

Policy Guidance

Eligible Individual-Revised

Length of time required in an Inpatient Facility
Medicaid Eligible- days required for eligibility



May 17, 2010

1. Length of time required in an Inpatient Facility

The purpose of this guidance is to provide clarification on statutory changes affecting the eligibility criteria for an individual to become a MFP participant and transition out of an institutional setting into home and community-based services under this demonstration.

Guidance: *Health Care Reform Act, Section 2403*“*Money Follows the Person Rebalancing Demonstration*”-- The Statute changes the number of institutional days required prior to transition.

Section 2403 of the Patient Protection and Affordable Care Act (PPACA) amended Section 6071 of the Deficit Reduction Act of 2005(DRA), the Money Follows the Person Rebalancing Demonstration.

(2) ELIGIBLE INDIVIDUAL – The term ‘eligible individual’ means, with respect to an MFP demonstration project of a State, an individual in the State--

*{The definition of an “eligible Individual,” in Section (b)(2)(A) of the DRA was amended **by striking** in (Bold)}*

Striking

(A) who, immediately before beginning participation in the MFP demonstration project--
(i) resides (or has resided, **for a period of not less than 6 months or such longer minimum period, not to exceed 2 years, as may be specified by the State** in an inpatient facility.

*{Section 2403 of the PPACA **replaces** that language and it **now reads-** in (Bold)}*

Replacing with

(i) resides (or has resided, **for a period of not less than 90 consecutive days** in an inpatient facility. **“Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i).”**

Background:

The language “short term rehabilitative services” is not defined in Medicare law or regulation. Since the purpose of the MFP program is to increase the use of home and community-based rather than institutional *long-term* care services, in determining whether an individual meets the length of stay requirement cited above it is appropriate for States to exclude Medicare covered post-hospital rehabilitative care that is expected to be short-term in nature. Individuals admitted to an institution solely for the purpose of receiving short-term rehabilitative services are those who are not anticipated to require long-term care services and thus would not be appropriate for inclusion in MFP.

Under Medicare, hospital insurance benefits under Part “A” include coverage of post-hospital extended care services, which can be skilled nursing services or skilled rehabilitative services, for up to 100 days during any spell of illness. Skilled rehabilitation services must be ordered by a physician and must require the skills of technical or professional personnel, such as physical therapists, occupational therapists and speech pathologists or audiologists, must be required on a daily basis and must be services that as a practical matter can only be provided in a skilled nursing facility (SNF) on an inpatient basis.

For the first 20 days of a stay that meets the level of care and other Medicare coverage requirements, Medicare pays for all covered services. For the 21st through the 100th day, Medicare pays for all covered services except for a daily coinsurance amount. The Medicare regulations provide examples of skilled nursing services and skilled rehabilitation services at 42 C.F.R. Section 409.33.

See publication no.CMS-10153, entitled "Medicare Coverage of Skilled Nursing Facility Care," which provides a basic overview of the SNF benefit under Medicare Part A and is available online at www.medicare.gov/Publications/Pubs/pdf/10153.pdf

CMS Guidance:

CMS has identified the following criteria for States to apply in determining whether to exclude days from the “90 consecutive inpatient facility days” required for MFP eligibility.

- States should review the admission to the SNF to determine if it meets all the criteria for Medicare coverage of post-hospital extended care services, including those summarized above. If the admission does not meet these criteria and/or Medicare coverage is not provided, the State should not exclude days;
- States should verify on the basis of admission records and any other appropriate records that the patient’s admission is solely for the purpose of receiving skilled rehabilitative services that meet the Medicare coverage criteria. The patient’s plan of care should indicate that the patient is expected to be discharged at the end of the Medicare coverage period;

- If Medicare does provide coverage of all or part of the services provided in the SNF, but the services the individual received were skilled nursing services and not skilled rehabilitation services, as indicated by appropriate records, the State should not exclude those days. States may refer to 42 C.F.R. section 409.33 for examples of services that are considered skilled nursing services but not skilled rehabilitation services;
- If, the inpatient days are in a skilled nursing facility the following definition applies (Section 1819[42 U.S.C. 1395i-3])
 - (a) ***Skilled Nursing Facility Defined.***—In this title, the term “skilled nursing facility” means an institution (or a distinct part of an institution) which—
 - (1) is primarily engaged in providing to residents—**
 - (A) skilled nursing care and related services for residents who require medical or nursing care, or
 - (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,**
 - and is not primarily for the care and treatment of mental diseases;

2. ***Medicaid Eligible- days required for eligibility***

Section 6071 of the DRA (b)(2)(A)(ii) defines who is eligible to become an MFP participant. Sub-section (ii) defines an eligible participant as one who is receiving Medicaid benefits for inpatient services immediately prior to participation in the MFP demonstration.

- (A) who, **immediately before beginning participation in the MFP demonstration project--**
 - (ii) is receiving Medicaid benefits for inpatient services** furnished by such inpatient facility;

Previous MFP guidance required that a individual be receiving Medicaid benefits for inpatient services for at least 30 days in order to become eligible to participate in the MFP demonstration.

New guidance requires that an individual be receiving Medicaid benefits for inpatient services for one day to become eligible to participate in the MFP demonstration.

Any questions concerning these changes, please contact your CMS Project Officer.