stay MA eligible in their E-track coverage group. Once guardianship is granted and the service case is closed, children in the Kinship Care Subsidized Guardianship Waiver Program must have their eligibility determined in the appropriate MA or MCHP coverage group other than the E-track. They are no longer eligible in the E-track. FIA Action Transmittal 01-02 dated 8/7/2000 addresses how to redetermine eligibility when the guardianship through the Kinship Care Program goes into effect for children previously certified in the E-track.

**Action Required:**

**I. Coverage Groups in the E-Track for IV-E or State Foster Care and Subsidized Adoptions.**

**The MA case manager should not test for income or resources for any of the coverage groups in the E-track as a condition of MA eligibility, but should still test for technical MA eligibility. The MA case manager should enter \$1 for the foster care or subsidized adoption income and enter any child support, SSI, or SSDI income with a valid value of "ON" ("other non-countable"). The MA case manager should narrate for each type of non-countable income that is entered and for any other of the child's reported income or resources of the child that are not counted for the E-track eligibility determination, but may be needed for a future application.**

Following is a description of the basic MA eligibility requirements for each coverage group in the E-track:

- **E01: IV-E or SSI Foster Care and Adoption**  
Federally matched MA is automatically provided, without a separate test for MA eligibility, to any child receiving adoption or foster care benefits who is either eligible under Title IV-E of the Social Security Act or SSI-eligible. Since CARES has little programming for E01, **a case should only be pended in E01 if the MA case manager confirms (through SVES, SDX, or SOLO) that the child is receiving SSI benefits or if IV-E eligibility is confirmed by the LDSS IV-E specialist**, not based on a presumption of SSI or IV-E eligibility.
  - If it is later found that an E02, E03, or E04 child is IV-E or SSI eligible, the MA case manager should "J" screen an existing E01 assistance unit (AU) or use "Add A Program" to establish an AU for the E01 coverage effective as of the 1st of the month after the MA case manager is notified of the IV-E or SSI eligibility. If a previous E01 AU is available, the MA case manager could "J" screen an existing E01 AU, if one was previously available.
  - OHP children who receive Supplemental Security Income (SSI) are included in E01, rather than in the S02 coverage group, even if they are not IV-E eligible. However, since CARES is programmed to deny an E01 application with SSI ("SI") income, the child's SSI income should be entered on the CARES UINC Screen with a valid value of "ON" for other non-countable income. The MA case manager should fully narrate in CARES. Note: CR 758 is obsolete, which stated that SSI children in OHP should remain in coverage group S02. (Note: This will

also involve clean-up of any OHP cases in S02, needing to be converted to E01 after this Policy Alert takes effect.)

- **E02: Non-IV-E Foster Care and Special Needs Subsidized Adoption**  
Federally matched MA is provided to foster care children who are not IV-E eligible, but who do meet the MA technical eligibility criteria at COMAR 10.09.24.05 (Chapter V of the Medicaid Eligibility Manual), including the MA citizenship requirements. Non-IV-E children also qualify for E02 if they are receiving subsidized adoption services through the Department of Human Resources, have special needs for medical, mental health, or rehabilitative care, and meet the MA technical eligibility requirements. Since CARES is programmed to apply the same medically needy financial rules for this group as for F98, the MA case manager must assure that CARES does not deny an eligible OHP case for E02 due to failing financial eligibility criteria (see Section II).
  
- **E03: State Funded Foster Care**  
The State funds full MA coverage for foster care children who are not federally eligible for E01 or E02.
  - Since CARES does not trickle properly to E03 from E01 or E02, the MA case manager should “Add A Program” or “J” screen an existing E03 AU and complete the eligibility process for an E03 AU if a foster care child is ineligible for E01 or E02. The MA case manager must assure that a foster care child is in the appropriate coverage group, and is only in E03 if MA technical eligibility criteria are not met (e.g., SSN, citizenship).
  - If it is later determined that the child is IV-E or SSI eligible, the MA case manager should “Add A Program” or “J” screen an existing E01 AU and complete the eligibility process for an **E01** AU.
  - If verifications later confirm that the non-IV-E foster care child meets the MA technical eligibility criteria in COMAR 10.09.24.05 (including citizenship requirements), the MA case manager should “Add A Program” or “J” screen an existing E02 AU and complete the eligibility process for an **E02** AU.
  
- **E04: State Funded Subsidized Adoption**  
The State funds full MA coverage for children in State subsidized adoptions who are not federally eligible for E01 or E02.
  - Since CARES does not trickle properly to E04 from E01 or E02, the MA case manager should “Add A Program” or “J” screen an existing E04 AU and complete the eligibility process for an E04 AU if a subsidized adoption child is ineligible for E01 or E02.
  - If it is later determined that the child is IV-E or SSI eligible, the MA case manager should “Add A Program” or “J” screen an existing E01 AU and complete the eligibility process for an **E01** AU.
  - If verifications later confirm that the non-IV-E subsidized adoptions child with special medical needs meets the MA technical eligibility criteria in COMAR 10.09.24.05 (including citizenship requirements), the MA case manager should “Add A Program” or “J” screen an existing E02 AU and complete the eligibility process for an **E02** AU.

## II. Procedures Followed by MA Case Managers for MA Eligibility Determinations in the E-Track.

### A. Notification by the Service Worker and IV-E Specialist.

A service unit (SU), which shows the type of service for the child, is created for each child entering foster care, kinship care, or subsidized adoption. This is based on the demographics, service information, and proper enumeration provided by the service worker. Either the existing Client ID is matched or, if there is no existing Client ID, a new one is created for the child.

1. The service worker promptly advises the FIA MA case manager of a child in foster care or subsidized adoption who needs to be certified for E-track OHP MA eligibility.
2. The service worker acts as the child's representative for purposes of filing the MA application. The service worker must provide all available information and verifications requested by the MA case manager.
3. The IV-E specialist provides information to the MA case manager about the child's IV-E eligibility. The MA eligibility determination should not be delayed by the IV-E determination. If the child meets technical eligibility for MA and the IV-E specialist has not yet determined IV-E eligibility when the MA application is being processed and finalized, the MA case manager should pend the application under Medical Coverage group **E02** and complete the eligibility determination process. If the child is later determined to be IV-E eligible, the MA case manager should "Add A Program" or "J" screen an existing E01 AU and complete the eligibility process for an **E01** AU as of the 1st of the month after the MA case manager is notified by the IV-E specialist.

### B. Screening and Pending the MA Case.

When the MA case manager is notified by the service worker of a foster care or subsidized adoption child requiring an OHP MA eligibility determination:

1. Perform an inquiry in CARES to research and determine if the child is a member of another AU as active, pending, closed, or denied. Because the service AU has already been opened by the service worker, these cases should already be known to CIS, and a match should be made to the client on the database. Make every effort to screen the child for an existing Client ID to prevent assigning multiple IDs. If more than one ID exists, refer to CARES Bulletin 98-17, Multiple Client IDs, for how to close the duplicate ID.

**Note:** When a child is adopted, there is usually a break with the old AU and Client ID number. The child may get a new Social Security number (SSN), also. Only if a complete break is not intended for the adopted child would the old SSN, AU, and Client ID be linked on CARES with the new identifiers.

2. Screen the child in the appropriate E-track coverage group, using **Option "J" on the AMEN** Screen in CARES.
  - Use **E01** only if it is confirmed that the child is IV-E or SSI eligible.
  - Use **E02** for all other foster care or subsidized adoption placements.

- CARES does not trickle properly from E01 or E02 to E03 or E04. Therefore, “Add A Program” or “J” screen an existing AU for **E03** if a foster care child is not eligible for E01 or E02. For a subsidized adoption child, “Add A Program” or “J” screen an existing AU for **E04** if the child is not eligible for E01 or E02.

*Refer to Section II.C.6. about the appropriate income types for entering income on the CIRC Screen. For instance, in option “J” screening for E02, use income type: SF-State subsidized Foster Care and include \$1 as the payment amount on the CIRC screen.*

### C. Interview.

After properly screening and pending the child in the appropriate E-track MA coverage group, select option “O” to complete the “**Interview**” process on CARES. The MA case manager should never bypass this step. Option “O” is necessary because the CARES system performs a “copy back” function of information between the ongoing month and the processing months.

1. An “**interview**” is conducted between the service worker and the MA case manager, often through a paper application rather than at a face-to-face interview. The DHR/FIA CARES 9708 is used as the MA application. The MA case manager is responsible for establishing and maintaining the MA case record. The MA case manager enters the information into CARES for the E-track MA AU created during the “J” screening process.

2. For the E-Track AU, be sure to enter the child’s appropriate **living arrangement code** on the **DEM1** screen.

- If the child is either IV-E or SSI eligible, enter the living arrangement as: “FE” Foster Care, IV-E; or “SE” Subsidized Adoption, IV-E.
- If the child is neither IV-E nor SSI eligible, enter the living arrangement as: “FC” Foster Care, Non IV-E; or “SA” State Subsidized Adoption, Non IV-E.
- **Do not use** the valid value “AH”, At Home, for children placed in foster care or State subsidized adoption.
- Complete all the necessary information to include Parental Status and the correlating **Absent Parent** screens, when applicable.
- Use caution when processing Subsidized Adoption cases, because absent parent information is not necessary.

3. If there is an active AU with the child as a member in another program (e.g., TCA, FS), contact the Worker of Record for the TCA/FS/MA/MCHP case to request that the child be removed from the existing AU as of the end of the current month. The entire AU may need to be closed if there are no remaining TCA eligible children. If the child is removed from the existing AU historically to the beginning of the month of OHP, the family may have to repay TCA and/or FS assistance received on the child’s behalf for that month.

- If the child is active for MA in the month of OHP as a member of a TCA, MA, MCHP, and/or FS AU, change the living arrangement to “NO” on the child’s DEM1 screen for the ongoing month.  
This includes SSI-eligible children. If the child is in an active SSI AU (S02), the child’s S02 AU must be closed then immediately processed under the E01 eligibility, in order to indicate foster care/subsidized adoption eligibility and to take advantage of the special HealthChoice rules and assistance for E-track children.
- If the child is a member of a pending TCA, MA, and/or MCHP AU in the month of OHP, make the living arrangement change effective the month of placement.
- If the child is in an active or pending FS-only AU in the month of OHP, change the living arrangement for the ongoing month.
- For any of the above instances, two narrations must be completed on CARES. Narrate on the TCA, FS, or MA NARR screen from which the child is being removed, as well as the NARR screen of the E-track MA eligibility case.

If this is an initial MA application for a child who does not have an existing active or pending TCA, MA, MCHP, and/or FS AU, pend the appropriate E-track coverage, narrate, and determine eligibility as of the month of OHP.

4. Determine MA eligibility in the appropriate E-track **coverage group**, as follows:

- Finalize MA eligibility as soon as possible within the 30-day time limitations, for either the current month or the ongoing month (see #3 above), even if the child support or IV-E eligibility information is not yet available. The child support information may be added later to the CARES screens when it becomes available. Any income from child support must be coded as “ON” so it will not affect the child’s MA eligibility.
- If the child is SSI-eligible or confirmed as IV-E eligible by the IV-E specialist, the MA case manager should finalize the case in E01, including closing an SSI-eligible child in S02.
- If the child is not eligible for IV-E or SSI or the IV-E specialist has not determined IV-E eligibility by the time that the MA case manager finalizes the case, the MA case manager should determine eligibility in E02.
- If the child is not eligible for E01 and E02, the MA case manager should “Add A Program” or “J” screen an existing AU for the State-only category of:
  - E03 if the child is receiving foster care assistance; or
  - E04 if the child is receiving subsidized adoption services.

5. For the E-track AU, enter on CARES the appropriate **address**. The authorized representative screen is optional, but may also be completed.

- For a foster care AU:
  - On the **ADDR** screen, enter the LDSS address as the residential address, as well as the service worker information as dictated by your

agency. The service worker will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility notices.

- Optional: On the **AUTH REP** screen, enter the service worker as the Authorized Representative, type “R2”, so that the OHP service worker will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility notices.
- For a subsidized adoption AU:
  - On the **ADDR** screen, enter the child’s adoptive home as the residential address.
  - Optional: On the **AUTH REP** screen, enter the adoptive parent as Authorized Representative, type “R2”, so that the adoptive parent will receive the MA card, HealthChoice enrollment materials (if E01 or E02), and all eligibility notices.

6. Presently, CARES requires that any child in the E-track have either foster care or State subsidized adoption income. Due to this requirement, enter \$1.00 on the UINC screen for such unearned income.

- Use income type “FC”, “DA” or “DD” for coverage group E01.
- Use income type “SF” for E02 or E03.
- Use income type “SS” for E02 or E04.

Since income and resources are no longer a factor of MA eligibility for the E-track, enter no other countable income or resources for the child. Enter any child support, SSI, or SSDI income with a valid value of “ON” for other non-countable income, and fully narrate on both the NARR screen and the Remarks screen about the child’s income and resources, which may be needed for a future application.

- CARES will deny any E-track AU once SSI (“SI”) income is entered. Therefore, to change the coverage group of an SSI child from S02 to E01, the amount of SSI income must be coded as “ON” (other non-countable income) on the UINC screen. In addition, \$1 of foster care income must be entered on the UINC screen to ensure the child’s technical eligibility on CARES for E01. Code the \$1 income as “FC” (IV-E foster care) and process the case.

Follow these procedures until you are notified that CARES has been modified.

#### D. Processing and Finalizing the Eligibility Determination.

Select options “**P**” **Process** and “**Q**” **Finalize**. Note that the eligibility tests for the E-track are different than the tests performed in other MA tracks, to facilitate prompt eligibility determinations. Please reference Sections II.C.2 and 6 of this Policy Alert, to assure that the appropriate living arrangements and income types are entered.

1. For **E01**, there are virtually no eligibility tests on CARES for MA eligibility. For that reason, a child must not be screened in this coverage group unless the child is **confirmed** as SSI or IV-E eligible. A child screened in this coverage group will not fail MA eligibility, but will be certified as federally eligible, if processed correctly with the correct corresponding valid values. Until modifications are made to CARES for E-track coverage groups, trickling should not occur.

2. For E02, CARES applies the same eligibility tests as for the FAC medically needy category F98, which are no longer applicable for E-track eligibility. This is why countable resources and income should not be entered for E02, except for \$1 of foster care or subsidized adoption income. The MA case manager must assure that CARES does not deny an E02 AU for financial eligibility reasons. If CARES denies an E02 AU for MA technical eligibility reasons (e.g., SSN, citizenship), the MA case manager should “Add A Program” or “J” screen an existing AU for a State-only E03 AU for a foster care case or E04 AU for a subsidized adoption case.

3. It is imperative that a child placed in foster care or subsidized adoption is certified as promptly as possible, and that there is no lapse of coverage when a child is removed from another AU to be opened in an E-track coverage group.

- It is optimal to remove the child from an active AU on one day and then to open eligibility in an E-track coverage on the following day, since two transactions (close/open) do not read over to MMIS through the interface on the same day. Check MMIS to make sure that the transactions took effect.
- All E-track applications must be finalized as soon as practicable, with or without complete verifications.
  - If IV-E eligibility has not yet been determined by the IV-E specialist, finalize the case in E02. If the child is not eligible for E02 due to MA technical eligibility requirements (e.g., verifications, SSN, citizenship), “Add A Program” or “J” screen an existing AU for the State-only category of E03 for a foster care case or E04 for a subsidized adoption case.
  - If there are any outstanding verifications, use the valid value of “OT” for “Other” so the E03 or E04 AU will process within the 30-day timeframe.
  - Create a 745 Alert to check on requested or outstanding verifications within a month if the child was not eligible for:
    - E01 because the IV-E specialist has not yet determined IV-E eligibility; or
    - E02 due to lack of verifications related to technical MA eligibility (e.g., SSN, citizenship).
  - If verification is later received that will enable certification in the federally matched coverage group, do “Add A Program” or “J” screen an existing AU, close the original AU, and certify the child in either E01 (for SSI or IV-E foster care or subsidized adoptions) or E02 (for non-IV-E federally-eligible foster care or special needs subsidized adoption).

#### E. Post Eligibility Activity.

Once the MA eligibility is certified on CARES, there is an overnight electronic transfer of the MA data from CARES to MMIS at DHMH. There is also an electronic transfer of absent parent data from CARES to the DHR Child Support Enforcement Administration. The service worker provides information about the absent parents for establishment of child support via the Eligibility Determination Document (EDD) from

CARES or the CARES 9708 application form, during the processing of the OHP MA eligibility for foster care cases.

If the child was not already MA eligible, DHMH issues the MA card and sends it to the service worker/unit for a foster care child or to the adoptive parent. If the child was already MA eligible, the MA case manager should process a request for a duplicate MA card, to assure that the service worker or adoptive parent has the child's MA card. The request should be entered the day after the E-track MA eligibility is committed to CARES, using the following CARES procedures:

- From the CARES Main Menu, select option "L – Financial Mgmt Misc."
- On "LMEN" select option "S – MA Card Reissuance" and enter the Client ID.
- On "MACR" (MA Card Reissuance) Screen, verify information and select "Y" in the "Reissue Another Card" field. Press Enter to commit the request.
- CARES will return to "LMEN" with a message of "Insert Successful".
- Update case narrative to reflect duplicate card request.

Children certified in **E01 or E02** are eligible for HealthChoice.

- If the child is already enrolled in HealthChoice, the child remains with the same Managed Care Organization (MCO) and primary care provider (PCP) when the child's coverage group changes to the E-track. The child's representative should follow HealthChoice procedures to request a different MCO and/or PCP, if necessary.
- If the child is not currently enrolled in HealthChoice but was enrolled within the past 120 days, the child is auto-assigned to the previous MCO. The representative may request a change of MCO and/or PCP if necessary.
- If the child is neither currently enrolled in HealthChoice nor enrolled within the past 120 days, the enrollment broker will send the HealthChoice packet to the representative for selection of an MCO.

Children eligible in the State-only coverage groups of **E03 and E04** are not enrolled in HealthChoice, but receive the full range of MA covered services on a fee-for-service basis. However, because they are not HealthChoice eligible, they may not be enrolled in the Rare and Expensive Case Management (REM) program.

Since CARES does not schedule an annual redetermination for an active E01 AU, the MA case manager should set a 745 Alert to review the case at least every 12 months, or sooner if the child is turning 21 within a year. Then, the MA case manager must verify with the IV-E specialist that the IV-E eligibility continues and verify with the OHP service worker that the OHP service case is still open.

Please refer to Policy Alert 03-8 for information about the policies and procedures related to redeterminations for the E-track, including unscheduled redeterminations when children are discharged from out-of-home placements.

**NOTE: ALL CASE ACTIVITIES MUST BE FULLY NARRATED IN CARES.**

*Please direct questions concerning this Policy Alert to the DHMH Division of Eligibility Services at 410-767-1463. If you need assistance with CARES processing for these cases, you may contact Cathy Croghan-Sturgill at 410-238-1247.*

**Policy Alert 03-9**  
**Children Discharged from Out-of-Home Placements – Unscheduled Redetermination**  
**Eligibility Policies and CARES Procedures**  
**Effective: Upon Receipt**

**I. Overview.**

Federal and State regulations provide for the prompt redetermination of Medical Assistance (MA or Medicaid) eligibility when there is a change in an individual's circumstances (e.g., living arrangements, income, resources) that may result in the loss or change of eligibility. Federal and State guidelines also stipulate that MA eligibility must continue until it has been determined that an individual no longer meets the criteria for continued eligibility.

This Policy Alert sets forth policies and procedures, **effective upon receipt**, which are to be followed to facilitate the transition when a court rescinds a child's commitment to the State's custody and the child is discharged from an out-of-home placement (OHP). Each local department of social services (LDSS) identifies which MA case managers are responsible for implementing these policies and procedures. These procedures ensure that these children will continue to receive health care benefits, **without a lapse in MA coverage**, until they have been given the opportunity to reestablish continued eligibility under MA (community or long-term care) or the Maryland Children's Health Program (MCHP).

When a child is discharged from the OHP, the service worker at the local department of social services (LDSS) is to give the child's parent or representative the child's Medical Care Program identification card, so the child may access MA services while the child's eligibility is being redetermined. If the child is enrolled in HealthChoice, the service worker is to inform the parent/representative of the child's Managed Care Organization (MCO) and primary care provider (PCP), and give the parent/representative the child's MCO card. The MCO should then be provided with updated contact information about the child's head of household or emergency contact.

Note: Scheduled redeterminations are required at least every 12 months for coverage groups E02, E03, and E04. Also, continued IV-E certification must be verified with the LDSS's IV-E specialist at least every 12 months for coverage group E01. For E02, E03, and E04, CARES automatically sends a redetermination package before the end of the certification period to the child's authorized representative—the OHP service worker/unit for a foster care child or the adoptive parents for a subsidized adoption child. The MA case manager must verify all factors of MA eligibility with the child's authorized representative before approving MA eligibility for another 12-month certification period.

**II. Procedures for MA case managers to Initiate an Unscheduled Redetermination When a Child Is Discharged from Out-of-Home Placement.**

A. Medical Assistance eligibility may not be terminated based on a child's discharge from OHP. The child's OHP MA eligibility must continue until it has been determined that no other MA or MCHP eligibility exists. The MA case manager at the LDSS must initiate an unscheduled redetermination. To facilitate this process and the child's transition from OHP to the community or a long-term care facility, **at most 90 days of extended MA eligibility** will

be granted after the child leaves the OHP, allowing time for completion of an unscheduled redetermination. The following applies when the MA case manager is notified by the service worker that the child has been discharged from OHP to the community or a long-term care facility (e.g., residential treatment center, hospital, nursing facility, ICF/MR):

- The MA case manager must change the redetermination end date to allow the case to go into the CARES automatic redetermination cycle.
- Since the child is still in an E-track coverage group as a household of one, CARES will send the DHR/FIA CARES 9708 application, rather than the CARES 9701 or MCHP application. CARES will send the redetermination package with the current worker of record as the contact person and with that MA case manager's district office (DO) as the return address, even if the case is being transferred to a different MA case manager for completion of the unscheduled redetermination.
- Income and resources will not be considered for the 90-day extension of MA eligibility, but will be considered for the new period under consideration.

B. The MA case manager follows these procedures to initiate the unscheduled redetermination when a child is discharged from out-of-home placement:

1. Leave the child as the head of household (HOH). Do not change information on the "DEMI" screen at this time, such as for living arrangements. Make no changes to the "UINC" screen for income or resources, except to delete the child's OHP income following the correct CARES processing steps or to make the changes indicated in #4 below for SSI income. Income and resources will not be considered for the extended period of MA eligibility after the discharge, only for the period under consideration for the unscheduled redetermination.
2. The "ADDR" Screen must be updated to reflect the discharge address indicated by the service worker as the child's new address. Delete any authorized representative information on the "AUTH REP" Screen for the OHP case.
3. After waiting at least a day to confirm that the address change has been updated on MMIS, the MA case manager should process a request through CARES for a duplicate card to be issued to the discharge address for the child, using the following CARES procedures:
  - From the CARES Main Menu, select option "L – Financial Mgmt Misc."
  - On "LMEN" select option "S – MA Card Reissuance" and enter the Client ID.
  - On "MACR" (MA Card Reissuance) Screen, verify information and select "Y" in the "Reissue Another Card" field. Press Enter to commit the request.
  - CARES will return to "LMEN" with a message of "Insert Successful".
  - Update the case narrative to reflect the duplicate card request.
4. **For E01:** A redetermination cannot be initiated on an E01 assistance unit (AU). Therefore, the redetermination end date cannot be shortened/changed on the MAFI screen, and CARES will not send a redetermination packet. The following procedure should be used to redetermine eligibility when a child, who is certified as an E01, is discharged from OHP.
  - Check SDX/SVES for whether the child is currently receiving Supplemental Security Income (SSI).
  - If the child is a SSI recipient, redetermine eligibility from E01 to S02 effective the 1st day of the next month, either through "Add A Program" or by "J" screening the child's old SSI S02 AU.

- Review the ADDR screen to assure the correct mailing address. Update accordingly.
  - Change the Living Arrangement code on the DEM1 screen to “AH”.
  - Delete all unearned income on the UINC screen.
  - Add the child’s SSI income back on the UINC screen as “SI”, and also enter any other verified countable income (e.g., child support, SSA, etc.) with the correct coding.
  - If necessary during processing, waive adverse action to assure that the begin date for S02 eligibility is effective the 1st day of the following month.
  - In order to avoid dual participation, the MA case manager must “507” the pending S02 AU while processing the application month.
  - Finalize the S02 AU and review the eligibility begin date.
  - Fully narrate.
- If the child does not receive SSI, change the coverage group from E01 to E02 so that an unscheduled redetermination can be initiated. This can be performed through Option L on the AMEN Screen via “Add-a-Program” to the existing E01 AU or by “J” screening a previous E02 AU.
    - On the KIND Screen, place a “y” in the selection field for Medical Assistance.
    - Continue through “Add A Program”. On the CIRC Screen under unearned type/amounts, enter “SF” as the valid value for FAC foster care income (OHP Income) and \$1 as the amount value. This will cause the proper coverage group to populate on the INCH Screen.
    - On the INCH Screen, place a “y” in the selection field for E02 Med Cov Group. Enter the current date as the application date, when the coverage group is changed from E01 to E02.
    - Proceed through “Add A Program” screens to completion.
    - On the AMEN Screen, the E02 AU Number will now be populated. Change the Option to “O” for Interview and process the case.
    - Review the ADDR Screen to assure the correct mailing address.
    - Remember to enter closure reason code “507” to the E01 AU on the affiliated STAT Screen in order to avoid dual participation in the ongoing months.
    - Change the Living Arrangement Code on the DEM1 Screen to “FC”.
    - On the UINC Screen, delete the E01 income by placing a “y” in the delete field and pressing PF 24. From the SHEL Screen, press PF7, which will return you to the UINC Screen. On the UINC Screen, enter “SF” and \$1 for unearned foster care income. Delete the “FC” or other E01 income from the UINC Screen for the ongoing month.
    - Continue through the “Interview” process. Upon processing eligibility, confirm and allow closure of the E01 coverage to avoid dual participation in the ongoing month. Waive any adverse action, and override any closure notification.
    - Back at the AMEN Screen, select “P” to Process Application Months.
    - Remember to “507” the E02 coverage for the current application month only to avoid dual participation with the E01 coverage already being received.
    - On the MAFI Screen for the ongoing month during finalization of the E02 AU, shorten the “Redet End Date” to 90 days from the “Redet Begin Date”. Complete CARES processing.

**For E02, E03, or E04:** The following procedures should be used to redetermine MA eligibility when a child who is certified as an E02, E03, or E04 is discharged from OHP.

- Using option “R” from “AMEN”, initiate and complete an unscheduled redetermination for the existing E02, E03, or E04 AU.
- On the “MAFI” screen, adjust the redetermination end date to 90 days from the first day of the month following the month in which the MA case manager became aware of the discharge from OHP, to allow inclusion into the CARES automatic redetermination cycle. Since the child remains in the “E” track until the redetermination is completed, the CARES 9708 application will be sent, even if the child is discharged back home.
  - If the discharge date is during the first nine (9) months of the child’s certification period, the redetermination end date must be adjusted to 90 days from the first day of the month following the month in which the MA case manager became aware of the discharge from OHP.
  - If the discharge takes place in the last three (3) months of eligibility, the MA case manager must initiate the redetermination in the month following the month in which he or she became aware of the discharge. Complete the redetermination and shorten the “REDET END DATE” to 90 days from the “REDET BEGIN DATE”. Following this procedure will ensure that CARES begins a “new redetermination cycle”, and in doing so, will generate a new redetermination packet to the discharge address.
  - If the assistance unit (AU) was closed on CARES during the previous month due to failure to complete the redetermination process, the MA case manager should “J” Screen the closed AU number from the first day of the month in which eligibility ended. Complete the application process and, in finalization, shorten the “REDET END DATE” to 120 days from the “REDET BEGIN DATE” to allow inclusion into the automatic redetermination cycle.

**For an E-track child returned to an active F-track household:** The MA case manager for the household’s F-track case should be contacted. If there is sufficient information for the MA case manager to determine that the child qualifies as a member of the F-track AU, there is no need to initiate an unscheduled redetermination for the child. If eligible, the child’s E-track AU is closed effective the end of the month that the MA case manager became aware of the child’s discharge from the State’s custody to the F-track household. The child is added as a member of the F-track AU effective the first day of the following month, so the household may begin to receive any public assistance for the child as soon as possible.

5. If a transfer of the case is necessary due to the child’s new address and living arrangements, electronically transfer the case through CARES and send a copy of the paper file to the appropriate DO and/or MA case manager. Set an Alert to notify any new MA case manager that the above action was completed, and forward the case for follow-up.
6. Be sure to narrate on CARES all case action in each E-track case.

### **III. Procedures for MA Case Managers to Redetermine MA/MCHP Eligibility for Children Discharged from OHP.**

- A. If the redetermination application is returned by the child's parent or representative, pend the new medical coverage group, applying all applicable rules for AU composition, HOH, etc. A face-to-face interview is not required.
- In "Interview", the MA case manager updates the ADDR Screen and the DEM1 Living Arrangement.
  - The MA case manager determines whether the child is living at home. The MA technical and financial eligibility factors must be met for all household members for whom benefits are requested. Since CARES will send the CARES 9708 form, the application will not collect information about other household members.
    - The MA case manager will contact the child's parent/representative to clarify who in the household is applying for benefits and for what types(s) of benefits. The MA case manager will inquire about the income and resources of any household members who are applying or who are considered as non-members of the AU.
    - If necessary, the MA case manager mails the CARES 9701 application to the parent/representative, specifying and highlighting the sections to complete (including signatures) that are not included on the CARES 9708 (for children considered as a household of one in an OHP, a long-term care facility, or a home and community-based services waiver).
    - For the application month of the household's new AU, the "FINL RESP" code for the child must be entered as "NM" to avoid dual participation and insure that eligibility is determined correctly for any other AU members.
  - If the MA case manager determines that the child is eligible for MCHP in the P-track and there is no associated case (e.g., Food Stamps), the MA case manager will change the D.O., electronically transfer the active P-track case, and mail a copy of the paper records to the appropriate local health department (LHD).
  - If the MA case manager determines that the child is eligible in a MA community or long-term care category, or if there is an associated case for an MCHP AU (e.g., Food Stamps), the AU remains active at the local department of social services (LDSS).
  - If the child moves into a household currently receiving Temporary Cash Assistance (TCA) or if the HOH applies and is found eligible for TCA benefits for the child and other household members, the child's MA coverage may need to be changed to the "F" track before the end of the 90-day extended certification period. Then, the family may receive TCA and perhaps also FS benefits for the child as soon as possible, and for any other newly enrolled household members.
  - If the child is discharged from OHP to a long-term care facility (including an RTC or IMD), the child's MA application and a copy of the case file may need to be transferred to another D.O. and/or MA case manager for a MA long-term care eligibility determination.
  - If it is determined that MA eligibility no longer exists for the child, the parent/representative must receive timely and adequate written notification, and the opportunity to request a hearing. A foster care child who is in the E03 State-only category because the MA citizenship requirements are not met will not be MA or MCHP eligible when discharged from the State's custody.
- B. If the redetermination application is not received by the end of the extended

certification period, even after reminder notices, CARES will close the child's AU due to failure to complete the redetermination. The procedures in Policy Alert 12-04 for tardy redeterminations apply if the application for continued eligibility is returned within four (4) months of the redetermination due date, or if a new application is filed within that time frame.

#### **IV. Procedures for the MA Case Manager to Follow When a Child Is Aging-Out of Benefits for Out-of-Home Placements.**

COMAR 07.02.11 specifies age limitations for services under the Out-of-Home Placement Program of the Department of Human Resources. The same age limitations apply for MA eligibility for children in OHP. Regardless of the circumstances, no one aged 21 or older should remain in the E-track, due to MA eligibility age restrictions for the E-track.

The MA case manager must consult with the service worker about the child's OHP eligibility and manually set a "745" Alert for 90 days prior to when the recipient will "age-out" of eligibility for OHP before the child turns age 21.

- On the ALWG screen (Create Worker-Generated Alert), enter all the necessary information to set a "745" alert.
- In the "Display Date" field, enter the date 90 days prior to the first day of the month in which the client turns 21 years old.
- In the "Due Date" field, enter the month, day, and year in which the child turns 21 years old.
- The MA certification period must be adjusted by the MA case manager so an unscheduled redetermination is initiated by CARES.
- Follow the steps outlined in this Policy Alert for all E-track redeterminations.

If the recipient will be at least 21 years old at the end of OHP eligibility, the recipient's MA eligibility must be redetermined for the appropriate adult category (e.g., blind or disabled adult, parent or caretaker relative of a minor child). CARES will generate an "age alert" one month before the child turns 21.

**NOTE: ALL CASE ACTIVITIES MUST BE FULLY NARRATED IN CARES.**

*Please direct questions concerning this Policy Alert to the DHMH Division of Eligibility Services at 410-767-1463. If you need assistance with CARES processing for these cases, you may contact Cathy Croghan-Sturgill at 410-238-1247.*

## INTRODUCTION

A The LDSS is responsible for determining eligibility for MA using policies and procedures which are supported by the Code of Maryland Regulations (COMAR). The Medical Assistance application form is the instrument through which information pertinent to making a determination of eligibility is gathered.

B DHMH publishes information sheets and maintains a website ([www.dhmh.state.md.us/mma](http://www.dhmh.state.md.us/mma)) about Medical Assistance. These resources provide information about eligibility, covered services, and the rights and responsibilities of applicants and recipients. In addition, the LDSS must make income and resource scales available to anyone requesting to see them. If anyone requests further information, the LDSS must provide it either orally or in writing.

Public  
Information

## GENERAL APPLICATION REQUIREMENTS AND PROCEDURES

The general 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 for them. These are addressed specifically under "Application Procedures for Institutionalized Persons."

**Persons Eligible for MA Without Filing a Separate Application**

E Individuals receiving Supplemental Security Income (SSI) or Temporary Cash Assistance (TCA) are eligible for Medical Assistance without having to file a separate MA application. Child Born On Or After 10/1/84 To A Mother Eligible For And Receiving MA

Certain newborns born on or after October 1, 1984 are automatically eligible for MA for a period of up to 12 months (end of the month of the 1st birthday). Requirements for coverage of the newborn under this provision are:

- The mother is eligible for and receiving MA on the day of the newborn's birth;
- The mother remains eligible for MA throughout the 12-month period; and
- The child is a member of the mother's household throughout the 12-month period.

The newborn's Medicaid coverage is tied to the eligibility of the mother and, therefore, no determination or redetermination of the newborn's eligibility is required in order to add the newborn to the currently eligible assistance unit and to certify the newborn on the MA eligibility file. Coverage of the newborn under this policy applies irrespective of any ineligibility factor that may pertain to the newborn.

If the mother is eligible for and receiving Medical Assistance (MA) or the Maryland Children's Health Program (MCHP) at the time of the birth, the child is certified in coverage group P03 (See MCHP COMAR 10.09.11.11B and MA COMAR 10.09.24.04D).

If the newborn is added to a TCA household, the automatic eligibility period (12 months) may be terminated by a change in circumstances of any family member, including the newborn, which changes the eligibility status of the mother, which in turn changes the automatic eligibility status of the newborn. The newborn's automatic eligibility status is also immediately lost if the child ceases living with the mother.

Automatic Eligibility of Members

Requirements for Coverage

Basis of Eligibility

Change in Circumstances

Upon expiration of the 12-month period at the end of the month of the 1st birthday (when there has been no change to precipitate an earlier termination or status change), the automatic coverage of the newborn expires. A redetermination of eligibility must be conducted to determine the family'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 period because of the linkage of the child's eligibility to that of the mother must be considered at this time.

Redetermination  
after 12 months  
coverage expires

NOTE: A MA ineligible child must be considered for possible coverage under the Maryland Children's Health Program (MCHP).

Certification Procedure for the Newborn Effective June 1, 1985

Effective 6/1/85, certification of a newborn on the Medical Assistance Master File will be initiated by the DHMH Office of Operations and Eligibility (OOE). This revised procedure, which will result in more timely certifications of newborns and fewer worker activities, must be followed by both hospitals and local departments.

The revised procedure is as follows:

- OOE will be notified by the hospital, via the DHMH 1184 (Hospital Report of Newborns), that a child has been born to a mother who is a Medical Assistance or MCHP recipient. OOE will certify the newborn on the Medical Assistance Master File using the mother's case number to establish a temporary case number (but there will be no CARES IRN for the child at this point) until the CARES interface assigns a permanent case number for the child.
- OOE will send a completed 1184 to the LDSS or LHD for eligibility processing, as appropriate.
- Upon receipt of DHMH 1184, the LDSS/LHD will take the following action:
  1. Review the case record to make certain eligibility existed for the mother on the date of the newborn's birth and that eligibility currently exists;
  2. Record certification of the newborn in the case record and on CARES (Add-a-Person);
  3. Review the 1184 for any errors or inconsistencies (name, address, eligibility dates, category codes, etc.) and take necessary corrective action as needed;

←  
Test For  
MCHP  
Coverage



2/88



4. In the instance where the MA/MCHP mother was eligible and on the MA Master File on the date of the child's birth but subsequently became ineligible, take appropriate action to cancel the case (including the newborn) in accordance with timely and adequate notice requirements. If the mother was certified under MCHP, see COMAR 10.09.11.11B; and
5. If there is a discrepancy between CARES and MMIS as to whether the mother was MA/MCHP eligible on the date of the child's birth, the LDSS/LHD will review the case record to determine the correct eligibility status and will then take the appropriate action.

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

No application is required to certify the newborn. Certification will begin no earlier than the date of birth and terminate 12 months following birth (at the end of the month of the 1st birthday). Automatic eligibility will also terminate when the mother is no longer eligible for MA or the child ceases to live with the mother. In these situations, 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 assistance unit.

#### Certification Procedure for the Newborn of a TCA Recipient

The TCA policy in regard to adding a newborn to the grant remains unchanged and is outlined in the TCA Manual. 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 Medical Assistance and certification for the mother and other eligible members of the TCA unit is 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 NPA-MA or MCHP for determination of retroactive eligibility.

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.

←  
Failure of  
Hospital  
to  
Initiate  
DHMH  
1184  
2/88  
←

D

**Persons Required to File An Application**

All persons requesting MA (or for whom MA is requested) who are not SSI or TCA recipients are required to file a written, signed application with the LDSS in order for an eligibility determination to be made.

C

**Request to File an NPA/MA Application With LDSS**

A person requesting to file an MA application must be given an opportunity to file. The application form must be made available to the person upon request.

Application Form Available Upon Request

In addition, the person must be provided assistance with completing and filing the application. He/she must be made aware of the significance of the date of application and its effect on retroactive eligibility, and be provided a list of basic information required, prior to or at the scheduled face-to-face interview.

Application Assistance

**Signature Requirements For Filing An Application**

F

Persons must be given the opportunity to file a written, signed application with the LDSS in the jurisdiction where their residence is located. A person who temporarily leaves the state but intends to return may apply by mail to the LDSS in the jurisdiction where his permanent residence is located.

How and Where to File An Application

Persons may mail the application or hand deliver it to the LDSS during regular agency operating hours, according to their preference.

In the case of a deceased person who did not apply before he/she died, a representative may complete, sign, and file an application on his/her behalf.

Deceased Persons

A written, signed application received by the LDSS (either by mail or in person) must be registered with an application date upon receipt. The LDSS must date stamp the application on the day it is received, even if the application is filed in a Maryland jurisdiction where the applicant does not live, as long as the applicant lives in another Maryland jurisdiction. There can be no delay in registering the application for any reason, including waiting until the face-to-face interview.

Determining the Date of Application

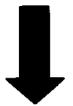
A signed application which is not completed to full specifications is still acceptable for the purpose of registering the application date. However, an application which has no signature does not constitute a valid application even if it is otherwise complete. Such an application must be immediately returned to the person with an explanation of the reason for the return and will not be registered with an application date until it is signed and returned to the LDSS. Refer to appropriate section for signature requirements for eligibility purposes.

Signature Requirement For Filing Purposes

**Voluntary Withdrawal**

H

A person who has filed an application may voluntarily withdraw that application. The application form, however, remains the property of the LDSS. The withdrawal of an application does not alter a penalty period associated with the disposal of a resource.



5/89

The period under consideration for a reapplication (reactivation) must be established in accordance with procedures in Policy Alert 04-1 (Revised 10/87).

When an applicant formally withdraws an application, they cannot subsequently be forced to apply for Medical Assistance for a prior month for which they do not want coverage. However, neither are they free to make multiple applications in order to shift months from the current period into a retroactive period. Setting the period under consideration is designed to prevent manipulation such as this. Therefore, any applicant who formally withdraws an application and subsequently applies for a later period only, should have their period under consideration set by the latter, not the withdrawn application. If a subsequent application includes the month of the prior withdrawn application, the original application is reactivated and sets the period under consideration.

**ELIGIBILITY DETERMINATION PROCESS**

Once an application has been filed with the LDSS and the date of application has been established, the process of determining eligibility, with its time limitations, begins.

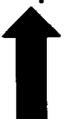
J(1)

The LDSS must make a prompt decision on each application that is filed. The decision must be made no later than 30 days from the date of application or, if the case involves a determination of disability, no later than 60 days from the date of application. Refer to section entitled "Extension of Time Standards" for exceptions to this rule. The 30 and 60-day time limits refer to the date the notice of decision is actually mailed to the applicant.

Time Limit for LDSS

A decision of eligibility or ineligibility is based on MA policy and procedures. Persons who apply as ABD are SSI-related and the eligibility requirements are basically those of the SSI program. Persons who apply as FAC are TCA related and the eligibility requirements are basically those of the TCA program (previously AFDC). A single assistance unit may not be a combination of the two.

Program Comparability



2. Apply the provisions of COMAR 10.09.24.04J(4) on Extension of Time Limits. Extending the time limits of the application means the application may remain pending beyond the 30-day time limit so long as the person continues to express the intent to enter an LTCF. If the extension of time limits is applied, the person must be sent written notice of this action. The case remains in pending status and eligibility is determined when the person is admitted to the LTCF. If the person does not enter the LTCF by the end of the period under consideration, an eligibility determination must still be made for that period.

One of the options above must be selected and should be used consistently within a given local department. An application for Medical Assistance may not be denied because the applicant is not institutionalized. Failure to enter an LTCF is not a basis for a person being determined ineligible.

**Admissions to Long Term Care Facilities for  
Anticipated Stays of Less Than 30 Days**

The policies in this section do not apply to persons institutionalized for more than 30 days or who were admitted with the expectation that they would be institutionalized for more than 30 days. Since these persons are considered institutionalized, a LTC application is required, and a DES 501 form would not be used.

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, eligibility is determined for community Medical Assistance under COMAR 10.09.24.09. Because this is not a LTC case, the applicant is not entitled to a residential maintenance allowance, and the spousal impoverishment provisions do not apply. If a financially-eligible person meets the medical eligibility criteria, as determined by the Medical Assistance Utilization Control Agent, for the services being rendered by the particular facility, MA will cover the cost of care for that person.

For persons enrolled in HealthChoice, the Managed Care Organization (MCO) is responsible for the charges during the first 30 days in a nursing home, chronic care hospital, or rehabilitation facility; therefore, the facility must bill the MCO.

The LDSS Case Manager will be notified by the LTCF 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 both be included on the same form so the stay of less than 30 days will be apparent. "Initial Placement" should be checked in field 8, and "Returned to Community" should be checked in field 12.

When a DHMH 257 is received by the LDSS from the LTCF verifying a total stay of less than 30 days, and the person has been determined eligible for Community Medical Assistance and was not enrolled in an MCO on the date of admission, complete the DES 501. Attach the DHMH 257 and forward both to:

**Department of Health and Mental Hygiene  
Division of Recipient Eligibility Programs  
LTC/Special Projects Unit  
201 West Preston Street, Room SS-7C  
Baltimore, Maryland 21201**

This procedure will enable payment to be made to the LTCF for brief admissions for fee-for-service (non-HealthChoice) recipients.

**Spend-Down in LTCF**

If the LDSS determines that an applicant's income exceeds the Medical Assistance standard, use the daily costs incurred in the LTCF towards spend-down. The facility will need to provide a bill to itemize the cost of care, ancillaries, and other medical expenses on a day-by-day basis. These applicants may then establish eligibility under the spend-down provision, but will be responsible for a portion of their expenses. A person certified under spend-down based on expenses incurred while in the facility must pay the facility the excess income remaining on the date spend-down was met (the first day of eligibility) as well as the charges used to meet spend-down prior to eligibility. Enter on the DES 501 the applicant's spend-down amount as of the date of eligibility. When eligibility is established, complete the DES 501 to enable payments to the facility.

**Medicare Coverage for MA Community or QMB Recipients in LTCF for Skilled Care**

Medical Assistance is obligated to pay Medicare co-payment days for any MA or QMB eligible recipient who is dually eligible for Medicare. When a community MA or QMB recipient enters an LTCF on Medicare days, the admission should be reported to the LDSS within 10 days, as with any other change in the case. If the recipient is on Medicare co-pay or needs MA to assist with the cost of the Medicare deductible, the LTCF must send a DHMH 257 to the LDSS. The 257 does not require UCA approval since Medicare's UCA has already determined the person's level of care as either skilled or chronic. After receiving the 257 requesting Medicare co-payment, the LDSS will issue a DES 501 to begin co-pay or begin pay effective the date specified on the 257. No further action is required of the LDSS. However, it is recommended that a long-term care application be filed before the 30th day in the LTCF, because the recipient may not require a skilled level of care paid by Medicare for the full 100 days of potential Medicare coverage. Eligibility for long-term care Medical Assistance should be evaluated on a case-by-case basis, so that it may take effect when Medicare coverage ends.

A MA or QMB recipient residing in a LTCF under full Medicare or Medicare co-pay can reside in the facility up to 100 days without being required to file an application for MA LTC. Therefore, if Medicare co-payment days go beyond the 30th day in the LTCF, MA will continue to cover the Medicare co-pay without the need to file a LTC application.

If the individual requires LTCF services beyond the 100 days of Medicare co-payment and is requesting MA payment towards the cost of care, the procedures in Chapter 10 of the MA Eligibility Manual must be followed. A long-term care application for Medical Assistance must be filed in a timely manner. The facility must send the DHMH 257 to Delmarva for a level of care determination for days not approved for Medicare coverage.

**Recipients Admitted to a LTCF**

For persons who were financially eligible for Medical Assistance when admitted to the facility, eligibility will not need to be reevaluated. A person who is already a recipient of community Medical Assistance or QMB at the time of admission to the LTCF will remain eligible throughout the month of admission and will have no income applied to the cost of care.

The above procedure does not apply to those who were admitted and determined eligible for MA under Chapter 10 based on the expectation that they would be institutionalized for 30 days or more, but who were unexpectedly discharged in less than 30 days.

Change in Level of Care

An increase in level of care will not affect MA eligibility or available income.

If a person's level of care is reduced to less than intermediate, the person no longer has a medical need for LTC. The LDSS may not cancel payment to the facility based solely on the reduced level of care until the facility notifies the LDSS that the patient has been discharged, or the LDSS determines that the patient is otherwise ineligible. The Program will continue to make payments to the LTCF at the facility's lowest rate so long as the facility documents, to the satisfaction of the UCA, that it is looking for suitable placement for the patient. Eligibility may be continued as long as this condition is met.

Medicare Coverage

A person who has Medicare may be eligible for Medicare to pay all or part of the LTC expenses. Partial coverage of the LTC expenses is referred to as "co-pay," meaning Medicare will pay a portion of the daily rate, and the remainder is the "co-pay" rate (the amount to be paid by the person, the Program or other insurance). Medicare will pay LTC expenses only for a person who requires skilled or chronic care and only for a limited period of time.

There is **no action required by the LDSS when an LTC MA recipient begins or ends Medicare coverage.** However, if an **applicant** is determined eligible for MA long-term care and needs coverage of Medicare co-pays or the cost of the Medicare deductible, the LTCF must send a 257 to the LDSS. The 257 does

not require UCA approval since Medicare's UCA has already determined the person's level of care as either skilled or chronic. Upon receipt of the 257 request to begin Medicare co-payment, the Case Manager must enter following onto the "INST" screen:

- o Enter "NH" under the "Inst Type" field.
- o Enter the date of entry under the "Entry Date" field.
- o Enter "S" under the "Level" field.
- o Enter the requested begin payment date under the "LTC Payment Auth Date" field.
- o Enter "A" under the "Medicare Cert" field.

On the "DEM1" screen, under "Living Arrgmt," enter "SN" for skilled or "CC" for chronic care. When the Medicare co-payment period has ended, **no action is required by the LDSS.**

Transfer From One LTCF To Another

An institutionalized person may transfer from one LTCF to another. The former LTCF should notify the LDSS by a 257 that the person has been discharged to another facility. The new LTCF must notify the LDSS of the admission date by a 257. The LDSS must enter the appropriate discharge date from the former facility to the new facility on the "INST" screen.

If the discharging facility fails to issue a 257 prior to receipt of the 257 from the new facility, do not delay entry of the admission date if a valid 257 confirming the admission is received from the new facility. In the absence of the discharging 257, use the date of admission to the new facility as the date of discharge.

Please note: the process of transferring from one facility to

another will take 2 days to complete. First, the Case Manager must enter the date of discharge from the previous facility onto the "INST" screen. Secondly, the Case Manager must send an Alert (745) for the next day to go back onto the "INST" screen and enter the new facility's information on the line below the previous facility's information. The second action must take place after over-night batch was run so that the leave date from the previous facility can be committed to CARES before the new information is received.

For the month of a recipient's transfer from one LTCF to another, the discharging facility is paid the recipient's available income for the cost of care, and the admitting facility is not paid a client contribution.

**COMAR 10.09.24.03-2**  
**Coverage Group for Women with Breast or Cervical Cancer—**  
**Eligibility, Determination, and Covered Services Process.**

of the Social Security Act;

(4) Medicare buy-in for Medical Assistance payment of Medicare premiums, copayments, and deductibles for Medicare eligible persons;

(5) Program of All-Inclusive Care for the Elderly; or

(6) Coverage for services in a long-term care facility exceeding 30 consecutive days.

COMAR 10.09.24.14-1

ABUSE

C. Procedures.

- (1) The Division of Utilization and Eligibility Review, Medical Care Compliance Administration, shall determine whether recipient abuse exists using the procedures in §C(2)-(8) of this regulation.
- (2) Cases may be reviewed on the basis of statistical reports, outside complaints, referrals from other agencies, or other appropriate sources.
- (3) A preliminary review shall be conducted to determine whether the recipient's alleged or noted behavior is of the form specified under §A(1)-(3) of this regulation or is of the form specified under §A(4) of this regulation.
- (4) If the alleged or noted behavior is one of the types listed in §A(1)-(3) of this regulation, all relevant and available information shall be forwarded for medical review as specified under §B(5) of this regulation.
- (5) If the alleged or likely behavior is of the type listed in §A(4) of this regulation, all relevant and available information shall be forwarded for administrative review as specified under §C(7) of this regulation.
- (6) When a case is referred for medical review, a medical professional employed by the Program shall determine whether the recipient's use of medical services constitutes abuse, as defined under §A(1), (2), or (3) of this regulation. The medical reviewer shall consider all relevant and available information including Program payment records and information secured from interviews, if conducted, in making a decision. The reviewer may, when appropriate, obtain records from other sources, including providers of medical services.
- (7) When a case is referred for administrative review, a determination shall be made by the Chief, Division of Utilization and Eligibility Review, or his designee, regarding whether the recipient's use of benefits constitutes abuse as defined under §A(4) of this regulation.
- (8) If a recipient has been convicted of a crime involving use of Medical Assistance benefits, as defined in §A of this regulation, the Program may consider the recipient to have committed abuse as described under §A(4) of this regulation.

## COMAR 10.09.24.14-1

### ABUSE

- D. Notice. A recipient determined to have abused the Program shall receive notice to that effect. Notice includes the following:
- (1) A statement of the reason or reasons why the recipient was found to have abused the Program;
  - (2) A statement that the recipient will be enrolled in the Corrective Managed Care Program and the effective date and duration of that enrollment;
  - (3) A statement regarding an opportunity to provide additional information which will be considered before enrollment becomes effective;
  - (4) A statement regarding an opportunity to identify a preference for an assigned primary medical care provider or pharmacy; and
  - (5) A statement of appeal rights under Regulation .13 of this chapter.
- E. Consideration of Recipient Information.
- (1) Additional information received from the recipient under §D(3) of this regulation is considered relative to the appropriateness of the recipient's enrollment in the Corrective Managed Care Program.
  - (2) Notice of the Program's determination regarding the additional information shall be sent to the recipient by the Department. The notice shall either confirm or reverse the decision to enroll the recipient.
  - (3) Information received from the recipient under §D(4) of this regulation is considered relative to the designation of a primary medical provider or pharmacy in accordance with §G(7) of this regulation.
- F. Corrective Managed Care Program. **(Note: This program was discontinued when HealthChoice managed care was implemented in 1996.)**
- (1) A recipient determined to have abused the Program shall be enrolled in the Corrective Managed Care Program in which the recipient shall be required to meet the requirements of §F(1)-(3) of this regulation.