Frequently Asked Questions: Nursing Facility Definitions

OHIO DEPARTMENT OF MEDICAID OCTOBER 2018

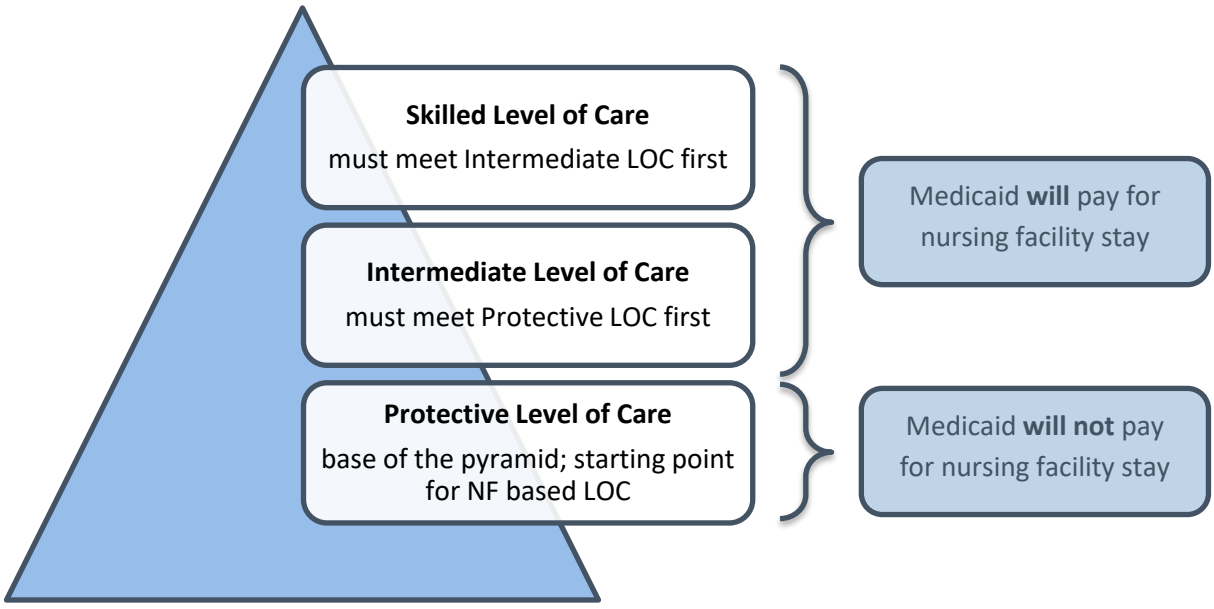
This document outlines common terminology related to nursing facility definitions for Medicare and Medicaid covered stays. This FAQ should be used as a resource for nursing facilities as it relates to individuals admitted to a nursing facility (NF) under Medicare, Medicaid Fee-for-Service or Medicaid Managed Care.

What definitions does Medicare use for NF stays?

- **Custodial Care –** non-skilled, non-medical (personal) care, like help with activities of daily living like bathing, dressing, eating, getting in or out of bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do by themselves. The care can reasonably and safely be provided by non-licensed caregivers. Medicare will not cover custodial care if it is the only care an individual needs.
- **Skilled Care –** individual requires daily skilled care that can *only* be provided by or under the supervision of skilled or licensed medical personnel. Skilled rehabilitation is considered daily for the purposes of this definition if the individual is offered and utilizes the rehab services at least 5 days per week. *Individual must also meet additional eligibility requirements for Medicare to pay for the skilled nursing facility stay (please reference the Medicare website for more information).*

What definitions does Ohio Medicaid use for NF stays?

- **Skilled Nursing Services** – means specific tasks that must, in accordance with Chapter 4723 of the Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.
- **Skilled Rehabilitation Services** – means specific tasks that must, in accordance with Title 47 of the Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.
- **Protective Level of Care (LOC)** – described in OAC rule 5160-3-06; Medicaid will not pay for a nursing facility stay if the individual only meets a protective level of care.
- **Intermediate LOC** – described in OAC rule 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets an intermediate level of care.
- **Skilled LOC** – described in OAC rule 5160-3-08; Medicaid will pay for a nursing facility stay if the individual meets a skilled level of care.



What terminology should NFs and Managed Care plans use related to NF stays?

For the purpose of using common terminology between Ohio Medicaid, the managed care plans, and the nursing facilities, the focus should be on **who is paying for the nursing facility stay**. Therefore, we will use the terms "Medicare Stay" and "Medicaid Stay" when discussing individuals residing in a nursing facility. See diagram below for further explanation.

<table>
<tr><td>Medicare Stay – criteria that has to be met for Medicare to pay for the NF stay</td><td colspan="2">Medicaid Stay – NF-based level of care criteria that has to be met for Medicaid to pay for the NF stay; can include one of the two below:</td></tr>
<tr><td>Skilled Nursing Facility Care – qualified hospital stay (3-day inpatient)*, doctor attests to needing daily skilled care (skilled nursing or skilled rehab) for a hospital-related medical condition (or condition that started while in SNF for hospital-related medical condition</td><td>Intermediate LOC Criteria met per OAC rule 5160-3-08</td><td>Skilled LOC criteria met per OAC rule 5160-3-08</td></tr>
</table>

*MyCare Ohio plans may choose to waive the Medicare requirement of a 3-day inpatient hospital stay for opt-in members.

- Medicare does not pay for any stay that does not meet Medicare's definition of a skilled care. For members enrolled in a MyCare Ohio Plan (MCOP), if an individual no longer meets the Medicare definition of "skilled nursing facility care", then Medicaid (the MCOP) would become the payer source. At this point, the MCOP should assess if the individual meets either the **intermediate or skilled level of care** criteria specified in OAC rule 5160-3-08 to determine if Medicaid payment is permitted.

- Nursing facility (NF) services are a distinct set of long-term care services that are included as a *mandatory* service in every state's Medicaid State Plan. This means that that NF services must be provided to any Medicaid-eligible individual. However, due to the high cost of long-term care services, CMS allows states to add extra criteria for these services to determine if payment is appropriate. In Ohio, the additional criteria is known as "level of care", and an individual must meet a NF-based level of care as defined in OAC rule 5160-3-05.

- Medicaid does not pay for **protective level of care**, as specified in OAC rule 5160-3-06, if that is the only care that an individual needs. For members enrolled on managed care, when an individual is assessed and is determined to only meet protective level of care, the plan must work with the nursing facility to discharge the individual to a setting that is more appropriate for their health needs.