MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE IN A NURSING FACILITY

A. GENERAL DESCRIPTION

The following describes coverage groups of eligibles who reside in an institution and who expect to remain in the institution for a period of time that equals or exceeds the long term care requirement as described below.

1. Institution Defined

Institutions, as referred to in this section, are medical institutions including hospitals, nursing facilities, intermediate care facilities for the mentally retarded, residential psychiatric facilities and swing-bed facilities.

2. Long-Term Care Defined (42 CFR 435.622)

Long-Term Care (LTC) is defined as a period of 30-consecutive days or longer in a medical institution. A period of 30-days begins with the day of admission and ends as of 12:00 midnight on the 30th day following admission; thus, 30-consecutive days equals 31 days.

Exception: The only exception to the fulfillment of the 30-consecutive-day requirement is if an applicant dies within the 30-day period while in a medical facility. In the instance of death, assume the applicant would have remained in the medical facility for 31 days.

3. Temporary Absence & the 30-Day Period

Applicants or recipients who transfer from one medical facility to another must maintain continuity of "patient" status to avoid an interruption in the fulfillment of the 30-consecutive-day requirement. A temporary absence is allowed from a medical facility provided there is continuity of "patient" status. The following guidelines have been developed to determine if the 30-day period is affected when a temporary absence occurs:

a. When a client is discharged from one medical facility and travels directly to another facility, there is no break in continuity and the 30-day period is not affected. The time spent in the first facility will count toward the 30-consecutive-day calculation. The means of transportation from one facility to the other is irrelevant. If an overnight stop is required due to the distance between the two facilities, this would still be considered direct travel. If distance is not a factor, a client with no break in continuity would require "same day" discharge from one medical facility (such as a hospital) and entry into another medical facility (such as a nursing home).

b. When a client is discharged from one medical facility and returns home or elsewhere before entering another medical facility, then there is a break in continuity and the 30-consecutive-day calculation begins over again at the time the client enters another medical facility. The length of the home visit is irrelevant.

Unless or until a facility discharges a client, the temporary absence provision described above does not apply. A temporary absence that a nursing home client is allowed due to therapeutic leave and/or hospital leave is not an eligibility issue unless the facility discharges the patient during such an absence.

4. Special Income Limit for LTC Clients (42 CFR 435.1005)

The 30-consecutive day requirement applies to those individuals who would not be eligible for Medicaid at-home as either SSI, MAO (any full service coverage group) or AFDC eligible but who would be eligible for Medicaid using a special income limit reserved only for long term **c**are applicants/recipients. This special income standard, as established by federal regulation, cannot exceed 300% of the SSI full benefit amount payable to an individual in his own home.

Individuals who are ineligible for Medicaid outside an institution must fulfill the 30-consecutive day requirement before eligibility can be established for long term care.

If an individual is already Medicaid eligible upon entry to an institution, the 30-consecutive day requirement is not applicable, however, a level of care decision as outlined in "Physician Certification" procedures may be required as specified in the discussion of institutional coverage groups below.

5. MAO LTC "Coverage Groups"

Individuals who are in LTC are placed in one of three coverage groups specified in federal regulation for statistical purposes.

a. 42 CFR 435.211 - Individuals in institutions who would be eligible for cash assistance if they were not in an institution. These clients are referred to as "SSI-eligible at-home" based solely on the client's own total income less a $20 income disregard.

b. 42 CFR 435.236 - Individuals in institutions who are eligible under a special income level. These are clients who would not be eligible for SSI at-home but whose income is below the 300% of the SSI limit set as the institutional maximum income limit.

c. 42 CFR 435.132 - Institutionalized individuals who were eligible in December, 1973. Clients in title XIX facilities for who vendor payments were made for the month of 12/73 who remain in the facility and continue to meet 12/73 eligibility standards and who continue to need institutional care must be reviewed under 12/73 resource criteria if found ineligible using current SSI-related resource criteria. Refer any such cases to the State Office for review prior to closing the case.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE ALTERNATIVES PROGRAM

1. **Long Term Care Alternatives Program**

P.L. 43-13-117(9), as passed by the 1999 Legislature requires the Division of Medicaid (DOM) to develop and implement an information, education and referral program for long term care alternatives. The DOM has contracted with the local Area Agencies on Aging (AAA) to contact Medicaid beneficiaries and applicants who apply for admission to nursing facilities. An evaluation will be completed to determine if the individual's required level of care could be appropriately and cost effectively managed in their home or in a community-based setting. If services are available either in the home or community, the individual can choose a home and community based alternative to nursing facility placement. However, the individual is always free to choose nursing facility care. Placement in a nursing facility will not be denied by the DOM if more appropriate alternatives to nursing facility care are available, or if the individual chooses not to receive the appropriate home and community-based services. The individual will also be advised if appropriate home or community-based services are not available in their community.

The DOM will provide through a yearly contract with the AAA, a program of information, education and referral to Medicaid beneficiaries and applicants about their alternatives to nursing facility care. The following procedures will be followed for individuals applying for admission to a nursing facility:

1. The Level Physician's Certification for Nursing Facility Care and MI/MR Screening (Form 260NF Revised 8/99) is completed and signed by a physician certifying that nursing facility placement is appropriate for the individual. The 260NF must be completed on all individuals applying for nursing facility placement regardless of source of payment. (42 CFR 483.40).

2. If the physician determines that the individual has a diagnosis of mental illness or mental retardation, a Level II evaluation must be conducted by a community health center for MI or a regional retardation center for MR. (42 CFR, Part 483, Subpart C)

3. Within twenty-four (24) hours of completion of the 260NF that does not require a Level II evaluation, a legible copy must be faxed to the DOM State Office in Jackson. A 260NF that requires a Level II evaluation will not be submitted to the DOM until the Appropriateness Review Committee (ARC) with the Department of Mental Health has approved the individual for nursing facility placement. The ARC will communicate this decision to the provider who originated the 260NF. The LTC fax number is 601-359-1383.

4. Upon receipt of the 260NF the DOM will perform the following activities:

   a. The DOM will determine the completeness of the 260NF and if incomplete, will contact the physician or provider who submitted the form to complete and re-submit.

   b. The DOM will determine through the Medicaid Management Information System (MMIS) if the individual is a Medicaid beneficiary or if the individual has an application pending for Medicaid.

   c. The DOM will identify the AAA that is closest to where the Medicaid beneficiary or applicant resides.

   d. The DOM will record the data from the 260NF and MMIS on a long term care assessment instrument.

   e. Information derived from the DOM assessment will be entered into the LTC Alternatives database.

   f. The DOM will fax a copy of the 260NF and DOM assessment to the AAA Case worker.

5. Upon receipt of the 260NF and DOM assessment, the AAA case worker will perform the following activities:

   a. The case worker will log receipt of the 260NF and DOM assessment, create a hard copy file and will enter the information into the LTC Alternatives database.

   b. Within two hours (2) business days the case worker will set up a personal appointment with the Medicaid beneficiary, applicant or the individual's legal representative; or will conduct a telephone interview to assess the individual's interest in LTC alternatives. The time limitation will be waived in cases of extreme hardship.

   c. The case worker will complete the LTC questionnaire with the individual which will provide the case worker general information necessary to discuss alternatives to nursing facility placement.

   d. The case worker will explain to the Medicaid beneficiary or applicant that they are free at any time to discontinue the process for exploring LTC alternatives.

   e. If the Medicaid beneficiary or applicant is in a hospital, the AAA case worker will contact the discharge planning team to provide information about LTC alternatives in the community, and will coordinate efforts necessary in order to avoid duplication of hospital discharge planning procedures.

   f. The AAA case worker will provide information and eligibility requirements of the Elderly and Disabled Home and Community-Based Services Waiver (HCBS). The worker will also discuss other alternatives to nursing facility placement if those services are available in their community.

   g. The AAA case worker will inform the individual of a proposed plan of care for services available if minimum program requirements for community services can be met.

h. If the individual chooses the HCBS waiver program, a referral will be made to the AAA Waiver Case Managers who will conduct a comprehensive assessment. If the program requirements can be met, the assessment and plan of care will be submitted to the Community Long Term Care Division at the Division of Medicaid for final review and approval.

i. If the minimum program requirements cannot be met for HCBS waiver programs, the AAA Waiver Case Manager will inform the individual of the decision. It will then be the case worker's responsibility to inform the individual of other possible LTC alternatives that are available in their community.

j. The AAA case worker will make an appropriate referral to an assisted living facility or a personal care home if the individual chooses this type of alternative to nursing facility placement. The individual will also be informed of any other services that could be provided, depending upon the individual's needs.

k. The individual will be offered an opportunity for a fair hearing if not given the choice of home or community-based services as an alternative to institutional care.

l. If the individual chooses nursing facility care, no further contact is required of the AAA case worker.

m. Upon final completion of the referral, the AAA case worker will enter the disposition of the referral in the AAA LTC Alternative database and will fax a copy of the referral disposition to the DOM. The DOM will enter the disposition of the referral in the DOM LTC Alternative database.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE IN A NURSING FACILITY

B. LONG TERM CARE IN A HOSPITAL (ACUTE CARE)

Individuals admitted to a title XIX approved hospital who remain in the facility without a break in patient status for 30 consecutive days or longer are considered long-term hospitalization patients. These individuals may apply for Medicaid benefits and be tested against the higher income limit applicable to long-term care applicants provided the individual is eligible on all factors other than income and fulfills the 30-consecutive-day requirement prior to approval of the long-term hospitalization application.

The following "exceptions" apply to those who are in "acute care only" meaning there are no plans to enter LTC in any other type of institution, such as a nursing facility:

- Obtaining a Physician's Certification (Form DOM-260) verifying level of care is not required prior to approval of a long term hospitalization application. Acute care status is approved by the peer review agency that certifies hospital admissions. These certifications are verified as claims are submitted.

- The Transfer of Assets policy provision does not apply to those who apply only for long term hospitalization (refer to the Institutionalization Section).

- Spousal Impoverishment rules apply to long term hospitalization applicants with a community spouse (refer to the Institutionalization Section).

- For clients who are already Medicaid eligible upon entering a hospital (in or out of State), there is no requirement to change the source of eligibility if the client remains in acute care only. An application for long term hospitalization would be required only if the source of eligibility terminates while the client is in acute care. For example, if SSI terminates while an SSI client is in acute care, then a separate application for LTC would be required.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE IN A NURSING FACILITY

1. Requirement Filing of LTC

All applications for long-term hospitalization must be filed in a timely manner since eligibility for Medicaid can be determined no more than 3 months prior to the month an MAO application is filed. For example, if a long-term hospitalization applicant enters a hospital January 25 and remains hospitalized until March 1, the deadlines for filing an MAO application would be: April 30 in order for eligibility to be determined retroactive to January; or May 31 in order for eligibility to be determined retroactive to February, etc.

2. Verification of Continuing LTC Status

Once a long term hospitalization application is approved, the worker must contact the hospital on a monthly basis to on a monthly basis to determine if the client remains in the hospital. The contact, which must be documented in the case record, is required at least monthly until the hospital verifies (verbally or in writing) that the client has been discharged.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE IN A NURSING FACILITY

C. LONG TERM CARE IN A NURSING FACILITY

Individuals admitted to a title XIX approved nursing facility or ICF-MR, must be approved for the level of care which they will receive as outlined in the Institutionalization Section. This means an approved Physician's Certification DOM-260 Form must be received from the nursing facility prior to approval of a LTC application.

EXCEPTIONS: No DOM-260 is required for the following LTC admissions:

- Children who enter Psychiatric Residential Treatment Facilities (PRTF),

- Swingbed admissions,

- Long Term Hospitalization admissions,

Individuals who are approved for their level of care and remain in a nursing facility for 30 consecutive days or longer may apply for Medicaid and be tested against the higher income limit applicable to institutionalized clients. All nursing home clients must be eligible based on all factors of eligibility including:

- The transfer of assets policy provision applies to all applicants and recipients of LTC in a nursing facility. Refer to the Institutionalization Section.

- Spousal Impoverishment rules apply to all LTC applicants who have a community spouse (refer to the Institutionalization Section).

When a Medicaid client who is eligible at-home enters a nursing facility, a change to MAO LTC is required in order to place the needed Liability and LTC information in MEDS to authorize the vendor payment to the facility. In order to authorize the vendor payment, follow the procedure applicable to the case.

MAO COVERAGE GROUPS/CRITERIA FOR THE AGED & DISABLED
MAO LONG TERM CARE IN A NURSING FACILITY

1. SSI Eligible Enters NF

If an SSI eligible enters a Nursing Facility (NF) and the individual will remain SSI eligible while in the facility, no new application for Medicaid is required. The client remains eligible as "SSI-only." If SSI terminates, an application for MAO LTC is required. Refer to the Institutionalization Section for complete instructions for handling SSI-only and SSI to MAO cases.

2. DHS Eligible Enters NF

If a child eligible through DHS enters a Nursing Facility (NF) for less than 31 days, no new application for Medicaid is required. The child remains eligible through DHS. If the child will remain in the facility beyond 31 days, an application for MAO LTC is required. Refer to the Institutionalization Section for complete instructions for handling DHS children that enter nursing facilities. If the child enters a PRTF, no new application is required regardless of the length of stay.

3. Adult Eligible Enters Out-of-State NF

An adult client who enters an out of state nursing facility facility whose residence will change may require a coverage group change to MAO LTC so that payment can be authorized until the case can be closed (after advance notice).

4. Child Enters PRTF

When a child is admitted to a Psychiatric Residential Treatment Facility, whether in-State or out-of-State, and the child is Medicaid eligible through any category of eligibility (AFDC, Foster Care or any type of DHS eligibility category or SSI) then no separate application for Medicaid as MAO is required. The child is eligible for PRTF admissions for the full length of single or multiple admissions as long as the source of eligibility remains open. This means that no DDS decision is required for DHS children entering a PRTF. If eligibility terminates from the original source, then the child must become eligible under another DHS category or apply as MAO (in which case a DDS decision would be required).

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D. LONG TERM CARE IN A SWINGBED

Rural hospitals with less than 100 beds may be reimbursed under the appropriate program for furnishing skilled services to Medicare or Medicaid recipients and intermediate services to Medicaid recipients. Approved hospitals may use their beds interchangeably as either hospital, skilled or intermediate beds, with reimbursement based on the specific type of care provided. In effect, the beds "swing" between the types of care provided; thus, the term swing bed was originated.

Application processing for a swingbed applicant is handled the same as for a nursing facility applicant with the following exceptions:

- No DOM-260 Form to verify Physician Certification is required.

- The facility must issue a DOM-317 to the Regional Office only if the facility plans to bill Medicaid for the swingbed stay. If the facility will only bill Medicare for the swingbed stay, no 317 is required for Medicaid purposes. If the individual needs Medicaid for Medicare cost-sharing purposes, then an application for LTC hospitalization may be necessary.

1. 30-Consecutive Day Requirement

Ongoing policy regarding institutional eligibility applies for swing bed applicants, i.e., all financial and non-financial eligibility factors must be met. If an application is to be approved prior to fulfillment of the 30-consecutive day requirement, a doctor's statement is required for the case record attesting to the fact that the patient is expected to remain hospitalized for 30-consecutive days or longer. The statement must be documented in the case record in the form of a written statement of telephone contact specifying the doctor's name and date of contact.

The swing bed patient's most recent admission date to the hospital counts toward the fulfillment of the 30-consecutive days requirement. A patient may spend several days as a regular inpatient in the swing bed hospital or may be an inpatient in another hospital and transfer directly to a swing bed hospital before the hospital designates the patient as a swing bed patient. Any time spent as a regular inpatient with no break in continuity of patient status will count toward the 30-consecutive day requirement.

2. Verification of Continuing LTC Status

The Regional Office worker is required to contact the swing bed hospital each month to verify whether the recipient continues to be a patient in the hospital until Form DOM-317 is received indicating discharge, transfer to a nursing home, etc. It is not necessary to verify whether the patient is in swing bed or inpatient status. The purpose of the contact is only to verify the patient remains hospitalized. The contact must be documented in the case record.

3. Swingbed Patients Currently Eligible for Medicaid

If a swing bed patient is already receiving Medicaid upon upon admission to the hospital via SSI, DHS or MAO at-home eligibility, a change to MAO LTC is required if the facility plans to bill Medicaid, for the swingbed stay. If the facility will bill only Medicare, it is not necessary to place Liability and LTC information on file for clients who are already Medicaid eligible for full services or QMB.