17.1 INTRODUCTION

This Chapter describes the Department's policies and procedures for determining long-term care eligibility. Nursing facility (long-term care) services are provided to eligible Medicaid individuals who reside in a nursing care or ICF/MR facility.

In addition to providing nursing facility services to eligible Medicaid recipients, two coverage groups are eligible for alternative long-term care services by virtue of their need for nursing care and the availability of home-based or community-based nursing care services. These two coverage groups are part of the same Title XIX Waiver, even though they were begun at different times. The coverage group for elderly or disabled people is the HCB Waiver; the other is for mentally retarded or developmentally disabled individuals who live in facilities within their own communities and is the MR/DD Waiver.

Certain programs, such as MR/DD, HCB Waiver and ICF-MR, require a medical and/or other determination by a community agency or government organization, other than DFA and a financial determination by an Income Maintenance Worker. When an applicant's medical eligibility for, or enrollment in, these programs is pending due to the lack of a waiver slot or other reason, he must not be refused the right to apply, but must be evaluated for any or all DFA programs.

This Chapter is organized the same way the entire Income Maintenance Manual is. Information in other sections of the Manual that also apply here are not repeated. Instead, reference is made to such information.

In determining eligibility for payment of nursing or alternative care, the Worker must ensure that the client, or his representative, is fully informed of the policies and procedures. This is necessary so that the client, his family or his representative is able to make informed decisions about the client's financial affairs.

However, the Worker must not, under any circumstances, suggest or require that the client, or representative, take any specific action in financial matters. The Worker must not act as a financial planner or make suggestions about the client's current or future financial situation. This includes comments about Estate Recovery. The Worker may respond to general questions, but must refer the client, or representative to BMS, for specific information. The Worker must not contact BMS on behalf of the client, but must refer the client or representative to BMS.

The Worker must refer all inquiries about billing issues from the nursing or ICF/MR facility to the LTC Unit in BMS. The Worker must not contact BMS on behalf of the provider, but must refer the provider to BMS.

Questions from county staff about any aspect of long-term care cases must be directed to the Economic Services Policy Unit in DFA, not to BMS.

NURSING FACILITY SERVICES

17.2 APPLICATION/REDETERMINATION

A. THE APPLICATION PROCESS

The application process for payment for nursing facility services is the same as the application process for the appropriate coverage group outlined in Chapter 1 with the following exceptions:

1. When the Department Participates in Payment

The Department participates in the payment of nursing facility services when it is established that:

The patient is Medicaid eligible or, if he must meet a spenddown, the monthly spenddown amount is equal to or less than the facility's monthly Medicaid rate.

Nursing facility care is medically necessary.

He is receiving care in a certified and Department-approved nursing facility.

2. Date of Eligibility

Payment for nursing facility services begins on the earliest date the three following conditions are met simultaneously:

- The client is eligible for Medicaid; and

  NOTE: If the client is eligible as an SSI-Related Medicaid client, his monthly spenddown is presumed to be met when the cost of his nursing facility care at the Medicaid rate exceeds his spenddown amount. Thus, his Medicaid eligibility begins the first day of the month of application or the first day of the month, up to 3 months prior to the month of application, when coverage is backdated.

- The client resides in a Medicaid-certified nursing facility; and

  There is a valid PAS or, for backdating purposes only, physician's progress notes or orders in the client's medical records.

  Section 17.11 contains specific information about the PAS and details specific situations in which the progress notes or orders are used. Additional examples are also found in Section 17.11.