

# Managed Care Contracts: “Return to Home”

## Overview

As providers explore agreements with managed care organizations or assist residents with understanding their Medicare Advantage (MA) plans, one provision that they need to be aware of is the “return to home” provision in the law. Added in 2000, this provision addresses the rights of a resident of a life plan community or skilled nursing facility (SNF) to return to their home SNF after a hospital stay, even if their SNF is not part of the provider network of the Medicare Advantage plan they are enrolled in. However, the home SNF must either have a contract with the Medicare Advantage plan or be willing to accept payment similar to what the MA plan typically pays their network SNFs.

Senior living providers (and residents) should have the statutory and regulatory language ready when interacting with MA plans. Although there is no private right of enforcement of the “return to home” provision in the legislation, or accompanying regulation, this language can be cited by residents or communities when encountering the situation of a hospitalization of a resident and the need for post-hospital extended care.

Sometimes MA plans are unaware of the “return to home” provisions in the law and regulations but they should honor the life plan community or nursing home resident’s wishes once the law is explained to them.

## History

The “return to home” language was included in the Medicare, Medicaid and SCHIP Improvement Act passed in 2000. As the explanatory statement in House Report 106-1004 detailed, Medicare Choice (now called Medicare Advantage) contracts entered into or renewed after December 21, 2000, required such plans to cover post-hospitalization skilled nursing care through an enrollee’s “home skilled nursing facility” if the plan has a contract with the facility *or* if the home facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated SNFs that are under contract with the plan.

Thus, even if the home SNF is not part a provider under a resident’s MA plan, the resident could return home if the community agrees to accept similar payments under the plan as similarly situated SNFs under contract with the plan.

A “home skilled nursing facility” is defined as (a) one in which the enrollee resided at the time of the hospital admission that triggered eligibility for SNF care upon discharge, or (b) is the facility that is providing such services through the continuing care retirement community in which the enrollee resided at the time of hospital admission, or (c) is the facility in which the spouse of the enrollee is residing at the time of the enrollee’s hospital discharge. The beneficiary would be required to receive coverage for SNF care at the home facility that is no less favorable than he or she would receive otherwise in another SNF that has a contract with the plan.

Home skilled nursing facilities are permitted to refuse to accept Medicare Advantage enrollees or to impose conditions on their acceptance of such an enrollee.

## Statutory Language

The relevant statutory language is at 42 U.S.C. Section 1395w-22(l) and is included in its entirety below.

(l) Return to home skilled nursing facilities for covered post-hospital extended care services

(1) Ensuring return to home SNF

(A) In general

In providing coverage of post-hospital extended care services, a Medicare Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) Enrollee election. The enrollee elects to receive such coverage through such facility.

(ii) SNF agreement. The facility has a contract with the Medicare Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) Manner of payment to home SNF

The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) No less favorable coverage

The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare Choice plan.

(3) Rule of construction

Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A of this subchapter for Medicare beneficiaries not enrolled in a Medicare Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) Definitions

In this subsection:

(A) Home skilled nursing facility

The term “home skilled nursing facility” means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare Choice plan, any of the following skilled nursing facilities:

(i) SNF residence at time of admission. The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF in continuing care retirement community. A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF residence of spouse at time of discharge. The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) Continuing care retirement community

The term “continuing care retirement community” means, with respect to an enrollee in a Medicare Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

The original bill number was H.R. 4577, 106<sup>th</sup> Congress. Here is a link to the statutory text and amendments: <https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap7-subchapXVIII-partC-sec1395w-22.htm>

## Regulatory Language

The regulatory language is also helpful when encountering this situation and is located at 42 C.F.R 422.133. The full text of the regulatory language is below.

42 CFR 422.133 - Return to home skilled nursing facility.

(a) General rule. MA plans must provide coverage of posthospital extended care services to Medicare enrollees through a home skilled nursing facility if the enrollee elects to receive the coverage through the home skilled nursing facility, and if the home skilled nursing facility either has a contract with the MA organization or agrees to accept substantially similar payment under the same terms and conditions that apply to similar skilled nursing facilities that contract with the MA organization.

(b) Definitions. In this subpart, home skilled nursing facility means -

(1) The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of posthospital extended care services;

(2) A skilled nursing facility that is providing posthospital extended care services through a continuing care retirement community in which the MA plan enrollee was a resident at the time of admission to the hospital. A continuing care retirement community is an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period; or

(3) The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from the hospital.

(4) If an MA organization elects to furnish SNF care in the absence of a prior qualifying hospital stay under § 422.101(c), then that SNF care is also subject to the home skilled nursing facility rules in this section. In applying the provisions of this section to coverage under this paragraph, references to a hospitalization, or discharge from a hospital, are deemed to refer to wherever the enrollee resides immediately before admission for extended care services.

(c) Coverage no less favorable. The posthospital extended care scope of services, cost-sharing, and access to coverage provided by the home skilled nursing facility must be no less favorable to the enrollee than posthospital extended care services coverage that would be provided to the enrollee by a skilled nursing facility that would be otherwise covered under the MA plan.

(d) Exceptions. The requirement to allow an MA plan enrollee to elect to return to the home skilled nursing facility for posthospital extended care services after discharge from the hospital does not do the following:

(1) Require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under Part A for Medicare beneficiaries not enrolled in the MA plan.

(2) Prevent a skilled nursing facility from refusing to accept, or imposing conditions on the acceptance of, an enrollee for the receipt of posthospital extended care services.

References: 68 FR 50857, Aug. 22, 2003, as amended at 70 FR 4723, Jan. 28, 2005 and link to regulatory language: <https://www.law.cornell.edu/cfr/text/42/422.133>