Medicaid Short-Term Rehabilitation Benefit

As you may know, there are three different levels of Medicaid coverage in New York State, each with different resource documentation requirements. These can be summarized as follows (see this more detailed chart):

Level of Coverage:	Community Coverage Without Long-Term Care	Community Coverage With Community-Based Long-Term Care	Institutional Medicaid
Services Covered:	Inpatient and outpatient medical care, prescription drugs, durable medical equipment	All of the services listed to the left, plus home care (including PCA, CHHA, MLTC, assisted living, waivers)	All of the services listed to the left, plus nursing home care
Resource Documentation:	Applicant need only attest (i.e., signed statement without proof) to value of resources	Applicant must provide documentation proving value of resources as of the first day of the month of application	Applicant must provide documentation of resources going back five years

One little-known benefit under the first level (Community Coverage Without Long-Term Care) is a short-term rehabilitation benefit that allows someone who has merely attested to their resources to get limited home care, and someone who has not provided five years of resource documentation to get limited nursing home care.

Until September 1, 2004, anyone needing Medicaid to pay for rehabilitation care in a nursing home had to provide 36 months of resource documentation. This was true even for short term stays, or where one needed Medicaid only to pay the Medicare co-insurance after 20 days of Medicare coverage. Now, even for a client who has done "simplified asset review," (no longer called by that name - see below), or who has merely *attested* to the amount of her resources, this new service is available -- but only for a very short period of time.

Short-term rehabilitation includes:

- one period of Certified Home Health Agency (CHHA), up to a maximum of 29 *consecutive* days in a twelve-month period; and
- one short-term nursing home admission, up to a maximum of 29 *consecutive* days in a twelve-month period. A recipient may receive one of each type of service for a total of 58 days in a 12-month period.

The 29 days must be *consecutive*. Client cannot spread it over two or more rehab stays in a year. EX: Client is transferred from the nursing home rehab program after only 15 days, and sent back to the hospital. The 14 remaining days of the 29-day maximum are lost and cannot be carried over. She would not qualify until the next year. She would have to do 36-month resource documentation to receive more nursing home care after the hospital stay.

Spend down cases - Attestors only need to meet a one-month spend-down requirement for Medicaid payment for each month during a 29-day period of short-term rehab. Note that the 6-month spend-down requirement for hospital care does not apply. ADM p. 10.

The 29-day short-term rehabilitation begins on the first day the applicant/recipient receives CHHA services or is admitted to a nursing home on other than a permanent basis, regardless of whether the client has Medicare or other insurance to pay for the early part of the stay, *IF the client applies for Medicaid during that stay.*[1]

Example : A recipient is admitted to a nursing home for rehabilitation on November 8, 2004. Medicare covers November 8 through 27 (20 days) in full. Medicaid coverage for short-term rehabilitation is available starting November 28 through December 6 (the remaining 9 days of the short-term rehabilitation allowance).

Note: If the individual was not in receipt of Medicaid upon admission and applied for Medicaid coverage to begin December 1 (not retroactive to November), November 8 would still count as day one of the short-term rehabilitation.

Exception - If an individual does not apply for Medicaid coverage for a commencement of CHHA services or nursing home admission, that commencement/ admission is **not counted** toward the one commencement/admission limit per 12-month period. So she needs to predict how long a stay might be to decide if it is worth applying for Medicaid for that stay

TIP - Before client applies for Medicaid for nursing home care using the 29-day short-term Medicaid benefit, consider:

- whether client has Medicare with or without Medigap, and whether that insurance is expected to pay for most of the stay. If so, don't apply and waste the 29-day benefit. If client doesn't have Medigap for nursing home co-insurance, and stay is expected to be more than 20 days, Medicaid might be needed
- It is early or late in the year, and how likely it is that client will have a 2nd nursing home admission this year for which she'll need Medicaid. Use your crystal ball!

Example of Beating the Odds: Mrs. S applies for Medicaid coverage for a three-week nursing home stay which began on September 4, 2004. Six months ago she had a short-term nursing home stay but did not apply for Medicaid, expecting it to be less than 20 days and fully covered by Medicare. Medicaid coverage for short-term rehabilitation is available starting September 4, 2004.

Example of Losing the Gamble: The same Mrs. S had the same short-term stay six months ago. She applied for Medicaid for that stay, just in case she'd stay more than 20 days. She has no Medigap insurance so was concerned about the $114/day co-insurance (2005). She left on Day 22, so Medicaid paid the coinsurance for 2 days using the short-term rehab benefit. For the 3-week nursing home stay beginning on Sept. 4, 2004, she has NO short-term Medicaid rehab coverage, even though she only used 2 days in the last stay. The days must be consecutive. She will have to do the full 36-month lookback to qualify for Medicaid to supplement the Medicare coverage. Next year she will have a new 29-day benefit.

Background, Directives, and Effective Dates: New Section 366-a(2) of the Social Services Law, enacted by Chapter 1 of the Laws of 2002, eliminated the resource documentation requirement for individuals not seeking Medicaid long-term care services**.**

- 04 ADM -06 - Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources)(July 20, 2004) implements the changes effective 8/23/04 but retroactive to 4/1/03, all attachments posted at https://www.health.ny.gov/health_care/medicaid/publications/pub2004adm.htm
- The NYS Dep't of Health further clarified the starting-date of the 29-day period in the **February 2005 Medicaid Update** and **GIS 05 MA 004**

- NYC Medicaid issued an ALERT explaining the changes on September 1, 2004
- Emergency proposed rule amending 18 NYCRR 360-2.3(c)(3) published 3/16/05, eff. 2/25/05.
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This article was authored by the Evelyn Frank Legal Resources Program of New York Legal Assistance Group.

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