The Patient Advocate's Guide To

Empowered and Informed Patient Advocacy:

Find the Right Nursing Home
Avoid Dangerous and Expensive Mistakes
Know Patient's Rights, Medicare and Medicaid
Get Good Care

"You *can* do it"

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INTRODUCTION
To Long Term Care

Sometimes There Is No Choice

"Placing my mother in a nursing home was the hardest thing I've ever done. I cried all night."

Problem

Your loved one needs to be placed in a nursing home. **You are responsible**. No, you did not wish for the responsibility, but you must act. Your loved one is completely vulnerable and dependent on you. You must make the right choice about something which you have always heard about, but never wanted know about. You must find a good *nursing home*.

Resolution

You *can* do it, with the help of persons who have been this way before. There are professionals who can and want to help you. You may find the assistance of Elder law attorneys, Geriatric Case Managers, Nurses and Social Workers helpful at this time of one of the most difficult decisions in life. This booklet is but one example. It was put together by Jim Schuster, Certified Elder Law attorney, with the hope that it will give you information that will make this burden a little lighter. He has helped many and he hopes he will help you.

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TABLE OF CONTENTS

You Need Legal Authority. . . . . -7-
Healthcare Power of Attorney. . . . . -7-
Designation of Patient Advocate. . . . . -8-
General Durable Power of Attorney
. . . . -9-
Trustee Successorship.. . . . . -9-
Guardianship. . . . . -9-
Guardianship Or?. . . . . -10-

Post Hospital Care. . . . . -8-
The Patient Advocate and the Rights of the Medicare Patient . . . . -8-
Written Notice of Patient's Rights. . . . . -8-
Premature hospital discharge. . . . . -9-
Follow Procedure in the "Important Message from Medicare" Notice. . . . . -9-
Inappropriate Discharge. . . . . -10-

Discharge Planning.. . . . . -15-
Time to Change Your Medicare Provider?. . . . . -17-

Post Hospital, Short Term Care In a Nursing Home -18-
The Medicare Benefit.. . . . . -20-
The Care Planning Process. . . . . -21-
How Care Planning Works in Practice. . . . . -22-
Appeal Premature Termination of Medicare Coverage. . . . . -25-
How to Appeal Premature Termination of the Medicare Skilled Benefit. . -26-

Hospice. . . . . -29-

Long Term Care: Nursing Home or?. . . . . -32-
Assisted Living . . . . -32-
Nursing Home.. . . . . -33-

How to Select a Nursing Home. . . . . -35-
What If There Are Problems?. . . . . -39-

The Nursing Home Contract.. . . . . -42-
Written Contract Required. . . . . -42-
Required Financial Disclosure. . . . . -42-
Financial Admission Discrimination. . . . . -43-

Illegal Admission Requirements.. . . . . -44-
No Third Party Guarantee. . . . . -44-
A Patient Advocate May Not Be Required. . . . . -44-
A Guardian May Not be Required for admission. . . . . -44-
No Minimum Payment before Applying for Medicaid.. . . . . -44-
No Required Deposit of Funds. . . . . -45-
The "Responsible Party. . . . . -45-

Nursing Home Residents' Rights. . . . . -47-
The Right to Achieve and Maintain the Highest Practicable Level of Functioning . . . . -47-
The Right to Make Health Care Decisions. . . . . -47-
The Right to Be Free of Unnecessary Restraints.. . . . . -48-
The Right to Be Free From Abuse.. . . . . -48-
The Right to Accommodation of Individual Needs and Preferences. . . . . . . -48-
The Right to Independence, Dignity and Participation in All Activities. . . -48-
No Waiver of Rights. . . . . -48-

The Six and Only Reasons for Discharge.. . . . . -49-
Appeal of Discharge. . . . . -49-
Planning Prior to Discharge. . . . . -50-
Transfer to Hospital is Not Discharge. . . . . -50-
The Long Term Care Ombudsman.. . . . . -50-

Medicaid – Payment for Long Term Care
(Pay the Nursing Home Without Going Broke). . . . . -52-
What is Medicaid? . . . . -52-
Excluded Assets and Countable Assets.. . . . . -55-

Should I Seek Professional Advice for Medicaid?. . . . . -59-

Medicaid – Questions & Misconceptions. . . . . -61-
Myth: Medicaid Will Not Provide Quality Care. . . . . -61-
Medicaid Tip: Purchase Additional Insurance. . . . . -62-
Medicaid Rules for Married Couples.. . . . . -64-
Case Study No. 1
Medicaid Planning for Married People. . . . . -66-
Case Study No. 2
Medicaid Planning for Married People. . . . . -67-
Case Study No. 3

Planning for Veteran's Widow. . . . . -68-
Case Study No. 4
A Trust for a Disabled Child. . . . . -69-
Case Study No. 5
Employment or Gifts to Children.. . . . . -70-
"Will I Lose My Home?". . . . . -71-
Case Study No. 6
The $156,000 Mistake?. . . . . -72-

Conclusion. . . . . -74-

Nursing Home Evaluation Checklists. . . . . -75-

FORWARD

This book is addressed to two classes of nursing home residents: those in short term, post hospital care and the long term care nursing home resident. In the legal sense there is no distinction between the two. Both have the same rights. The difference lies in the cause for nursing home placement, the source of payment for the care and finally the expectations of the resident and family.

Most short term cases are caused by a medical condition that needs intensive treatment. This case may involve post hip surgery rehabilitative therapy, or treatment for an illness the patient should recover from such as pneumonia. The patient expects Medicare to cover the cost and to return to home.

Most long term care arises from conditions such as advanced dementia or major stroke where the patient's family cannot provide sufficient care at home. In these cases the family does not expect the patient to return to home. Medicare does not cover long term care.

There is a too common case where a short term stay turns into long term care. Sometimes the patient does not get better and in fact may get worse. Sometimes it should be expected: the patient may be sicker or weaker than thought. But, too often long term care results from preventable causes. One of the missions of this is to minimize these cases by empowering the Patient's Advocate to get the best of care.

We hope we have succeeded.

Terms – A note about terms.
"Patient advocate:" means any person who is assisting the patient with the management of healthcare. It might be one person or it might be a family team. Note that under Michigan law "patient advocate" is a term used to mean the agent who speaks for the patient concerning end of life care, when the patient cannot speak for him or herself.

"Patient" and "Resident:" When we look to Medicare to pay the bill the person is a "patient." When a person is in a nursing home they have legal rights of a "resident." This is because the law reflects the old practice of using the nursing home as a home for the "resident." The law grants the patient or resident rights in the nursing home setting be it short term or long term care.

Gender: I often refer to the patient/resident in the female gender instead of switching between he and she. I use this device for ease and uniformity.

You Need Legal Authority
(Get it from the patient or the probate court)

If you have a family member in a hospital, you may be asked for papers to show your *legal authority to make decisions* for your loved one. It does not matter if you are husband, wife, parent or child - you need legal authority to make decisions for another. In addition to managing the delivery of healthcare you may be signing contracts, filing applications for assistance, filing tax returns or appealing a denial of benefits. You may have to withdraw funds from a brokerage account and sell property. You will need documents to prove your authority and if you have none, then either the patient must execute those or you will have to go to probate court. Proceeding without authority is risky. At a minimum you may find yourself paying expensive healthcare bills and at worst your family member's life may be at risk.

What do you need? You need either powers of attorney or be appointed the person's guardian by the probate court. Note that powers of attorney are narrowly read and only give the powers stated in the document. Nothing is implied. That means when it comes to making all decisions for another you need *complete* authority. If you don't have it you will need to get it from the probate court.

Can your patient give you legal authority if he or she has significant medical problems? If she can communicate with you the answer is likely "yes." Persons with only minimal capacity to make decisions, may give another authority to act for them.

Healthcare Power of Attorney

You should have a complete power of attorney to all make medical decisions. The power should be immediately effective. If it is not then it is "springing" and you have to satisfy the springing condition, typically getting two doctor's letters declaring incapacity, before you can do anything.

A complete power of attorney authorizes medical providers to share confidential medical information covered by the privacy portions HIPAA law and the Michigan Medical Records Access Act. But you need more authority than to just receive information. You must have authority to make all decisions. That includes decisions about mental health care. Many times a patient/resident is referred to a psychiatrist for a behavior problem, such as depression, anxiety, side effects from medications and so on. You must have authority to consent and withdraw consent for such treatment. And, your authority must include end-of-life decision making.

You need the power to make all necessary medical decisions, including:

a. approve or refuse, consent or withdraw consent to, all types of medical care, treatment, and procedures;
b. be designated as the Health Insurance Portability and Accountability Act or "HIPAA" personal representative authorized to access medical records, disclose the contents to other medical providers, and execute medical releases;
c. authorize admission to or discharge from (even against medical advice) any hospital, nursing home, or care facility;
d. contract for any health care related service or facility, without incurring personal financial liability for such contracts;
e. hire and fire medical and other support personnel responsible for care;
f. execute documents including releases and refusal of treatment forms or do-not- resuscitate orders, that a facility may require to carry out patient instructions regarding medical treatment.

Designation of Patient Advocate

When it comes to end-of-life medical treatment decision making, Michigan has strict conditions for any power of attorney that would allow termination of life sustaining treatment. The law allows the creation of a document called a "designation of patient advocate." It is more than a "living will" that merely states a person's wishes for end of life care. It names the patient advocate(s), gives them their end-of-life decision making instructions, and gives them the authority to make all necessary medical decisions.

The authority granted may only be exercised when two doctors have certified that the patient *unable to participate* in medical decision making.

The document must give instructions to the patient advocate as to when treatment may be terminated. The patient advocate may not make the decision on his own.

The document must state that the patient understands that termination of treatment *could allow death*.

The document must be signed by two witnesses who are not related to the patient, and do not work a healthcare facility where the patient is receiving treatment. A notarized signature will not suffice.

The designation is effective only in an emergency and should be carefully reviewed after the emergency passes.

A Designation of Patient Advocate Is Limited to End-of-life Decision Making

When you are not dealing with end-of-life medical treatment you cannot rely on a Designation of Patient Advocate form from a hospital or nursing home. These generic forms address end-of-life medical treatment only. They are necessarily limited in scope and authority granted. These address who is the patient, who is the patient advocate, and what are the end-of-life instructions? What if the patient

recovers from the "terminal" condition? These forms do not address ongoing care needs. They do not allow the patient advocate to participate in decision-making if the patient *can*. They do not address mental health treatment (e.g. depression, paranoia) or managing healthcare in general. Again, if you do not have the authority you need you will have to petition the probate court for the appointment of a guardian. Consult an elder law attorney to ensure that the document grants sufficient *immediate* authority for healthcare decisions. It should cover present needs as well as the end-of-life authority and instructions.

General Durable Power of Attorney

A general durable power of attorney is an authorization granted by a "principal" to an "agent," sometimes called an "attorney in fact." The agent can handle the all business of the principal, even if the principal is incapacitated. That is what "durable" means. The authority granted may include that to sign contracts, file applications or tax returns, appeal denial of benefits, and pay or contest bills. One Michigan probate judge observed that almost all guardian or conservator proceedings could be avoided by a durable power of attorney. A person need not be fully healthy to sign a power of attorney. He need have the mental capacity to be aware of his need for help, who he wants to help him, and what he wants that person to do.

The power of attorney only grants authority that is expressly given. A complete power of attorney must address all needs of the principal including retirement plans, insurance, credit cards, opening and closing accounts. An elder law focused power considers special powers such as the authority to make gifts, sell property to family members at discount, employ family members or draft a trust for an estate plan. While these powers may not be important to a healthy person, they can be invaluable for an elder to have her wishes carried out. An elder law attorney should be consulted for drafting a suitable and complete document.

Trustee Successorship

If the person you are helping has property in a trust, you may need to activate the successor trustee. You must review the trust for the procedure or consult an attorney to handle the review and necessary paperwork.

Guardianship

<u>If</u> you do not have power of attorney <u>and</u> your loved one does not have minimal capacity, you will need to "petition" the probate court for a hearing to be appointed *guardian* or *conservator*.

The *guardian* makes the personal decisions for the *ward* such as what medical treatment will be needed, who will administer the treatment, and where the ward

will reside. The *conservator* makes the financial decisions and handles the money.
Both guardian and conservator report to the probate court. One person may handle both roles. The appointment of a full guardian or conservator removes the legal right of the patient to make decisions.

The *petition* is a form available at the county probate court. You may complete it yourself, or you may have a social worker who can complete it. The petition must be correctly completed and filed at the probate court. Of course, you may hire an attorney who will complete and file the petition and represent you in court at the hearing. You can ask the court to have the patient repay you.

The filing fee is $150 for guardian or conservator. The court will schedule a hearing within four to eight weeks, unless there is an emergency in which case the court can appoint a temporary guardian. An emergency means that the person's health or finances are at risk for immediate harm. An example might be emergency surgery is needed. There is a $20 additional fee for emergency petitions.

The court will appoint a *guardian ad litem*. This is an attorney who will make an investigation and file a report with the court. This attorney will speak to the petitioner and the alleged incapacitated person, and make any other needed inquiry to report whether the petition should be approved and whether the proposed ward objects or agrees. The fee for the guardian ad litem ranges from $450 to $600 in uncontested matters and it will go much higher. Attorneys require a retainer to take on a case. The retainer for the usual services required. The fee will be in the thousands of dollars. If a case is contested the fee can easily be over $10,000.

On the hearing date the judge will decide whether a guardian/conservator should be appointed and, if so, who that person should be. The "alleged legally incapacitated person" may agree or object. If there is any contest on the need for a guardian/conservator, the judge will hold a hearing. When the court appoints a guardian or conservator it issues *letters of authority.* These spell out the authority given. The guardian and conservator are subject to the supervision of the probate court and must file annual reports. The conservator files an inventory and annual accounting. The guardian files a report of the person's condition.

Guardianship Or?

Given that full guardianship *removes the rights of an individual to make decisions,* and the costs of obtaining guardianship – the filing fee, the guardian ad litem fee, time off work and costs of a private attorney – many people ask, "What are my alternatives?" This is a legitimate question, since the law requires the probate court to inform petitioners for appointment of a guardian of the alternatives to public-court supervision. The court carries out its mandate by Probate Court Form 666, see: courts.mi.gov/Administration/SCAO/Forms/courtforms/guardian-conservator/pc 666.pdf

What are the alternatives? As stated in Michigan Probate Court Form 666 they are:

1. **Health Care Power of Attorney**. There are two types: a *patient advocate designation* and a *durable power of attorney for health care*.

2. Do-Not-Resuscitate Order. A do-not-resuscitate order is a document directing that the patient named in the order not be resuscitated if the patient's spontaneous respiration and circulation stop in a setting outside a medical facility.

3. **Power of Attorney**. A power of attorney is a document signed by a competent person giving another person the power to manage some or all of his or her affairs.

4. **Trust**. A trust may be a substitute for a conservator and a will. The trust expresses the desires of the maker (called a *settlor*) about the management of his or her assets during his or her lifetime and when physically or mentally unable to manage the assets.

5. **Joint Ownership**. A joint owner can apply the funds of an account for the disabled co-owner without court action. This can involve the loss of sole control over the funds by the disabled person and can result in dishonest use of funds by the co-owner.

The courts recognize that powers of attorney are affordable alternatives to court proceedings. But what if a person is no longer competent? PC 666 recognizes the following alternatives to full guardianship even if the individual is mentally incapable of making decisions.

1. **Limited Guardian**. A guardian who makes only those decisions for the individual that the court allows.

2. **Conservator**. A conservator is a person appointed by probate court and given power and responsibility for the estate (financial assets and property) of an adult (called a *protected individual*).

3. **Protective Order.** When only a single transaction affecting the property of a disabled person is required, the probate court may enter a protective order for this one time matter without appointing a conservator or a guardian.

4. Representative Payee. A representative payee is appointed by the Social Security Administration to handle benefits. There is no court involvement. The representative payee's authority is limited to the benefits.

5. Special Services for the Aging. Many communities have voluntary services available upon request to help the aging with their financial affairs.

Post Hospital Care

A short term stay in a nursing home is most often preceded by hospital treatment. But, long term care often begins in the hospital as well. There are a number of reasons. An elder may suffer a fall requiring surgery, then recuperation does not go well enough for a return to home. It may be a major stroke requiring care beyond that can be provided at home. Post surgical complications may develop into long term care. Often Alzheimer's Dementia becomes much worse after a hospital stay. Sometimes the hospital stay makes a caregiver, most often a spouse, step back and realize he cannot do it anymore.

There are practical reasons for the hospital stay to be the beginning of long term care. First it is a much easier transition for the elder/patient and much easier for the family to go from home to hospital. The second is that the hospital discharge planners have the duty to find an open bed at a nursing home. That makes it much easier on the family who would otherwise have to go driving around to nursing homes with the medical and financial information for the nursing home to review. Often families are told there is a year waiting list only to find that a call from "Big Hospital" gets immediate placement and the waiting list disappears.

A hospital is under great pressure to discharge because once the treatment is done, Medicare stops paying. The discharge planner may just say to the nursing home "Take this one as a favor to us. We'll make it up later." The downside of the hospital making placement is that it may be at a facility it regularly does business with. This may be a nursing home that does not have open long term care beds and the patient needs long term care. Finally the nursing home may not the patient and family's first choice. You always have the right to arrange a better placement

The Patient Advocate and the Rights of the Medicare Patient

Even if the resident did not enter a nursing home from the hospital, the patient advocate must be knowledgeable about Medicare processes. A long term nursing home resident may have trips to the hospital. When the resident enters the nursing home on a post-hospital skilled care stay, the quality and completeness of treatment may dictate how well the patient does. Sometimes the patient returns home only through the vigorous advocacy of the patient advocate. The patient advocate is essential to the patient receiving quality care.

Written Notice of Patient's Rights

Medicare participating hospitals must deliver written notice, the *Important Message from Medicare*, of a patient's rights as a hospital patient including discharge appeal rights, at or near admission. The notice must contain the following essential pieces

of information:

- The name(s) of the patient's physician(s) and the patient's ID number.
- A statement of the right to file an appeal or raise questions with the Medicare Quality Improvement Organization (QIO) about quality of care, including hospital discharge.
- The name and telephone number of the QIO that serves the area in which the hospital in question is located.
- A space for the beneficiary or representative to sign and date the document.
- The steps necessary to appeal a hospital discharge decision or to file a complaint about the quality of care.

Premature hospital discharge

In the context of this publication a premature discharge may occur when the patient still needs hospital care or when the proposed discharge plan is inappropriate. If a person is too ill or weak to return to home where there is not enough support, then discharge to home care is inappropriate. The at-home spouse may not be able to care for the hospital spouse because of her own medical problems. Sending the patient home in that case leads to emergency return to the hospital, often with even worse problems such as a broken hip from a fall.

The Medicare patient has the right to appeal premature termination of hospital benefits. The entire complex and lengthy appeal process may proceed through the levels of "review", reconsideration, Administrative Law Judge hearing, Appeal Council review and finally federal district court. The patient advocate may be most effective at the time of notice of discharge, which is the review stage. We will focus on this latter point.

Follow Procedure in the "Important Message from Medicare" Notice

The advocate must follow the procedures in the ***Important Message from Medicare*** Notice. This form is given to the hospital patient on admission. There are <u>very strict and short time lines</u>. The advocate must request a review either orally or in writing no later than the day of discharge. A "timely" request is no later than midnight of the <u>day of discharge and before leaving the hospital</u>. The request is made with **KEPRO**, the Quality Improvement Organization (QIO) for Michigan. Once this is done the patient may remain in the hospital without charge at least until noon of the day after the QIO review decision. Contact **KEPRO** at (855) 408-8557.

Immediately Contact the Patient's Physician

Without missing the "same day" deadline, above, the advocate must also *immediately* contact the physician in charge of the patient. This doctor is the "attending physician" assigned by the hospital. If the doctor does not agree with the discharge plan, the doctor then must advise the hospital Utilization Review Committee. Often the discharge is stopped at this point. If the hospital proposes to

continue with the discharge, it must then present its decision and the patient's record to KEPRO for review

It is vital to present to the patient's doctor the reasons why the termination of hospital coverage is wrong. Where the discharge is ill advised the decision to discharge may well be more related to the Medicare payment system than the needs of the patient. Medicare pays for services according to treatment group and that means that some patients need more care and others need less. That creates an incentive to provide less care. However the Medicare benefit covers all medical care that is reasonable and necessary for hospital treatment of the patient. The advocate must advocate for the individual needs of the patient.

Payment for Hospital Expenses During Review

Patients are *not* financially liable for hospital costs incurred during the KEPRO review; they are responsible only for coinsurance and deductibles. If the KEPRO decision is in agreement with the hospital (unfavorable to the patient), then the patient becomes liable for the medical expenses incurred beginning at noon on the *day after* notification of the decision is given.

Inappropriate Discharge

What if the patient agrees with discharge but disagrees with the discharge plan? For example, what if, as mentioned above, the plan is to discharge to home where the spouse is unable to meet the recuperative needs of the patient? Medicare *requires* a discharge plan that is appropriate to the patient. Or, suppose a patient needs skilled nursing care but a bed is not available locally. Medicare coverage can continue until the appropriate discharge may be made. That means the hospital may not discharge a patient to a nursing home so many miles away that family cannot visit. Again, such a decision could be reason for a KEPRO Review of the discharge plan.

Discharge Planning
(A critical step too often poorly executed)

Discharge Planning Evaluation[1]

Medicare requires an evaluation of the needs of the patient before making a discharge plan. The patient's physician may order the planning. The plan must assess the feasibility of the patient returning to his home. It must reassess the plan if it is inappropriate. It must identify the skilled nursing facilities available to the patient for skilled care. The regulation is found at 42 CFR 482.43.

The Right of the Hospital Patient to Discharge Planning

Medicare requires that the hospital patient be discharged according to an appropriate care plan. The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is not adequate discharge plan. A plan may also be requested. The components of the process are:

(1) The hospital must provide a discharge planning evaluation upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician.

(2) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, the evaluation.

(3) The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post- hospital services and of the availability of the services.

(4) The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital.

(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge.

(6) The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and must discuss the results of the evaluation with the patient or individual acting on his or her behalf.

This includes consideration of more than medical treatment. For the patient who requires skilled nursing care, the discharge must be to a nursing facility within a

[1]Note: I have provided references to law and regulation for some of the points below. I do this for two reasons: 1) these statements are not "just my opinion" and 2) you can "look it up" and prove it if you meet resistance. CFR means Code of Federal Regulations. USC stands for United States Code, the compilation of the laws of the US government.

"reasonable" area. A nursing home placement that would cut the patient off from family and community support is inappropriate and could be medically harmful. What if the hospital cannot find an appropriate placement?

Medicare law provides for continued hospital care if the patient requires skilled nursing care and no appropriate bed is available. 42 U.S.C.1395x(v)(1)(G)(i), 42 CFR412.42(c)(1), 412.80(a)(1), 424.13(b). The primary burden of locating a bed is placed on the hospital. 42 USC 1395x(ee), 42 CFR 412.12(b). Because of the financial pressure to discharge patients, this requirement is often ignored by hospital staff.

Given the difficulties some patients face in securing a skilled nursing facility bed following hospitalization, this is an area where appeals are often appropriate. Financial difficulties, including problems relating to securing eligibility for Medicaid are not valid reasons for denying Medicare coverage. The sole issue is whether the patient was offered placement in an appropriate Medicare-certified Skilled nursing facility. Timely appeals of notice of discharge are made to the **(KEPRO) (855) 408-8557** .

The primary burden of locating a skilled nursing facility bed is placed on the treating physician, 42 CFR 412.12(b), and on the hospital discharge planner, 42 U.S.C. 1395x(ee). Patients and their families need only cooperate with the efforts of the hospital discharge planning staff. However the advocate will want to personally inspect any facility to be assured that it *will* provide the requisite level of care and is reasonably close to the patient's home or family so that daily visits are possible.

Whether a person is in a hospital or a nursing home, the law requires "discharge planning." It is a plan of care and treatment made specially for the patient. This involves more than mere "transfer." A facility may not say words to the effect "He will be in the lobby at noon." In practice, discharge planning is a mix of commonsense actions and procedures required by law.

When the planning is properly completed, the patient/resident will have been involved in decisions about what will take place after leaving the facility. The patient may request assistance in arranging necessary services prior to discharge. For example, if the person is going home, the plan may include obtaining transportation to the scheduled follow-up appointment with the doctor.

The patient or advocate should have answers to important questions prior to leaving the facility. The plan must address:

where the patient is going after the facility and what will happen after arrival;
the medication regimen including how to obtain and administer;

the name and phone number of a person to contact should problem arise during transfer;
the potential side effects of medication and who to call if they occur;
what symptoms to watch out for and who to call should they arise;
how to keep the health problems from becoming worse;
if the patient is going home, whether there is someone to support the patient at home who knows what will be needed.
For any follow-up or referral appointment, the patient must know the time, date, location and who the appointment is with.

The above is adapted from the discharge preparation checklist by Dr. Eric Coleman, UCHSC, HCPR.

Legal Issues

Discharge planning is a formal process required by law. Resident records should contain a final resident discharge summary which addresses the resident's post-discharge needs *(42 CFR §483.20(l))*. Facilities must identify patients who are likely to suffer adverse health consequences in the absence of discharge planning services. They must develop plan of care with the participation of the resident and family. The plan must be designed to assist the resident to adjust to his or her living environment. This applies to discharges to home, to a nursing facility, or to another type of residential facility such as assisted living. *(42 CFR §483.20(l))*.

A proposed discharge may not be appropriate. It may be too soon, the patient is not healthy enough, or necessary post-hospital services have not been arranged. A discharge of a long term care patient to a nursing home without open Medicaid beds is inappropriate. If the problem cannot be resolved prior to the discharge date, the advocate may ask for review. That is done through the local Quality Improvement Organization (QIO). The patient's hospital discharge notice should provide the name, address, and phone number of the QIO serving the hospital, along with instructions on how to ask for review *(42 CFR §§412.42-412.48)*. **KEPRO** is the QIO in Southeast Michigan. Contact them by (855) 408-8557 or by www.KEPRO.com.

Time to Change Your Medicare Provider?

What if the patient's Medicare Advantage provider does not cover all nursing homes? You may not be able to secure Medicare paid treatment in a local nursing home. A little known fix is that a patient in a hospital or nursing home can change to traditional Medicare at any time and go back to the HMO after the treatment is completed. Just enroll in traditional Medicare before the end of the month, early enough to change the official record, and your patient will have a choice of any nursing home to provide her Medicare benefit. After the treatment is over simply re-enroll in your chosen Medicare Advantage plan.

Post Hospital, Short Term Care In a Nursing Home
The Medicare Benefit

One of the most important subjects the patient advocate must know about is the post-hospital Medicare "skilled care" benefit in a skilled nursing facility. This is a *100 day ma/imum* benefit. All skilled nursing facilities are nursing homes. It does not matter whether the facility refers to itself as a "rehabilitation center" or a "short term care facility." If it is not licensed as a *nursing home* then Medicare will not pay.

A Patient Advocate must know what "skilled care" is. If the nursing home care is not "skilled" then it is considered "custodial" or "personal" care and Medicare will not pay. One may think that all care in a nursing home is skilled care since a nursing home is a licensed medical facility with trained, certified, medical personnel. That may be true but when it comes to the Medicare benefit if the care is not "skilled" such as performed by a nurse or a therapist, then Medicare will not pay for the nursing home. But, even if the patient receives skilled care, it is possible for Medicare to refuse payment.

The "Observation Status" problem: Medicare will not pay for post-hospital skilled care:

Medicare will not pay for post-hospital skilled nursing care in a nursing home unless there was a hospital "admission." That is not the same as a hospital "stay." There are four conditions that must be met by the hospital before Medicare will pay. First, must received "hospital care." That simply means that medical treatment could not have been performed in any other setting. Second, the patient must have been "admitted" to the hospital. Third, the patient must have stayed two midnights. Fourth, the patient must be discharged with an order for skilled care. We will cover the **first two** and then discharge orders later.

"Medicare A" Coverage

Let us first understand that at its core this discussion is about whether or not Medicare will pay for post hospital skilled care in a nursing home. This is a "Medicare A" benefit. Thus, this discussion is about Medicare coverage, not medical terminology.

"Admission to Hospital"

This term has caused great confusion, denials of coverage, cases in court and Congressional hearings and action. For the lay person the term "admission" has changed in definition. It used to be that if you got a bed in a hospital you were "admitted." Now, for purposes of the Medicare benefit you may not have been a

admitted. Not all services in a hospital are covered under Medicare A. Medicare B pays for services by medical professionals. In addition to doctors these include Nurse practitioners, Physician assistants, Clinical nurse specialists and Certified registered nurse anesthetists (CRNAs).

Treatment in the emergency department is not hospital care. It is covered under Medicare B. This distinction continues if the patient is moved to a room "upstairs" in a hospital room for post emergency care.

"

Get the Most out of Your Medicare Benefit

What is *skilled care*? Skilled care is service so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. The skilled care may be for therapy, such as in the case of a broken hip. It may be medical as overcoming a severe infection. But, basic medical care, even in a nursing home, is not skilled care.

For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a pre-existing acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

When it comes to choosing a nursing home the Medicare skilled benefit is an important unspoken consideration. For example, where a patient is in the nursing home for post-hospital rehabilitation the compensation for the nursing home can vary from $300 to over $700 per day. That makes the patient very attractive to any nursing home.

The higher payments are connected to intensive rehabilitation services. For example 720 minutes or more (total) of therapy per week in at least two disciplines is "Ultra High Intensity" 500 minutes or more (total) of therapy per week in at least one discipline for at least 5 days is "Very High Intensity." 325 minutes or more of therapy in at least one discipline for at least 5 days is High Intensity.

The patient advocate may take away two points: first, the more intense the work the better chance of improvement; second, the more the facility may receive the more attractive the person is as a resident. This last point is an often unspoken bargaining chip you have to get your person into the nursing home of your choice. That choice might be exercised at the initial placement or could be used for transfer to another nursing home.

The quality of patient advocacy can determine the quality of the outcome. The first, official, stage for patient advocacy comes in the care plan setting.

Care Plan for Both Post Hospital Skilled Care or Long Term Care
Medicare requires a care plan in a skilled nursing facility. But, care planning applies to both short-term, post-hospital and long term care. All nursing home residents must have a care plan. The Nursing Home Reform Law of 1987 was passed to improve the care of nursing home residents. The law requires that nursing home

care result in improvement, if it is possible. Where improvement is not possible, the care must maintain abilities or slow the loss of function. It requires individualized care planning to meet these requirements. That process is made of the following components.

Care planning is most formal and "visible" during the Medicare skilled care benefit period. The patient advocate needs to be familiar with it, especially when there are patient issues that need attention.

The Care Planning Process

The delivery of the Medicare post-hospital skilled benefit is determined by the care plan assessment and report. For example, the team assesses and reports the extent of and the minutes per week of therapy received. The second component is accurately identifying the amount of assistance the patient needs with ADLs (Activities of Daily Living).

Federal Regulation – The Comprehensive Assessment.

The care planning process involves the initial assessment and periodic comprehensive re-assessments, of the functional capacity and needs of each resident. It is to take place within 14 days of admission. If the resident's physical or mental condition significantly changes, a re-assessment is required. The assessment must be accurate, comprehensive and standardized. 42 Code of Federal Regulation (CFR) 483.20.

Federal Regulation – The Comprehensive Care Plan.

42 CFR 483.20 (k) requires the care planning process to result in a comprehensive care plan for each resident. The plan must include measurable objectives and timetables to meet a resident's medical, nursing, mental and psycho-social needs as identified in the comprehensive assessment. The care plan must address

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psycho-social well-being; and

(ii) Any services that would otherwise be required under but are not provided due to the resident's exercise of rights including the right to refuse treatment.

(2) A comprehensive care plan must be--

(i) Developed within 7 days after completion of the comprehensive assessment;

(ii) Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and

(iii) Periodically reviewed and revised by a team of qualified persons after each

assessment.
42 CFR 483.20 (k)(2).

Long Term Care
The second role of the assessment is to define the care plan and provide a base for determining the patient's progress toward or decline from the care plan standard. The input of the patient advocate is critical. The team does not know how the patient was before: was he active or did he sit in the recliner all day? Was he happy or always cranky? They need your input.

How Care Planning Works in Practice
Every resident must have a treatment plan tailored to their individual needs. This includes the personal, as well as medical dimension. A person with profound hearing loss will not respond if her hearing aids are lost. She may be considered demented and unable to communicate. Staff must be sure she has her hearing aids and must be sure they have her attention when they speak to her. Most people with hearing loss must first see a person's face before they can hear them. A person Alzheimer's dementia may worsen after placement. Her confusion may increase to the point she stops responding or becomes agitated and aggressive. The care plan should include steps to improve the resident's adaptation and staff knowledge of her individual needs.

The care plan must not only the resident's present medical needs but must meet all needs. A person can lose the ability to walk if they remain in bed or a wheelchair 24 hours a day. A person can become incontinent if they are give a "diaper" and never taken to the bathroom when needed. A diabetic can suffer severe consequences if her medication regimen is not followed. These are just examples of the conditions that must be addressed in a resident's care plan.

A care plan must be able to change as needed. A patient who loses bladder control after entry into the nursing home has experienced a significant change in status. The staff must develop a new care plan that addresses this new need. For long term care residents the care plan must be reassessed, not just reviewed, annually.

The Assessment Team. The care plan is developed by a team from the nursing home, which may include a doctor, nurse, social worker, dietitian and physical, occupational or recreational therapist. They not only use medical information but must consider input from both the resident and the family about the resident's medical and emotional needs.

The Patient Advocate's Role. Your role is to be in charge of the care. You must

first make your family member a person to the team, not just a "chart." You want to be sure they know his/her personality, values and abilities. You need to have a goal in mind for the facility. What should they accomplish? Is it return to home? Is it adaptation to long term care? They need your input. The advocate should be sure to inform the team of any allergies or adverse reactions to medications the resident may have. The scope of the assessment includes the resident's psychological, spiritual and social needs. The advocate should contribute information about the patient's preferences and routines. For example, is the resident usually talkative and social or more reclusive?

Your Input to the Assessment Team. During the assessment process, the patient advocate provides personal information beyond the hospital discharge order. For example, you may have noticed signs of depression along with symptoms of Alzheimer's. The assessment team may not notice these signs, so your input will be invaluable. Before the meeting, make a list of the resident's:

Medical needs; Psychological needs; Spiritual needs; Social needs; Preferences and usual routines; Dietary preferences; Items that could be lost, such as eyeglasses, hearing aides, or false teeth; anything else you deem important (It's easy to forget something in the pressure of a meeting!).

The team must be informed of factors that may affect the resident's behavior and what has worked before to address problems. A daughter might inform "Mother cannot hear without her hearing aid. She gets embarrassed about her inability to hear, so if she does not hear and understand something she will act as if she heard nothing at all." Without that information a staff person may think there is no point trying to talk with her since she does not understand.

Rule to remember: Only you know the patient. The care plan team does not. You know what she was capable of before entry into the hospital or nursing home. You should make sure the staff sets realistic goals - they should neither be too high nor too low. If too high the patient may be quickly seen as not suitable for rehabilitation. If too low, therapy will be terminated before the patient makes all the progress he or she could. For example your patient may have a broken hip. As patient advocate you might inform the team "Dad was walking before he fell and broke his hip. We expect him to walk out of the nursing home." Take special notice that a care plan may call for *rehabilitation* and *return to home*. It need not plan for a long term stay. Remember a return to home means the patient's home. If it has steps then the therapy must include the ability to get up the steps.

The assessment team uses the information they gather to develop an individualized formal care plan. The care plan defines specific needs of the resident and how the

staff will meet them. The assessment team meets during the first month of a new resident's placement. The patient advocate *must* attend since the resident likely cannot or if s/he attends s/he may be too passive. Do not be passive, be active. Remember, you have hired them to help you.

The Care Plan Team. When you go to the care plan meeting keep in mind the goal you believe should be met by the therapy. Is it return to home or assisted living? Is it adaptation to long term care? Whatever the desired result, bring along a copy of the list of needs you gave the assessment team earlier. Together, you can discuss your loved one's needs and the care plan the team has developed. And, if some need has been overlooked, you can ensure that the assessment team addresses it during this meeting.

The care plan becomes part of the nursing home contract. It should detail the resident's medical, emotional and social needs and spell out what will be done to improve or maintain the resident's health. The goals should not be too low - that can make the difference between a using a wheelchair and walking. If the goal is to return to home, then the resident *must be rehabilitated* enough to live at home with the support that is there.

Use the Care Plan. The patient advocate must monitor the patient's care to be sure the nursing home is following the plan. The advocate will attend all care planning meetings and give input on where the plan is succeeding and where it is not. The advocate can call for a specially convened conference because of a change in health. The affirmative use of the care planning process is the best way to ensure that the patient gets personal and appropriate care in the nursing home and achieves the highest level of functioning.

No "Improvement Standard" for Medicare Covered Therapy

It used to be common to hear that a patient's Medicare covered therapy was being discontinued because the patient had "plateaued" or "was not improving." This should no longer be the case since the decision in *Jimmo v. Sebelius*, a nationwide class action case, in 2014. The question is whether the skilled services of a health care professional are medically necessary, not whether the beneficiary will "Improve." Persons with chronic conditions such as Alzheimer's should not be denied coverage for critical services because their underlying conditions will not improve. CMS, the federal agency responsible for Medicare, has issued conforming guidance to Medicare providers.

The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration

or preserve current capabilities. 42 CFR 409.32(c).

While there is no "improvement standard" Medicare does require proof that skilled care is necessary. Medicare stipulates that coverage will "not be available in a situation where the beneficiary's maintenance care needs can be addressed safely and effectively through the use of nonskilled personnel." This means that the clinical record must support the need and the provider must bill Medicare appropriately as either rehabilitative or maintenance therapy. As Medicare says in its "Jimmo v. Sebelius Settlement Agreement Program Manual Clarifications Fact Sheet"

> "In the case of *rehabilitative therapy*, the patient's condition has the potential to improve or is improving in response to therapy; maximum improvement is yet to be attained; and, there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time. "
>
> "In the case of *maintenance therapy*, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient's functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers."

Appeal Premature Termination of Medicare Coverage

What if you and the patient believe she needs skilled care and coverage is denied *before completion of 100 days*? In general we always recommend review by the Medicare QIO. It is quick, free and often easier to work out the problem at the earliest level. Appeal is a more serious undertaking. It requires the service be first provided and then a Medicare denial of payment-coverage for an expense already incurred. Then you can appeal. An appeal is an expensive undertaking that should only be done with complete preparation.

A Quick Screen for Review/Appeal of Termination of Medicare Coverage

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1. The physician must certify that the patient needs skilled care.
2. The patient must require "skilled nursing or skilled rehabilitation services, or both, on a daily basis."

–Points to Consider on Appeal

1. The restoration potential of a patient is not the deciding factor.
2. The management of a plan of only various "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.
3. The requirement of "daily" skilled service is met if skilled *rehabilitation* services are provided five days a week.

4. Examples of skilled services:
    a. overall management and evaluation of the care plan;
    b. observation and assessment of the patient's changing condition;
    c. Levin tube and gastrostomy feedings;
    d. ongoing assessment of rehabilitation needs and potential;
    e. therapeutic exercises or activities;
    f. gait evaluation and training.
5. The doctor is the patient's most important ally. If it appears that Medicare coverage will be denied, ask the doctor to help demonstrate that the standards described above are met.
6. If the nursing home informs the patient that Medicare coverage will terminate before the 100 days and the patient seems to satisfy the criteria above, ask the home to submit a claim for a formal Medicare determination. The nursing home must submit a claim if the patient or representative requests; the patient is not required to pay until s/he receives a formal determination from Medicare.
7. Don't be satisfied with a Medicare determination unreasonably limiting coverage; appeal for the benefits the patient deserves. It will take some time, but most appeals win. Appeal when you are right since if you lose the patient must pay the bill.

For more information on the law relating to the skilled care benefit see "Selected Medicare Regulations on Skilled Care"at the end of the book.

How to Appeal Premature Termination of the Medicare Skilled Benefit
Often the patient advocate is given information such as "rehab will end Friday" - rehabilitative therapy being the most commonly used Medicare skilled benefit. An oral communication is not sufficient for you to take *legal* action. You *must* receive *notice in writing*. Demand your proper notice and once you do you can begin the process by contacting KEPRO, (855) 408-8557, for an immediate review. They will issue their determination within 36 hours. If not favorable you should receive the written notice and then sign the request for appeal. You then follow the appeal steps in the notice. A hearing will be scheduled and you may have an attorney. In most cases the cost of care may make this step an unaffordable gamble, since Medicare appeals are for *reimbursement of incurred e/pense.*

Before you pursue your *legal* options review your advocacy options. How to respond to the information? Decide if you agree. The first point to consider if the patient is trying? If not, see if you can work out a plan. Having a family member present during therapy to encourage participation can produce results. Is the resident sleepy during therapy? Perhaps therapy should be scheduled for the

patient's best time of day. For some it is morning and others it is the afternoon. Is the resident in too much pain? Maybe the therapy and pain medication need to be better coordinated. Try to determine the problem and a solution. Is the patient not trying because she is depressed? Perhaps medication for depression might work. Maybe a family member could be present to cheer and encourage her on. However, if he patient merely does not want to try then there is no point in continuation.

Is the reason for termination that the initial goal for therapy has been met? Should it be revised? What if the goal was that the patient would walk with a walker? What if the patient has made rapid progress, but not enough to return home and live independently? He may be able to walk with a walker but not able to manage the stairs in the home. If so, then the goal should be updated.

What if the reason is that the patient cannot make any more progress? What if you just *know* that more can be expected? Here we are considering the continuation *rehabilitative* therapy not *maintenance* therapy. Has the staff really observed progress made? Many times progress is slow, barely observable to those who do not know the patient. Is the patient functioning at her highest practical level? What if she broke her hip and can now walk with a walker, but cannot transfer from chair to walker? Do you think she could transfer if therapy were continued? Remember the Medicare benefit is to be used to achieve the highest practicable level of functioning.

Ideally you should not get to the point of appeal. As patient advocate you will have monitored your resident's progress under care you have "supervised." When skilled coverage is terminated you should be in agreement that no more benefit can be received. Nonetheless it is true that not all providers do the job they should.

If you cannot work out a continuation with the staff, prepare for the next step, the review by KEPRO, (855) 408-8557, the Medicare QIO. Be sure to have your facts. It is simply necessary to have the support of the patient's doctor. That is another a good reason to keep the patient under the treatment of her personal physician. Review will be completed in 24 to 48 hours.

The next step is formal appeal. Note, appeal does not continue Medicare payment. Medicare *payments* are ended until and unless reinstated by the judge on appeal. The patient must either pay for skilled care and look for reimbursement or incur the liability with the hope that Medicare will pay after appeal (where successful). Skilled care is very expensive and that is why you should take all steps to ensure success. Though the Medicare appeals are more "customer" friendly than courts, an attorney can be of key importance especially where the value of the benefits greatly exceeds the cost of the attorney.

If upon conclusion of Medicare skilled benefits the patient does not leave the nursing home the patient advocate will be presented with a contract by the nursing home. It may not require the signing of a contract as long as the patient is receiving those Medicare benefits. Contracts are covered in later sections.

Hospice

Hospice is commonly understood as end of life care. While that part is true, hospice is much more. The essence of hospice is an alternate healthcare practice of palliative care. That means the focus is not on curing the condition but making the patient more comfortable. The Medicare benefit does not require a patient to be at end of life. In fact the Medicare requirement is that a doctor need only certify that death is reasonably likely within *si/ months*. Hospice is a Medicare benefit for alternative treatment. It is true that many people leave hospice because their health has improved. Medicare allows a person to elect hospice and elect out of hospice at will.

For those who qualify, hospice is an additional option on discharge. The information below is from the Centers for Medicare & Medicaid Services publication " *Medicare Hospice Benefits*.":

What is Hospice?
Hospice is a special way of caring for people who are terminally ill, and for their families. This care includes physical care and counseling. The goal of hospice is to care for you and your family, not to cure your illness. It is also a special Medicare benefit and may be an additional health insurance benefit.

Medicare covers hospice care if:
* You are eligible for Medicare Part A; and
* Your doctor and the hospice medical director certify that you are terminally ill and probably have less than six months to live; and
* You sign a statement choosing hospice care instead of routine Medicare covered benefits for your terminal illness; and
* You get care from a Medicare-approved hospice program.

Under your Medicare benefit you choose hospice as your treatment for the terminal condition. Medicare will still pay for covered benefits for <u>any</u> health problems that aren't related to your terminal illness. For example, a patient may enter a hospice program and still have her HMO Medicare provider handle claims for all other conditions.

If you qualify for hospice care, you will have a specially trained medical team and support staff available to help you and your family cope with your illness. Hospice comfort care helps you make the most of the last months of life. Hospice comfort care includes use of drugs for symptom control and pain relief, physical care, counseling, equipment, and supplies to make you as comfortable and pain free as possible. The focus of hospice is on care, not cure. Those involved in your care

include
- you, your family,
- a doctor, a nurse,
- counselors, a social worker,
- speech-language therapists,
- home health aides, homemakers, and volunteers.

What will Medicare pay for?

The care you get for your terminal illness must be from a Medicare-approved hospice program. You can receive a one-time-only hospice consultation with a hospice medical director or hospice physician to discuss your care options and management of pain and symptoms. You don't need to choose hospice care to take advantage of this consultation service. Medicare pays for these hospice services for your terminal illness and related conditions:

- Doctor services
- Nursing care
- Medical equipment (such as wheelchairs or walkers)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control or pain relief (you may need to pay a small co-payment)
- Home health aide and homemaker services
- Physical, occupational therapy and speech therapy
- Social worker services
- Dietary counseling
- Grief and loss counseling for you and your family
- Short-term inpatient care
- Short-term respite care (you may need to pay a small co-payment)
- Any other covered Medicare services needed to manage your pain and other symptoms, as recommended by your hospice team

What Is Respite Care?

Respite care is care given to a hospice patient by another caregiver so that the usual caregiver can rest. While in hospice care you may have one person who takes care of you every day, such as a family member. Sometimes this person needs someone to take care of you for a short time when he or she needs a break from care giving. During a period of respite care, you will be cared for in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home.

Room and Board

Room and board is not a Medicare hospice benefit even if your receive the benefit in a nursing home or a hospice residential facility. However, if the hospice medical team determines that you need short-term inpatient or respite services that they arrange, your stay in the facility is covered. You may be required to pay a small co-

payment for the respite stay.

Important: Hospice care is given in periods of care. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period of care, the hospice medical director or other hospice doctor must re-certify that you are terminally ill, so that you may continue to get hospice care. A period of care starts the day you begin to get hospice care. It ends when your 90-day or 60-day period ends.

Hospice Residence

While most people receive hospice care in their current residence be that home, assisted living or nursing home, there are hospice residences. Payment for these may be by private insurance or by **Medicaid** if the hospice has beds that are certified for hospice payment. Ask the residential provider about what they accept for payment for *all* charges.

Special Note: Check Your Insurance Coverage

Some pension plans have insurance that covers hospice over and above Medicare. Check your benefits booklet or your "Summary Plan Description" to learn what the your coverage includes. It may pay daily charges in a residential hospice.

A copy of the above publication is available at: www.medicare.gov/Pubs/ pdf/02154.pdf

Long Term Care: Nursing Home or?

Whether your family member has gone through Medicare skilled care or you are considering that your patient can no longer live independently, you face a choice: assisted living or nursing home? Some folks recall the time when a person could not live at home they had to go to a nursing home. There was no other choice and that is why we call it a nursing *home*. Now there is a choice. There is a wide array of "assisted living facilities" that provide an alternative to the institutional care of a nursing home.

What Is the Difference Between Assisted Living and a Nursing Home?

First, you should know what a nursing home is and what it is not. Many families find very nice "memory care" or "dementia care" facilities that charge almost as much per month as a nursing home. These are generally known as "assisted living facilities." They seem to offer many services including on-premises home health services. Some present the question: "What about these assisted living facilities that I hear about? Are those new kinds of nursing homes?" The short answer is "No," but here is the more complete answer. What is the difference?

The first thing to understand is that an *assisted living facility* is not a medical treatment facility. Providers of medical services must be specifically licensed. While assisted living facilities may offer much in services, and may even have a nurse on duty during the day, they may not offer medical treatment. Since not all people need the 24 hour medical service that a nursing home offers, a brief review of each may be helpful.

Assisted Living

The term *assisted living* has a common sense meaning that a facility provides assistance to a resident in an apartment. This assistance may cover meals, housekeeping and laundry, more or less. A facility need not obtain a license to open and call itself "assisted living" though some do. In Michigan we have the following kinds of assisted living facilities:

Unlicensed. There are no regulations stating what the facility must do for its residents. This is the majority of assisted living facilities.

Licensed Adult Foster Care. Some facilities are licensed as Adult Foster Care Facilities. These may be certified for up to 20 people. Many are converted homes in single family neighborhoods and these are *limited to si/ residents*. The license of an adult foster home requires that each resident receive a written care agreement and that the facility follow a physician's health care plan. The facility is also required to promote independent living. The facility does not render medical treatment and cannot accept or retain a "patient" or person who requires continuous

nursing care. That is the province of the nursing home.

Licensed Home for the Aged. This is a licensed facility with over 21 beds, that offers meals three times a day including therapeutic diets, laundry service, 24 hour staff, and assistance with personal care to persons over age 60. It, too, is required to promote independent living. The facility may not accept a resident with serious mental disturbance or one who needs intensive 24 hour nursing care.

State law provides residents of the above licensed facilities with a list of legal rights, the same as nursing home residents. A resident who feels that his/her rights have been violated or is not receiving proper care may file a complaint with either the Michigan Long Term Care Ombudsman or Department of Health and Human Services. See the ***Resources*** section in the back of this book.

Nursing Home

A *nursing home* is very different legally from an assisted living facility. It must be licensed before it can operate and it is extensively regulated by state and federal law in all aspects of the building and the delivery of care and medical treatment to the patients-residents. Most, but not all, nursing homes obtain certification to operate as "skilled nursing facility" and that means it has been certified to provide Medicare paid treatment for up to 100 days post-hospitalization. Most, but not all, are certified to receive payment for care for those residents who are in "Medicaid beds."

Regulation and care in a nursing home is complete. All of the following services are covered by regulation:

(a) Admission, discharge, and transfer of patients;
(b) Categories of patients accepted and not accepted by the home;
(c) Clinical records;
(d) Physician services;
(e) Nursing services;
(f) Dietary services;
(g) Rehabilitative services;
(h) Pharmaceutical services;
(i) Diagnostic services;
(j) Consultation services; (k) Dental services;
(l) Podiatry services;
(m) Social services, including counseling services;
(n) Mental health services;
(o) Diversional activities;
(p) Interdisciplinary patient care planning;
(q) Discharge planning;
(r) Care of patients in an emergency, during a communicable disease

episode, when critically ill, or when mentally disturbed.

The nursing home resident's rights are extensively protected even before admission. Federal and Michigan law regulate admission contracts for facilities that participate in Medicare and Medicaid. Once admitted, patients are protected by the Patients' Bill of Rights under Michigan law and the federal Nursing Home Reform Act of 1987. The nursing home is required to maintain the patient at the "*highest practicable level of functioning*" unless decline is medically unavoidable. In addition a "discharge" from a nursing home is strictly controlled by law and regulation. Residents have a long list of rights, *see below.*

How Do I Choose between Assisted Living and Nursing Home?

Sometimes you will have a choice between a nursing home and an assisted living facility. A nursing home can, by definition, offer "memory care" and "dementia care." How do you decide? Here's how you can make that decision.

If a person does not have extensive medical needs but cannot live independently then assisted living may offer a more residential option than a nursing home would. A person with advanced Alzheimer's Disease may be otherwise healthy but needs a safe place to live where needs can be met 24 hours a day. Some facilities specialize in care for Alzheimer's disease or other memory problems. Some are large facilities that offer much social stimulation and interaction. Others are much smaller and do not have the array of services but offer a more home-like setting. "Adult foster homes" may have only six residents and are often in residential neighborhoods. Finally, the monthly charge of an assisted living facility may be less than a nursing home, but the resident will have to move when he runs out of money. So, how does one choose?

At this time Medicaid will pay for a nursing home but not an assisted living facility, unless one is lucky enough to get a "Medicaid Waiver" slot through the "nursing facility transition program." That program pays part of the expense. Medicaid payment of the entire bill may seem a strong weight in favor of nursing home placement. The reality is that nursing home care is almost always institutional care whereas assisted living homes offer a more residential, apartment style of living. If it is truly a case of a choice then visit your local options.

Does a person really *need* nursing home level of care? Perhaps the best "objective" answer is to consult the"7 Doors Medicaid Screen"in the back of this book. It will tell you if the need is serious enough to qualify for nursing home payment by Medicaid. Medicaid will not pay for people who do not truly need a nursing home. If there is a question of whether the patient's condition can improve, you may have a doctor

perform a geriatric assessment. This is a complete review of the person's medical condition, including medications and diet. Many elders' health can improve by making adjustments to their current regimen.

How to Select a Nursing Home

If your family member cannot live at home or assisted living any longer then the only choice is a nursing home. We can say that there are good and bad nursing homes. But, your conclusion will ultimately be based on your experience with a facility. A major part of that is the patient/resident's adaptation to the nursing home environment. The first factor then is the person you will be placing.

First: How Well Do You Know the Patient?

We often know little about those with whom we do not live. Perhaps you are helping an aunt or uncle, or just a friend. Even children may not know their parents as adults – they may still relate to them as "mom and dad." Children may live in different states and have not closely observed their parents in years since going off and starting their own home. Then, when crisis strikes they come back to find a frail elderly person about whom they know little of their every day life.

If you have not lived with your loved one, you may consider the following questions before or during placement. You will want to be ready to observe any changes that are due to a lack of good care. Here, we will use the feminine gender for ease of reference.

With whom did your relative/friend live before coming to the nursing home?
About how often have you seen her?
Are you familiar with her preferences and daily routines when she was more independent and more able to make choices and express preferences?
- Does she enjoy any particular activities or hobbies?
- Does she tend to be more social or solitary?
- What types of social and recreational activities does she prefer?
- Did she work or volunteer in or out of the home?

What are her:
- Eating habits, food likes and dislikes?
- Sleeping habits, alertness at different times of the day?
- Religious/spiritual activities?
- Things that give her pleasure?

How would you describe the resident's lifelong general personality?
- Is she thought to be quiet, happy, argumentative, etc.?
- How did she generally adapted to change, prior to the current disability?
- How, for example, did the resident react to moving to a new residence, to losing a loved one, and to other changing life situations?
- Is she talkative or usually quiet, likely to express herself or not?

Evaluate the Nursing Homes
Once you've determined the facilities you want to consider you are ready to do your research.

Two Ways to Choose a Nursing Home
Perhaps the quickest way to review a home is through www.Medicare.gov website in the "find a nursing home" section and choose one based on the rating. The second, and more tradtional, is to simply choose one that is close by to family members who will visit the resident. The best is a combination of both.

Review Ratings on Medicare.gov
You may look up the nursing home on the federal government's Medicare web site, by using their "find nursing home" search:

http://www.medicare.gov/nursinghomecompare/search.html

You can select homes by zip code or city and state. You can review a summary report of the latest survey. You will find an interpretation of the rating, for example rating violations by number, pervasiveness and severity. Medicare has a star rating system on three criteria: staffing, health inspections and quality measures. A home may rate from one to five stars. You can use the star rating as a means to choose between two homes. In general a home should not be chosen on the basis of the number of stars. The first choice should be by proximity or ease of visitation. See the comments about "location" below.

Nursing Home Compare "Quality Measures"
The Medicare web site nursing home compare gives additional insight to the particular home by offering quality measures. It shows the percent of residents suffering from a number of conditions that the searcher may select. It allows the advocate to focus on a particular condition or see overall how the residents fare. The measures show how the facility compares, on the average, with other homes in the state. This can be due to the type of patient the nursing home has, for example more post-hospital rehabilitation than long term patients, or a "specialty" in treatment of difficult issues such as advanced bed sores. The advocate can use the quality measures in selection of a home and after selection of monitoring particular conditions.

Review the Latest State Survey
You will find that part of the Medicare star rating is based on the state annual survey of the home done by the State of Michigan Department of Consumer and Industry Services. You can ask to see a copy of that report. The home is supposed to have notice of it posted in a prominent place and available for review. How do you evaluate a home by reviewing the survey report? You may find it confusing

and hard to interpret, *e.g.*, how serious is a violation? In any event, you can speak to the nursing home representative about steps they have taken to address the deficiencies reported.

Location
Sometimes the patient advocate finds that the only home with a vacancy that is convenient for visitation is lower in overall measures than others. The importance of active involvement in the care process including frequent visitation cannot be overstated. Most advocates would agree it is better to have a patient in a “poorer” home where frequent visitation is possible versus a “better” home that is so far away the patient can only be visited on weekends.

As a practical guide, choose a nursing home that you can visit on 10 minutes notice. That way you can run over there "at the drop of a hat." Good care requires constant monitoring. Daily visitation by a family member is almost mandatory. Your family member will not get good care if you visit only on the weekends. That is why being close is important. You want to be able to make a quick "pop in" visit to check up. You want to be able to get there immediately in case something bad happens. Remember even the best of nursing homes require oversight. There is no "set and forget."

Allow me to use a hypothetical. Suppose you live in Rochester Hills, your brother lives in Plymouth and a sister lives in Royal Oak. Now the Lake Orion Nursing Center is a top rated facility but it would be very difficult for your brother or sister to get to. In the same way the Star Manor of Northville is top rated and would be convenient for your brother to get to, but is not for anybody else. You might try to find a nursing home that would be convenient for two of you. Marycrest Manor in Livonia may be doable for yo1ur brother and sister. Or, you might look at Woodward Hills in Bloomfield Hills, while not top rated and it has few Medicaid certified beds, it might be doable for you and your sister.

Visit the Home and Make Your Own Review the Homes
You will want to record your own impressions. You can use our Nursing Home Evaluation Checklist in the back of the book to make an informed record of your judgment. In addition to your own observations you should speak with family members who are visiting residents and ask about their experience with the home.

Select the Home
Once you are armed with your own findings, have spoken with residents, family and staff and reviewed the reports, you *will* be confident you have made the best possible choice.

Long Term Care
(You Can Get Good Care in a Nursing Home)

How does one get good care in a nursing home? The answer goes beyond selecting the right home. The patient or "resident" must have a patient advocate who will participate in the care planning process and monitor the patient's condition by frequent visitation and communication with the nursing home staff. Many of the same strategies that you use to maximize your Medicare benefit can be used to get the best long term care.

Contrary to common belief, the nursing home is not a place to be passive about receiving care. Good care, including medical and personal, comes through patient advocacy by an informed, involved advocate. How does one do that? Families find that the world of nursing homes is completely new to them. Some families have found a way to quick-start the process: hire a nurse care manager. See that section below. Whether you hire professional assistance or not, your first step is to be informed.

You are in charge. <u>You</u> have hired these people.

The Care Plan

The law requires every resident of a nursing home have a care plan. This is the same process that was covered above under the Medicare skilled care benefit.

Even with a care plan, we can expect things will not go smoothly and in some cases it will not go well at all. Here again, you must be vigilant and carefully watch the resident's condition.

The Professional Care Manager

The patient advocate may hire a "Professional Care Manager" who can quickly get the advocate up to speed. This person may be a nurse, social worker or other professional. It is not necessary for every patient or family to hire independent services. However, many have found that a Professional Care Manager can educate them on the role of the patient advocate in the nursing home, the patient's current treatment regimen, what to expect, what to look out for and how to get the best result.

What can the care manager do? Conduct an assessment of the patient. This would include a review the medical record, consult with patient's physician and medical team and then report and recommend to the patient advocate. The care manager could also assist the advocate and attend care conferences. The result would be an

informed, individualized patient treatment program upon admission and ongoing. If the need arises after admission the patient advocate would have an accurate assessment of the problem and steps to take to resolve it.

What If There Are Problems?

There are times when, even in the best of nursing homes, a person's condition deteriorates. Sometimes this is the path of the disease process and other times due to inadequate care. What can you do if you suspect that your loved one is not being properly cared for? You should be vigilant, educated and protective. Working in advance, you should exercise the patient's right to choose medical providers. This includes not only treating physicians but what hospital your patient may be moved to. Note, the exception here is that if 911 is called in emergency they are limited to which emergency room they can take a person. In all other cases if the nursing home's default choice is not satisfactory, choose the hospital in advance. You have authority to reject one and select another. But, what if there is a problem with care?

Involve Staff. You can and should report your concern to the appropriate staff. Depending on the nature of the problem it may involve aides, nurses, Director of Nursing, administration, or the doctor. For example, "bed sores" can be the result of inadequate resident attention by aides. If that continues the resident can develop very serious skin ulcers that will require hospital care. If the problem is a medical one, find out who is the doctor's assistant and speak with that person. If it is serious and the treatment team cannot tell you what is wrong, insist that they involve a specialist and if they do not, consider making an appointment with a doctor yourself as the healthcare agent.

Remember that the patient has the right to select her own doctor. That may mean transporting the patient to the doctor rather than relying on a visit by the nursing home doctor. The patient's personal physician will order the care/treatment plan. The nursing home doctor supervises the nursing home and the delivery of care.

Be a Patient Advocate. Actively monitor your patient's condition. Don't rely on the assurances of staff. Review the medical chart. Be watchful for a loss of weight – an indicator of declining health. Monitor prescribed medications and inquire of the nurse and doctor if there are changes you do not know about. Be especially vigilant about psychiatric medications. Know the side effects and changes those may cause. Elders, especially those in poor health may not be able to process the medication resulting in toxicity.

Check her mouth for oral hygiene and ears for proper care. Inspect her to make sure she is cleaned. If you question the quality of bathing, put a mark on her. Look for

bed sores. If a wound is bandaged, write a date on the bandage. Consider doing the laundry. That way you will know if clothing is soaked or soiled. Take pictures of her if there has been an upsetting incident.

Dehydration and Malnutrition. Be vigilant and monitor your loved one's nutrition and hydration. Studies have shown that many patient health problems arise from malnourishment and dehydration. When there are problems it is often because aides do not have the time to help all residents with their eating and drinking needs at meal times and in-between as well. When you visit, check and see if she completes her meals. Check and see if she is thirsty or has taken her fluids. Is the water glass within her reach? If you see a pattern, do not wait until she starts losing weight or worse. By that time your loved one's health is in decline.

Dehydration and Low Electrolytes - Sodium and Potassium

Dehydration means more than merely being thirsty, it also includes electrolyte imbalance in a patient's blood. And, if there is a problem with the electrolytes there may be a problem with the level of "toxins" from medications. For example we may say one is dehydrated if her sodium or potassium levels are seriously low. Low sodium may cause a person to be lethargic or confused. Staff may say "That's just the dementia getting worse. It's to be expected." But low sodium is not caused by dementia - it causes dementia. Low potassium can cause muscle weakness and exercise intolerance and that can be a cause for failure in skilled care rehab. It can also cause hallucinations, which may be mistakenly treated by antipsychotic medications.

Dehydration can be a perverse result of treatment. Low potassium can be caused by antibiotics and diuretics. Low sodium may result from antipsychotic medications used to treat dementia patients who become aggressive or, as observed above, to treat confusion that is the result of low potassium. Failure to diagnose *this form of dehydration will lead to a worsening condition that can result in death. See Taking Charge: Good Medical Care for the Elderly and How to Get It* by Jeanne M. Hannah and M.D. Joseph H. Friedman (2006). Ms. Hannah tells the story how her mother went from an active 83 year old lady to dead in 65 days. Remember: **Dehydration can kill.**

Get Help. If you do not get immediate cooperation in resolving your concern, contact the State Long Term Care Ombudsman Office, a professional care manager or an elder law attorney such as the author. See the **Resources** section in the back of this book.

Good care is a combination of selecting the right home, knowing the patient's rights and regularly visiting and monitoring and managing your loved one's treatment.

In other words, being a real “patient advocate.”

Conclusion

Remember that there is a legal obligation between the nursing home and your loved one. In exchange for a monthly fee, the nursing home has agreed to provide individualized care to maintain the highest level of well-being for your loved one. In addition, the home is required by law to improve, or if not possible, maintain her health.

In your role as advocate you will be the vigilant protector. You will participate in the care planning forum to bring your information, questions and concerns to the table. You will identify your loved one's needs and develop solutions for any problems that may arise. You will monitor the delivery of care. In short, you are in charge of the treatment team.

The Nursing Home Contract

(You do have rights)

Since no contract is required for Medicare skilled care, the patient advocate will not be presented with a nursing home contract as long as Medicare is paying the bill. But if the patient will remain in the nursing home at the end of Medicare skilled care, then a signed contract will be required. Of course, if the patient/resident enters the nursing home without a Medicare stay then the patient advocate will be presented with one upon admission. These contracts are regulated by law. There are limits to what the nursing home can demand.[2]

On entry into long term care, the nursing home will provide an admission agreement or contract. The law requires nursing homes to provide detailed contracts with "residents." Nursing homes are licensed under section 21711 of the Public Health Code, *Michigan Compiled Laws* (MCL) 333.21711. The law and regulations that create rights in the home's residents also cover admission contracts.

Written Contract Required

The Michigan law regulating the contracts of admission to a nursing home is found at Michigan Compiled Laws (MCL) 333.21766. The contract must be written in "clear and unambiguous" language. *Id,* Section (6). The contract must specify all of the following:

(a) The term of the contract.

(b) The services to be provided under the contract and the charges for the services.

(c) The services that may be provided to supplement the contract and the charges for the services.

(d) The sources liable for payments due under the contract.

(e) The amount of deposit paid and the general and foreseeable terms upon which the deposit will be held and refunded.

(f) The rights, duties, and obligations of the patient, except that the specification of a patient's rights may be furnished on a separate document that complies with the requirements of section 20201 (the resident's rights section).

MCL 333.21766(7). The contract must specify all services and charges, including those not included in the per diem rate.

Required Financial Disclosure

As noted in (d) above, the admission contract must address the sources liable for

2 You will notice below the references to "MCL, USC and CFR." These are used so that you know it is the law, not the author's opinion, and so you can look up the "citations" and the law yourself.

payments. Michigan law further provides that a patient is responsible for providing the facility with "accurate and timely information concerning his or her sources of payment and ability to meet financial obligations." MCL 333.20202(7). This disclosure of financial ability does not create a guarantee that the resident will not apply for Medicaid within a set period of time or that the resident will spend the money on the nursing home. *See* "Illegal Admission Requirements."

Financial Admission Discrimination

May a facility use the financial disclosure information and discriminate against applicants who have less funds? There is no protection against it. The Nursing Home Reform Law does not address the issue. The law prohibits discrimination based on source of payment in ``transfer, discharge, and the provision of services.'' It does not address admissions. 42 United States Code (USC) 1396r (c)(4)(a) , 42 Code Federal Regulations (CFR) 483.12 (d)(1).

Illegal Admission Requirements

No Third Party Guarantee.
Federal law *prohibits* a *requirement* of a third-party guarantee of payment, 42 USC 1395i-3(c)(5)(A)(ii), 1396r(c)(5)(A)(ii); 42 CFR. Section 483.12(d)(2). However, a person may *voluntarily* agree to be responsible. You must be careful to read the admission agreement so that you are not "tricked" into a guarantee. For example some nursing home contracts have language buried in the middle pages of the agreement where it says the person signing is responsible for payment and securing Medicaid. Be safe and have a lawyer review what you are given to sign.

A Patient Advocate May Not Be Required.
Michigan law does not allow a nursing home to require a patient advocate designation to be executed as a condition of providing, withholding, or withdrawing care, custody, or medical treatment. Federal law does not allow a home to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. 42 CFR 489.102(a)(3).

While a facility may not require an advance directive, it must inform all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. 42 CFR 483.10 (b)(8).

A Guardian May Not be Required for admission.
Michigan's guardian statute requires consideration of less restrictive alternatives before a petition is filed. The petitioner must be informed of the alternatives including, but not limited to, a limited guardian, conservator, patient advocate designation, do-not-resuscitate declaration, or durable power of attorney with or without limitations on purpose, authority, or time period, and an explanation of each alternative. MCL 700.5303 (2).

No Minimum Payment before Applying for Medicaid.
A home certified for Medicaid may not require oral or written assurances that the resident will not apply for Medicaid. 42 USC 1396r(c)(5)(A)(ii), MCL 333.21765a(1).

Michigan law further prohibits a nursing home from requiring a patient to remain in private pay status for a specified period of time before applying for Medicaid. MCL 333.21765a(2). The law does not prohibit an inquiry of a patient about "accurate and timely information concerning his or her sources of payment and ability to meet financial obligations." MCL 333.20202(7). Contracts that go beyond disclosure and attempt to disallow "divestment" or require the applicant apply the assets disclosed to the nursing home bill violate Michigan and federal law.

A person who violates section MCL 333.21765a (1) or (2) is liable to an applicant or

patient in a civil action for *treble* the amount of actual damages or $1,000.00, whichever is greater, together with costs and reasonable attorney fees. MCL 333.21799c(2).

No Required Deposit of Funds.
A contract may not require direct deposit of resident's income to the facility. 42 USC 1395i-3(c)(6)(A)(i), 1396r(c)(6)(A)(i); 42 CFR 483.10(c)(1). Nor may the home require the resident to turn over funds or property to the home. MCL 333.20201 (3)(g). However a resident may require the home to manage resident funds and hold them in a trust account. MCL 333.20201 (3)(c).

The "Responsible Party"
Federal regulations and Michigan law allow an admission contract to provide for a designated "responsible party." That refers to a person with access to the resident's funds or assets. The responsible party does not incur personal financial obligation other than to use the resident's funds on behalf of the resident, MCL 333.21766(9). The "responsible party" may be required to provide facility payment from the *resident's* income or resources. 42 CFR 483.12 (d)(2). Michigan law require a person with access to a resident's funds, an agent or joint tenant for example, to be responsible for paying the nursing home bills *from the resident's funds*, MCL 333.21766(8).

Being a responsible party does not make one liable for the nursing home bill. It is illegal to require a "third party guarantee," *see above.* However if responsible party misappropriates the resident's funds then he or she may face criminal prosecution.

A responsible party *may* be found liable for the bill if he or she signs nursing home contract/agreement that includes language such as "the responsible party shall be responsible for obtaining Medicaid approval." Many admission agreements have such provisions. Before you sign the contract, have a lawyer review it. You can be certain the contract was written by the nursing home's lawyer for the benefit of the nursing home.

The above does not mean the patient's representative payee need not use the patient's funds for the patient's benefit, *including payment of the nursing home*. That would be illegal as elder abuse or criminal embezzlement.

The responsible party should exercise great caution if the resident does not have enough money for all bills. Suppose savings are running out: what bills should be paid? Should you pay the credit card off and not pay the nursing home? Should you pay the taxes on the home and not other bills? Can you prepay a funeral for the resident? If you are in this situation, seek legal counsel lest you be sued yourself.

Advocate's Tip: Have the Patient Sign the Admission Contract
Citizens who enter a nursing home does not lose their legal rights. They have the right to be treated as adults who can make their own legal agreements. A patient

advocate, whether spouse, child, sibling or friend is under no duty to sign a nursing home contract. That is true even if the person is the patient's representative payee for social security funds. So, if you signed the agreement go back to the admission office and say the resident wants to sign her own agreement. Get a new agreement/contract, have her sign and then have the admission person tear up the one you signed.

A helpful person who is assisting the patient can avoid being sued on the contract by simply refusing to sign. This refusal could lead to refusal of *admission* to an applicant, but it cannot lead to *discharge* of a patient already admitted. For example, upon completion of the Medicare paid skilled care many facilities approach the patient advocate with a contract to sign as "responsible party." What if neither the patient nor the patient advocate sign the contact? The facility may not discharge a resident because the contract was not signed. However, contract terms would still apply to the resident but not to the patient advocate.

Nursing Home Residents' Rights
(Residents have rights and you don't have to pay their bill)

The source of the rights of nursing home residents is the law Congress passed in 1987 to address the serious problems of care in nursing homes. The law is known as the "Nursing Home Reform Law." Since it was passed as part of that year's budget bill, the Omnibus Budget Reconciliation Act, it is also known as OBRA 87. This law applies to nursing homes that participate in the Medicare or Medicaid program. Michigan followed federal law and passed a law protecting nursing home patients rights. It is found in *Michigan Compiled Laws* (MCL) 333.20201(2), (3). It applies to all nursing homes. The resident's rights guaranteed by federal law are found in the *United States Code* (USC) and the *Code of Federal Regulations* (CFR). Not all and every nuance are included here. Some of the major rights follow.

The Right to Achieve and Maintain the Highest Practicable Level of Functioning
Some patients are critically ill or "actively dying." Others are long term residents. All residents have the right to maintain function not affected by their illness. The resident has the right to, and the nursing home must provide services, including:

- therapy (physical, speech and occupational). For example, it is a violation of a resident's right to cause a loss of ability to walk where the loss is not a necessary result of the patient's medical condition;
- assistance with Activities of Daily Living (ADL) – eating, bathing, grooming, transferring and ambulating.

Given the wide spread problem of malnutrition and dehydration, reported by the Commonwealth Fund and others, it is hard to overstate the importance of assistance with ADLs to maintain independence. The advocate can find provisions in 42 USC 1396r(b)(4)(A)(I), the statute, and 42 CFR 483.45, the regulation that require these needs be met in the residents plan of care.

The Right to Make Health Care Decisions
Federal law, 42 USC 1396r(c)(1)(A)(i), 42 C.F.R, Section 483.10(b)(4), guarantees the right to:

- make medical treatment decisions, unless judged incompetent;
- decide who the attending physician will be;
- accept or refuse medical treatment;
- be fully informed in advance of any changes in care or treatment that may affect the resident's well being;
- the right to review and have copies of medical records;
- participate in planning care and treatment or changes in care and treatment by the patient or advocate.

The right to make health care decisions and participate in the process is fundamental

to the concept of quality care in a nursing home through patient rights.

The Right to Be Free of Unnecessary Restraints
Physical or medical restraints not required to treat the resident's condition are not allowed. A restraint may be imposed only upon a physician's order and the patient or advocate's agreement. 42 USC 1396r(c)(1)(A)(ii).

The Right to Be Free From Abuse
The resident has the right to be free of willful abuse be it physical or mental. Abuse encompasses intimidation or punishment resulting in harm or anguish.

The Right to Accommodation of Individual Needs and Preferences
The nursing home must allow the resident to choose "activities, schedules, and health care consistent with his or her interests, assessments and plans of care." 42 CFR 483.15(b). The only exception is health and safety of the residents.

The Right to Independence, Dignity and Participation in All Activities.
The patient's right to dignity and independence is stated by the right to:

- privacy in treatment, communications and visits with family. 1396r(c)(1)(A)(iii).
- confidentiality of records. 1396r(c)(1)(A)(iv).
- have grievances addressed by the facility. 1396r(c)(1)(A)(vi).
- participate in resident or family groups. 1396r(c)(1)(A)(vii).
- participate in social, religious or community groups. 1396r(c)(1)(A)(viii).
- examine survey reports made by the state or federal inspectors.

See also a comparable list under 42 USC. 1395i-3(c)(1)(A)(i).

No Waiver of Rights.
A nursing home may not require individuals applying to reside or residing in the facility to waive their rights. 42 USC 1395i-3(c)(5)(A)(ii), 1396r(c)(5)(A)(ii).

Summary
Congress recognized the rights of nursing home residents to quality care in the nursing home. These rights are not obstructions to good care but the guarantee of it. If the rights are observed the patient will have individualized care with maximum respect for the patient's person, independence and dignity.

The Six and Only Reasons for Discharge

A nursing home may inform you of its intention to discharge your family member. This commonly happens when he or she is difficult to care for and especially true if "agitated" and upsetting other residents. It happens when Medicaid drags its feet and the home has not been paid for months. It happens when Medicaid denies an application. Can the nursing home effect an involuntary discharge in times like these?

These are the *only* reasons the law allows an involuntary discharge of a resident. A nursing home may involuntarily discharge a patient when:

(1) transfer or discharge is necessary for the resident's welfare because the resident's needs cannot be met in a nursing facility;

(2) transfer or discharge is appropriate because the resident's health has improved to the point that s/he no longer needs nursing facility services;

(3) the resident's presence endangers the safety of individuals in the facility;

(4) the resident's presence endangers the health of individuals in the facility;

(5) the resident has failed to pay (or to have paid under Medicare or Medicaid) for facility services; or

(6) the facility is going out of business.

42 USC 1396r(c)(2)(A), 42 CFR 483.12. Michigan follows federal law, MCL 333.21773. Note that (5) is satisfied if If a resident has submitted appropriate paperwork to a third party payer and is waiting for a response to the claim. That paperwork may be a Medicaid application or the filing a claim with your insurance carrier.

The discharge notice must be written and be given a minimum of 30 days before the proposed discharge. The 30 day requirement may be waived if medically necessary as shown by written orders and medical justification of the attending physician, or if mandated by the physical safety of other patients and facility employees. The notice must be accompanied by notice of the right to appeal. MCL 333.21773.

Appeal of Discharge

Upon receipt of a Notice of an Involuntary Transfer or Discharge to a nursing home resident, the resident or authorized representative may file an appeal with the Department of Community Health. This appeal must be in writing and made within ten days of the date of the notice to the Director of the Department. A Request for Hearing will then be sent to the Bureau of Hearings who will notify you of the hearing date to be held at the facility. For more information see http://michigan.gov/documents /mdch/bhsGUIDANCE_for_Inv_Transfer_321820 _7.pdf

Planning Prior to Discharge
A nursing home is strictly limited in discharge procedures. They may not simply "put him in the lobby" and tell the family to "come and get him." Whenever a home discharges a patient, voluntary or involuntary, it must have a discharge plan that will meet the patient's needs.

The patient may disagree with the discharge plan, file a complaint and have a hearing on the adequacy of the plan. Your first action should be to contact the Long Term Care Ombudsman (below) as soon as you hear of the discharge plan, and if discharge notice has been given then ask for a review of the discharge plan by **KEPRO, (855) 408-8557**.

A complaint may be made by the Complaint Hotline (800) 882-6006or online at:
www6.dleg.state.mi.us/parsers/complaints/onlineform.asp

Note: Transfer to Hospital is <u>Not</u> Discharge
There are times when a nursing home will transfer a difficult patient to the hospital for treatment. The patient is <u>not</u> discharged, even if the patient does not pay a bed hold fee. Often the facility will not have a vacant bed when the patient is discharged from the hospital. What then? The hospital discharge planner must make another nursing home placement. That does <u>not</u> mean the patient has been discharged from the first nursing home. The patient has the right to return to the facility to the first available bed.

If the nursing home wants to discharge a patient the home *must follow formal discharge procedures* including 30 day notice and information of the right to appeal. Once a person is admitted as a resident s/he may only be discharged for one of the six reasons above. The burden of proof is *very* high. The facility is in the business of meeting the medical needs of its residents. To discharge it must show that the particular condition is not one that it is licensed to treat, a difficult proof to make.

The Long Term Care Ombudsman
If the patient or advocate has any complaint with the patient's treatment or a violation of the patient's rights they may ask the Michigan Long Term Care Ombudsman for help. See the **Resource** section below for contact information.

The Long Term Care Ombudsman office is required by Federal and Michigan law. The Ombudsman duties are to identify, investigate, and resolve complaints made by residents regarding the health, safety, welfare, or rights of the residents (including the welfare and rights of the residents with respect to the appointment and activities of guardians and representative payees). The Ombudsman will also represent the interests of the resident before governmental agencies and seek

administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents. The Ombudsman program is established in federal law found at 42 USC 3058g and Michigan statute at MCL 400.586h.

Medicaid – Payment for Long Term Care
(Pay the Nursing Home Without Going Broke)

Many people think Medicare will pay for the nursing home. It does not pay for long term care. It only has a limited post-hospital nursing home benefit for "skilled care." The maximum benefit is 100 days. While it's never possible to predict at the outset how long Medicare approve payment for skilled care, from our experience it often falls far short of the 100 day maximum. But even if Medicare does cover the 100 day period, what then? Unless the patient has supplemental skilled care insurance, the patient will have to pay by long term care insurance, life savings, or apply for Medicaid.

Those who do not enter the nursing home on a Medicare stay are private pay from the start. Their payment options then are: 1) long term care insurance - if they have it; 2) "private pay" out of life-savings; 3) Medicaid if they apply for the benefit and are approved.

What is Medicaid?
Medi<u>*caid*</u> is a long term care program you have already paid for by your taxes. It is "means tested." Medicaid is overseen by the Centers for Medicare and Medicaid Services (CMS). It is primarily funded by the federal government, the states fund the remainder and administer the program.

One must apply for Medicaid and prove "eligibility." It is a complicated, at times illogical, benefits program drafted by Congress, implemented by states with variations in program and interpretation. That means rules do vary from state to state. Sometimes rule application varies from county to county in a state.

Med<u>icare</u> is the program that all wage earners and dependants over 65 receive. Its benefits are very limited in the nursing home. Medicare only pays for "skilled care" up to 100 days. It does not pay for long term care. Medicare does not pay for nursing home care for all diseases or conditions that result in long term care, for example Alzheimer's or Parkinson's disease. Even though the patient receives medical care, it is not *skilled care.* Of course if such patient needs skilled care, such after surgery for a broken hip, Medicare will pay for that. Medicaid will pay for long term care in a nursing home, if the resident applies and is eligible.

How Does Medicaid Work?
Medicaid will pay for nursing home care if the applicant:

1) the patient needs nursing home level of care;
2) if the patient is financially eligible;

3) is in a Medicaid bed;
4) has no "divestment penalty period;"
5) successfully completes an application.

All of the above steps must be satisfied. And finally we will add a sixth item of Medicaid and that is:

6) post-death estate recovery. The government comes after your home.

Problems with all of the above can be avoided with competent advice and representation.

The complexities and lack of knowledge about Medicaid make professional advice essential to avoid a substantial loss of money and property. Even the family home is at risk. We consider each below.

The Requirements for a Good Medicaid Application

Requirement 1: "Seven Doors to Medicaid"
An applicant's level of care need must severe enough to require nursing home care. Medicaid uses the "Seven Doors" screen to make that determination. One will satisfy the proof of need for a nursing home by entering through any one of the "doors." The doors or screens are:

1. **Activities of Daily Living**. The patient needs supervision or extensive assistance with moving around in bed, transferring from bed to chair or wheelchair, or standing, toileting or eating.
2. **Cognitive Performance**. The patient has severe problems with memory or making decisions about basic daily needs.
3. **Physician Involvement**. The patient is under the care of a physician for treatment of an unstable medical condition.
4. **Treatments and Conditions**. The patient has received treatment for conditions in the last two weeks: diabetes with daily insulin and order changes; stage 3-4 pressure sores; intravenous or parenteral feedings; intravenous medications; end of life care (life expectancy less than 6 months); daily tracheostomy care, daily respiratory care, daily suctioning, pneumonia, daily oxygen therapy, peritoneal or hemodialysis.
5. **Skilled Rehabilitation Therapies**. Has the patient been scheduled to receive, or is receiving, speech, occupational, or physical therapies and continues to require skilled rehabilitation therapies?
6. **Behaviors**. Wandering, verbal or physical abuse, socially inappropriate behavior, resists care, hallucinations or delusions.
7. **Service Dependency**. The patient has been a Medicaid participant for at least one year and requires ongoing services to maintain current functional status. No other community, residential or informal services are available to meet the patients needs.

We have reprinted the Seven Doors to Medicaid at the end of this book.

Fail the Seven Doors Screen?
Failure to pass any of the screens means that the person does not need nursing home care. What should the Patient Advocate do? Before you reconsider a re-assessment of the person's need you should be sure that the screen was not based on inaccurate or incomplete information. Speak with whomever did the screen. Review the screening *and* the medical chart of the patient before asking for a second screen. Make sure all care needs are recognized and recorded. Do your own screen using the 7 Doors To Medicaid in the back of this book. You may request a re-screening at any time. It may be requested the same day as the first screening. Once

the 7 Doors screen is accurately done your patient's needs will be recognized.

If you agree your patient/resident does not pass the 7 Doors screen, that means he or she does not need a nursing home. You need a good individualized discharge plan. For example, the resident may not be able to return to home because there is no one who can assist and the resident cannot afford in-home care. Note that even if the resident fails the 7 Doors screen, he may still qualify for the Michigan MiChoice waiver Medicaid program. It might pay for enough care for the resident to leave the nursing to home or an assisted living facility. Contact the local Area Agency on Aging about application procedures and to determine their waiting list.

The VA improved pension program should be considered if the resident is a wartime veteran or surviving spouse of such a veteran. This VA program provides a monthly cash benefit to help with "unreimbursed medical expenses."

Requirement 2: Applicant Must be Financially Eligible

Medicaid will pay for nursing home care if the applicant is "resource eligible." Medicaid breaks financial resources into two categories: income and assets. To qualify for Medicaid the applicant must *not* have sufficient *income* to pay the medical bills. This is not a problem in the nursing home. The applicant is strictly limited in the amount and kind of *assets* that may be kept. Each category has its own rules.

The applicant will be eligible if she meets the asset test, that is she must not have excess "countable assets." Before we get into that, let's first understand what "assets" are.

Excluded Assets and Countable Assets

The main categories of Medicaid assets are "*e/cluded*" and "*countable*" assets. *E/cluded assets* are those which Medicaid will not take into account at the time of application. The primary excluded assets are:

- Homestead, equity limited to $552,000 if no spouse. The home must have been the principal place of residence and the nursing home resident must "intend to return home" even if this never actually takes place. The limit is removed if a spouse, child under 21, or the client's blind or disabled child is residing in the home.
- Ordinary and usual personal belongings and household goods
- One vehicle
- Equity in income-producing real estate, equity limited to $6,000.
- Burial spaces and certain related items for applicant, spouse and immediate family members
- Up to $1,500 designated as a burial fund for applicant and spouse

- Irrevocable prepaid funeral contract
- Life insurance of face value $1,500 or less.
- Assets that applicant or spouse do not have the legal right to use or dispose of are excluded from countable assets.

- Real Estate that has been for sale for at least thirty days during the last three months and has not been sold. The asking price must be at fair market value and no asking price purchase offer may have been denied.

Most other assets are *countable* and subject to "spend down." Essentially all money and property, and any item that can be valued and turned into cash, is a countable asset unless it is one of those assets listed above as excluded. This includes:

A. Money in:
- Cash, savings and checking accounts, credit union share and draft accounts
- Certificates of deposit
- U.S. Savings Bonds
- Individual retirement accounts (IRA), Keogh plans, (401Ks, 403Bs)
- Nursing home trust funds
- Prepaid funeral contracts which can be canceled
- Trusts (depending on the terms of the trust)

B. Equity in:
- Real estate
- second motor vehicle, boats or recreational vehicles
- Stocks, bonds and mutual funds
- Land contracts or mortgages held on real estate sold

While the Medicaid rules themselves are complicated and tricky, it's safe to say that a single person will *not* qualify for Medicaid until the "countable assets" are $2,000 or less.

Medicaid "Spend Down"
The applicant must have no more than the maximum allowable "countable assets." The process of reducing the amount of such assets is called "spend down." Here are common examples of spend down:

- Pay Bills. Medicaid does not allow a credit for outstanding bills. For example a person may have $5,000 in the bank and owe $25,000 on the home mortgage. Medicaid would be denied until the $5,000 is spent down to $2,000. Sometimes there is not enough money for all bills. In that case talk to an elder law attorney about which to pay.

- Prepaid Funeral. Medicaid regulations permit the purchase of a prepaid funeral within limits. See your elder law attorney or reputable funeral director for guidance.

- Home Purchase. A community spouse may purchase a new home, even after the applicant enters the nursing home and it will be excluded. Where there is no spouse, the applicant may not purchase a home after long term care entry.

- Home Repair/maintenance. Money may be spent on needed maintenance or repairs, but they must be done quickly to be spent down.

- Home Improvements. Expenditures on the home are not limited to repairs. You can make improvements as well. But be sure you are not improving it just for the State of Michigan. See Requirement 6 below.

- New Car. One might consider purchasing a new car, though it is a declining investment.

- Long-Term Care Insurance for a Healthy Spouse. While long term care insurance will not be available for the nursing home resident the at home spouse may qualify.

Advanced Strategies. There are a number of advanced strategies that can reduce countable assets without "spending." These depend on the applicant's specific situation. An experienced Medicaid planning or elder law attorney should be consulted. If the attorney is not experienced you can lose thousands of dollars while the attorney "gets up to speed" on your case.

Requirement 3: Applicant must Be in a Medicaid Bed

Medicaid will not pay a nursing home bill unless the applicant is in a "Medicaid bed." Without the "Medicaid bed," Medicaid will not pay even if the person spent down and was approved for Medicaid. For most nursing homes this is not a problem. It is a problem in nursing homes that try to limit the number of long term care residents in favor of serving the post hospital Medicare skilled patients. See the tables in the back of the book to see if your nursing home is only "partially certified" for Medicaid. No Medicaid bed means transfer to a nursing home that does have an open Medicaid bed. That is why when you believe it will be long term care be sure that discharge from a hospital is to a home that has 100% Medicaid certification. See our list of nursing homes in the back of the book.

Requirement 4: Applicant Must Not have a Divestment Penalty
Since February 8, 2006, when President Bush signed the Deficit Reduction Act of 2005, Medicaid has a five year look back. Before then it was three years. The look back means that an applicant must disclose all transfers of assets within the five years before the date of application.

"Divestment" refers to the act of divesting oneself of assets to get down to financial eligibility. It is broader than giving away assets. It includes purchasing assets for more than "fair market value." Divestment includes not only gifts but any action that reduces the applicants control over an asset. It includes adding names property, removing names from accounts and more. For example adding co-owners to real estate or investment accounts can be divestment since the co-owners now own part of the property. Some transfers are permitted such as those between husband and wife.

Divestment made within the look back period will be treated as though being made *when the person applies for Medicaid*, which could be up to five years later.

Divestment creates "penalty period." That is a period of time during which Medicaid will not pay the nursing home. This period will *only after application for Medicaid* and the person is in a nursing home. Divestment as small as $407 will result in a one day penalty period. Greater amounts result in longer periods.

> Example: Within five years of applying for Medicaid, Mrs. King "loaned" her son $15,000 to avoid foreclosure on his home and gave two grandchildren a gift of $1,000 on their graduation. None of this money can be returned to her. Result: Total "transfers" of $17,000. A penalty period of a month and a half will begin *after* she has applied and after she has spent down to $2,000. How she will pay the $18,324 nursing home bill when she has only $2,000 is unknown.

Requirement 5: Applicant Must Successfully Complete the Application Process
Here are the necessary minimum conditions for a successful application:

1. Be sure you have authority to apply for the nursing home resident. Unless you have a power of attorney that authorizes application for government benefits, you may have to be petition the probate court to be appointed the resident's guardian and conservator. When it comes to maximizing the savings allowed by Medicaid's "loopholes" probate court can be both unfriendly, slow and very expensive.

2. Get a copy of the Medicaid application and be sure you have written proof for everything you write down. Failure to provide adequate documentation will result in dismissal of the application. It absolutely must be complete.

3. Prepare to report any transfer of assets including closing of an account and putting the proceeds in another. Tax returns and bank accounts should be

investigated for missing assets. Be sure you have *all* assets. Check safe deposit boxes, look for CDs and insurance policies. Inquire of siblings about assets. Sometimes a parent will buy a car for a child and not tell the others. Inquire about loans or gifts. These will be considered divestment. If assets have been "divested" see an experienced elder law attorney.

4. Plan to Apply Timely. Ordinarily an application should be filed as soon as spend down is complete. But planning for the application and spend down must begin as soon as long term care is certain. Application processing by the Department of Human Services often takes months. If it is denied there may not be time to correct the mistake and get full coverage. However, an application will simply be denied if filed before spend down is complete. That means have your spend down and documentation of assets and expenditures well organized. In a rare case an application can be filed too early if a substantial divestment must be reported and the five years has almost run on the transfer of assets. In that case better to wait until the five years has run and then file the application.

5. Remember, it is a process. It is not enough to file a complete application. You must be able to give the Medicaid worker information requested in the short period of time allowed. For example you will need current values of all assets and those must be in writing. You must be able to document your spend down and the closing of accounts. Be prepared. Be on alert for the request to come by mail to you, your resident's home or to the nursing home. You do have the right to ask for one extension of 10 days, but that may not be enough time for you to get the information requested. Your application will be denied, you will have to reapply and you may lose months of coverage. The nursing home may sue to recover the unpaid bills.

Requirement 6: Plan for Post-death Estate Recovery

The government wants pay-back after the death of the Medicaid recipient. Under the current Michigan program this is done through probate. That means that any legal work done for Medicaid eligibility should contemplate probate avoidance as well. The state collection office will contact the family after the recipient has died, whether or not probate will be commenced. You should contact an elder law attorney upon receipt of the notice.

If probate is needed, the state will present its reimbursement claim. Note that the probate process and the estate recovery program have allowances, deductions and credits. It is best to contact an elder law attorney in this case.

Should I Seek Professional Advice for Medicaid?

Yes. Consider the income tax return. Most elders have their return done by a professional. Why? To be sure to save as much as possible. You will find that if you hire an elder law attorney you will save much, much more than any fee charged. As we have discussed above, the Medicaid application process is much more complex

than any income tax return. That correctly implies that a professional offers three advantages: first, you will be advised of "loopholes" you did not know about; second, your application will be completed quicker than you could have which means earlier Medicaid coverage; and three, the application process will be successfully completed without denial.

Consider what is at risk - the average cost of a nursing home in Michigan is $8,084 per month. The applicant will get only one chance on application – it will be approved or denied. The needs and security of the patient and family is at stake. Without professional assistance many people find their application is needlessly, legitimately and avoidably denied. Mistakes are extremely expensive. The family security is irreversibly damaged.

So the answer is "Yes, immediately get advice" whether the applicant has little or much that must be "spent down." If nothing else use a bit of the spend down on attorney review the application you propose to submit. It will be inexpensive insurance against denial of benefits.

Medicaid – Questions & Misconceptions

"Do they count joint accounts with someone other than my spouse?"
Yes. The entire amount is counted unless the applicant can prove some of the money belongs to the other person. This rule applies to cash assets such as:

- Savings and checking accounts
- Credit union share and draft accounts
- Certificates of deposit
- U.S. Savings Bonds

"**Can I give my assets or income away?"**
Giving away or *divesting* assets or income for less than fair market value by the applicant, spouse or joint owner will result in a penalty period. "Divestment" includes:

- allowing another person to take assets or income from a joint account, and
- losing control over an asset by adding a joint owner or putting the property in certain kinds of trusts.

Divestment of assets during the look back period will result in a "penalty period." That means Medicaid will not pay the nursing home bill for period that is determined by the amount of the assets divested. Medicaid looks at transfers that occur up to five years before application for nursing home. However, there is no penalty if assets are transferred in accordance with the Medicaid rules between spouses, to blind or disabled children, or are transfers for value.

"I heard I can give away $10,000 per year. Can't I?"
Many people have heard of the *federal Gift Ta/* provision that allows them to give away $10,000 per year. That amount has been adjusted for inflation to $14,000 per year. What they do not know is that this refers to a Gift Tax exemption. It is not an absolute right. You may give away $14,000 per year per person without incurring tax, but those gifts will result in months of Medicaid ineligibility.

Still, some parents want to make gifts to their children before their life-savings are all gone. There are limited circumstances when assets may be transferred to others within the look-back period. In addition there is a Medicaid asset protection strategy that uses gifts to children. These rules are subject to change and you should consult with an elder law attorney if gifts or transfers have been or will be made during the five year look-back period.

Myth: Medicaid Will Not Provide Quality Care
Many people are concerned that if they have Medicaid pay the nursing home bills,

they must go without quality healthcare. That is false. Almost all nursing homes are "Medicaid" nursing homes. An inspection of the nursing home listings in the back of this book will show that few homes in Michigan do not participate in Medicaid. What if Medicaid does not cover a treatment? You can still get uncovered medical services paid, see below.

Do I Lose My Other Insurance If I Receive Medicaid Assistance?
No. Medicaid allows and one might say encourages medical insurance such as Blue Cross. The Medicaid recipient's "monthly patient pay amount" is the amount the patient must pay to the nursing home each month from his monthly income. Not all of the income goes to the nursing home. Medicaid allows a deduction for monthly health insurance premiums. Patients keep their private insurance and Medicaid covers the rest.

Medicaid Tip: Purchase Additional Insurance
A too little known provision is that Medicaid will allow a patient to purchase additional health insurance and will allow the patient to use monthly income to pay the bill. The patient pay amount to the nursing home will decrease accordingly. This provision allows the patient to make sure his or her needs are met. For example the patient may purchase vision or dental insurance. The nursing home will not provide the service but can arrange transportation to the provider.

The importance of complete coverage cannot be overstated. One dentist who specializes in dementia and nursing home patients, Dr. Katherine Martin, observed that over 25% of nursing home patients have serious dental needs. Even a three month stay without daily dental hygiene can cause a patient to go from having healthy teeth to having serious tooth decay.

Medicaid Tip: Uncovered Medical Expenses – Use the "Patient Pay Amount"
Others are concerned that they must give up certain treatment since the nursing home does not provide it or Medicaid does not cover it. A too little known fact is that Medicaid will allow the patient's monthly co-pay, called the "patient pay amount," to be used to pay for "non-covered service." Here is the word right from the Michigan Medicaid department's publication "Know Your Rights -- Your Medicaid Care And Coverage In A Nursing Facility":

- A doctor must document that the medical service is needed.
- Medicaid may limit the amount you can deduct from your patient-pay to obtain non-covered services.
- The provider of the service will bill you or the person handling your funds.
- It is up to you to pay the bill. Your monthly patient-pay amount is the most you will have to pay each month toward paying off a medical bill.
- You present a copy of the bill to your home. The bill will go towards your

patient-pay amount for the next month. If the bill is less than your patient-pay amount, you must pay the rest of your patient-pay amount to the home.

• If you wish, you may payoff a bill that is more than your monthly patient-pay amount. This will result in lowering or replacing your monthly amount the following month(s). After you have received credit for the total bill you paid, your patient-pay amount will go back to the amount it was before you paid off the bill. See the example below. Example:

Your January patient-pay amount is: $200
You pay a medical bill of: $500
Your February patient-pay amount is: $0 because the paid bill will go against your February patient-pay amount of $200
Your March patient-pay amount is: $0
Your April patient-pay amount is: $100
Your May patient-pay amount is $200

You must give the nursing home a copy of the bill each month. In this example, February, March, and April.

There it is, from "the horse's mouth." Medicaid will cover all current medical needs.

Medicaid Tip: "Pre-eligibility Medical Expenses" – Use the "Patient Pay Amount"

Bills incurred up to 90 days prior to the application for Medicaid may be paid out of the patient's income. This is the result of a lawsuit the Michigan Elder Law attorneys supported. Pre-Eligibility Medical Expenses (PEME) are those that were incurred in the three months prior to application for Medicaid. The medical expense(s) must be:

- Unpaid, and an obligation still exists to pay.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient pay amount.
- Can include cost of room and board for Medicaid long term care (LTC) facilities, remedial care and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.

Special approval from the Medicaid Lansing office must obtained before the patient pay amount may be used to pay on these bills. You will need to work with the nursing home, your healthcare provider and your Medicaid worker.

Medicaid Rules for Married Couples
(Yes. You can save everything.)

Special rules apply to married couples due to the Spousal Impoverishment provisions of the Medicare Catastrophic Act. Where one spouse needs nursing home care and the other remains in the community, the law provides that the "community spouse" will be allowed enough savings to remain independent. The law recognizes that it makes little sense to impoverish both spouses when only one needs Medicaid assistance for nursing home care.

Assets

Medicaid considers the assets, property and money, of both husband and wife. The couple gathers all of their countable assets together in a review. Excluded assets, discussed above, are not counted. The at-home or "community spouse" is allowed to keep *one-half of all countable assets.* In 2015 the *minimum is $23,844* and the *ma/imum is $119,220.* This allowance is called the Community Spouse Resource Allowance (CSRA). The remaining "half" of the countable assets must be "spent down" until $2,000 or less remains.

To make it clear let's look at two hypothetical couples, the Smiths and the Joneses. Medicaid requires them to disclose the amount of assets they had on the "snapshot date." That is the date the applicant, here the husband, began a stay of 30 days or longer in a hospital and or nursing home - in other words "long term care."

Let's assume that the Smiths had $100,000.00 in countable assets. The Joneses have $250,000.00. How much is the spend down and how much is at risk of being lost to long term care?

Smith		**Jones**	
Countable Assets on "Snapshot Date"	$100,000.00	Countable Assets on "Snapshot Date"	$250,000.00
Community Spouse Allowance (CSRA) *half of countable assets*	$50,000.00	Community Spouse Allowance (CSRA) *-ma/imum allowance*	$119,220.00
Nursing home spouse allowance	$2,000.00	Nursing home spouse allowance	$2,000.00
"Spend down"	$48,000.00	"Spend down"	$128,780.00

Comments. Note that the "spend down" does not mean how much they will spend.

It refers to how much lower the countable assets will be before Medicaid will assist. For example assume Mrs. Smith is very frugal and Mr. Smith has a good pension. Their spend down is $48,000. Does that mean they only need to spend $48,000? No. They will actually spend more.

Suppose the Smiths' total income is $2,800.00 per month. Mrs. Smith lives on just $600 per month and the remaining $2,200 goes to the nursing home. The average cost of nursing home care in Michigan in 2015 is $8,084 per month. That means she would have to take $5,884 out of savings every month. How long will it take for her to spend $48,000 of savings? Over 8 months. She would be paying $8,084 each month and the total expense would be <u>over $64,000</u>. It is possible for her to capture and save <u>all</u> of this money

Note that in the Jones case the community spouse is not "allowed" half of the countable assets. That would be $125,000. Instead her allowance is $119,220 because that is the *ma/imum* Community Spouse Resource Allowance (CSRA).

Must Mrs. Smith and Jones actually spend their savings? No. They could protect it by methods we will cover below.

Income

Under Medicaid the nursing home resident's income goes to the nursing home. However Medicaid will first allow: $60 per month for personal needs; amount needed pay health insurance premiums; and the spousal allowance. The remainder is his "patient pay amount."

The spousal allowance is called the <u>Community Spouse Income Allowance</u> (CSIA). The Medicaid office may "allow" the community spouse a minimum monthly income ranging from $2,643 to $3,024. The higher amount includes "excess shelter expense."

To illustrate, assume the at-home spouse receives $800 per month in Social Security and pension. Also assume that her needs are calculated to be the minimum of $1,966. She is $1,166.00 short each month, as shown in the following chart:

$2,644.00 the Minimum Monthly Maintenance Needs Allowance)

<u>($800.00)</u> at-home spouse's pension and Social Security

$1,864.00 Short fall

In this case, the community spouse will be allowed up to $1,864 (the shortfall amount) per month from her husband's income. to meet the basic allowance of $2,643. She may be allowed more under an "excess shelter allowance." If it is less he will have no "patient pay amount."

$1,166 then she would only be allowed what he has in income. In that case there would be no patient pay amount. Where the spouse's income is less than the CSIA, Medicaid does not make up the difference in payment to the spouse.

Case Study No. 1
Medicaid Planning for Married People

Ralph and Alice were high school sweethearts who lived in Livonia, Michigan their entire adult lives. Two weeks ago Ralph and Alice celebrated their 67th Anniversary. Unknown to their children, Alice has been struggling to care for Ralph. He has Alzheimer's. Recently Alice heard some noise at 2:00 a.m. and got up to see Ralph went out, got in the car and was driving off. She called the police immediately. He was found a hours later. He was 20 miles from home and drove his car in a ditch. He got pretty banged up. They took him to the hospital and now he is in "rehab" at a nursing home. His Alzheimer's dementia got much worse. Alice wants to bring him back home, but she cannot if he does not improve. Ralph and Alice grew up during the Depression. They always tried to save something each month. Their assets, total $120,000, not including their house, are as follows:

Savings Account..	$35,000.00
CD's.	$65,000.00
Money Market Account.	$17,000.00
Checking Account.	$ 3,000.00
Residence -no mortgage.	$130,000.00

Ralph gets a Social Security check of $1260 each month. Ralph also gets a pension check of $650 a month. Alice's check is $680. Her eyes fill with tears as she says, "At $12,200 paid to the nursing home every month, our entire life savings will be gone in months!" What's more, she's afraid she won't be able to pay her monthly bills, because a neighbor told her that the nursing home will be entitled to all of Ralph's Social Security check.

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1. A Note about the Case Studies. No client information was used in the case studies. We do not publicize the confidential information of our clients. The studies are fictional examples of the application of Medicaid rules. You need not be concerned that your private information will be publicized in any way.

There is good news for Alice. It's possible she will get to keep everything – all of their assets and all of the income and still have the state Medicaid program pay Ralph's nursing home costs. The process is very complicated and she will need help.

If he returns home they can institute a five year plan using an irrevocable Medicaid Asset Protection Trust. They can save a good portion of their "wealth"and still qualify for Medicaid five years later. However, the plan must be flexible to allow for care prior to nursing home entry and unplanned events.

When and if Ralph applies for Medicaid, the state will "look back" *five years* to see if transfers of assets have been made. You cannot just give away your money or your property to qualify for Medicaid. Any gifts or ***transfers for less than fair market value*** that fall in the look-back period will delay Ralph's eligibility for Medicaid payments.

To apply for Medicaid, she will have to go through the Department of Human Services (DHS). If she does things strictly according to the way DHS tells her, she will only be able to keep about half of her assets, which is the "CSRA." Plus, they may only allow the minimum income allowance, "CSIA", of $1,966 per month. She can do better.

Medicaid has provisions for the spouse to keep all assets and income of husband and wife. The law allows the at home spouse to seek a court order directing the agency to allow such part of the assets and income as the court orders. While the law allows the at home spouse to have it all, judges must be shown need for the resources. The safest way to accomplish this is with the assistance of an experienced elder law attorney.

With proper advice and representation Alice will be able to avoid destitution and keep everything she and Ralph have worked so hard for. This is certainly an example of where knowledge of the rules, and how to apply them can be used to resolve a difficult dilemma.

Case Study No. 2
Medicaid Planning for Married People

George and Mary were never rich. George worked at the shop and Mary stayed home and raised their two sons. At times she thought of working; it might be nice to get a job and do office work like some of her friends had, but that opportunity never came.

Shortly after George turned 80 they sold their house and moved into a "senior living" apartment. George could not keep up with the home maintenance. The past five years have been comfortable, made possible with increasing assistance from the on-premises home health agency. But that

changed. George had a fall and broke his hip. Because of his diabetes and poor heart, he is just not improving. The doctor says that he probably will not leave the nursing home.

Mary is devastated. She is in constant crisis. She wants to care for her husband, but she also must take care of herself. She has her own medical issues. Mary does not want to become dependent on her children and does not want to move. She likes her neat apartment and they have made friends there. But, Mary fears for her own future. Will she be forced into a nursing home? She could not make it alone if were not for the meal, housekeeping and laundry services provided by the apartments. Mary worries day and night about her future. They never had much money and her rent is almost $2,500 per month!

The social worker at the nursing home told Mary that she could keep $75,000 of their $150,000 life savings. George would have to spend his $75,000 on the nursing home. His will be gone in less than a year! Hers would be gone in a little more than two.

If Mary consults an Elder Law attorney she may learn that there are a number of strategies to enable to hold on to their life savings for her financial security. Her elder law attorney may obtain a court order or set up a Medicaid trust for that purpose. George's $75,000 may be saved for her and he will qualify for Medicaid for payment of the nursing home bill. Barring other expenditures, she will have $150,000 for her financial security. With frugal living she may make it on her investment income, social security and the income supplement from George's check.

Widowed or single persons in nursing homes have the problem of no spouse to act as protector. Children have their own families and jobs to attend to. But, what of the case where a child makes very large sacrifices to help her mother? The law allows her protection too.

Case Study No. 3
Planning for Veteran's Widow

Betty Johnson feels worn out. Four years ago her father died and for the past three years she has been caring for her aging mother. At first, it was little things: grocery shopping, trips to the doctor, help with her medication, things like that. As her mom's health continued to deteriorate, Betty's burdens increased. Now her mother can no longer live alone.

Betty, a single mother, was laid-off from work. That means she has time to help her mother but she is running out of money. She is caught between her own needs, her family and her mother. None of her siblings can, or will, help. Betty fears that she must place her mother in a nursing home so Betty can get

a job. She has been looking for work but has had no offers. The last six months have been brutal.

Mom has about $50,000 and would like to give it to Betty rather than to a nursing home. Betty, quite rightly, fears that such a gift would make her mother ineligible for Medicaid assistance if her mother soon needed a nursing home. And, it could outrage her siblings.

Betty made some inquiries about Veterans Benefits - dad was a wartime vet. She was hoping mom would qualify for the surviving spouse maximum benefit of $1,149 per month. But she found that mom has too much money and not enough "unreimbursed medical expense." In VA jargon she does not have enough "UME."

Betty is quite distraught. "Is there anything else I can do?"

Yes. Betty can be paid full market value for her services and if properly done, her mother can get the full VA benefit. For example if mom moves into Betty's home, then mom can pay her rent as she may an "assisted living" facility. Those facilities can exceed $7,000 per month. If Betty lives in mom's home then she may be paid the fair market value of the services she performs. These payments can be recognized by the VA as UME and will not be "divestment" if mom needs to apply for Medicaid. In addition, Medicaid may allow mom to give Betty her home. However, they must do everything exactly right.

They will need a formal contract that meets VA and Medicaid specifications before any payment is made and application for benefits made. Mom's need for the services must be documented by medical proof. In addition, to ensure family harmony all members must be informed and have input into the contract process. It is plain that professional assistance will be needed *immediately*.

This is just one example of a plan. There are actually a number of strategies that could be helpful. With any Medicaid planning it's especially important to seek the assistance of a knowledgeable Elder Law attorney to avoid violation of the Medicaid or tax rules. One can be assured that the plan selected will result in the greatest benefit for all without unintended consequences.

Sometimes planning must consider the family of the nursing home resident as well as the resident. For example, some children never gain independence – they remain forever dependent on their parents. What can be done in such a case?

Case Study No. 4
A Trust for a Disabled Child

For years Margaret and Sam took care of their daughter Elizabeth. She is

disabled and receives SSI (Supplemental Security Income). Three years ago Sam died and their other daughter Beverly began helping Margaret and "Betty." Until he died Sam was Margaret's caregiver. She has Alzheimer's. That's when Beverly stepped up as her mother's agent under her durable power of attorney. Mom's health has deteriorated to the point that Beverly had to place her in a nursing home. Beverly is paying the nursing home $8,084 per month. Mom and Dad always wanted to leave something for Elizabeth. Now Beverly is worried that there will not be any money left for the care of Elizabeth.

Beverly is satisfied with the nursing home that Mom is in. The facility has a Medicaid bed available and Medicaid would pay the bill if she were eligible. However, according to the information Beverly got from the social worker, Mom is $48,000 away from Medicaid eligibility. She wishes there were a way to save the money for Elizabeth. There is.

If Margaret executed a comprehensive elder law power of attorney then Beverly can consult an Elder law attorney to set up a *"special needs trust"* with the $48,000 to provide for Elizabeth. As soon as she does Mom will be eligible for Medicaid, Elizabeth will not lose her SSI benefits and her future security will be assured.

Note that most powers of attorney do not allow transfer of assets to qualify for government benefits and the creation of a trust. The best bet is to work with an experienced elder law attorney as soon as Alzheimer's is diagnosed.

Case Study No. 5
Employment or Gifts to Children

Helen's husband Harold is 78 years old and a veteran of the Korean Conflict. Last month he suffered a paralyzing stroke, an exhausted Helen seeks advice. Her hair is disheveled, dark circles have formed under her eyes. With her is daughter, assistant caregiver and all-around helper, Joan. She holds her mother's hand.

"The doctor says Harold needs long-term care in a nursing home," Helen says. "Joan and I can care for him in-home, if he doesn't have another stroke. I can pay for more help but I don't want to lose my house and all our hard-earned money. I don't know what to do."

Joan has heard that Medicaid will pay the nursing home if Dad qualifies, but doesn't want her mother be destitute to qualify. Joan wants to ensure that her father's medical needs are met, but she also wants to preserve Helen's financial security.

"Can't Mom just give her money to me as a gift?" she asks. "Can't she give

> away $19,000 a year? I could keep the money for her so she doesn't lose it when Dad applies for Medicaid."

Some of Helen's friends told her to simply "hide the money" and give it to Joan. This is bad, dangerous and incomplete advice. Giving away money and not disclosing on an application for government benefits is criminal fraud. Here are two points they should consider:

> First, Helen and Joan have confused federal gift tax law with the issue of *asset transfers and* ***Medicaid eligibility****.* A "gift" to a child in this case is actually a transfer and Medicaid has very specific rules about transfers and whether those are "divestment."
>
> Second, they have not heard that the Veterans Administration's Special Improved Pension for wartime vets. This benefit can contribute over $2,800 per month to help Harold get care at home. They can compensate Joan for her assistance to Harold.

They should contact an elder law attorney *immediately*. As we have observed above there are much better options than making gifts.

A final thought about gifting: remember, when it's given away, it's given away. Studies have shown that "windfall" money received by gift, prize or lawsuit settlement is often gone within three years. In other words, even when children promise that money will be available when needed, their own "emergencies" may make them spend the money.

"Will I Lose My Home?"

Many people who apply for Medicaid benefits to pay for nursing home costs ask this question. For many, the home constitutes most of their life savings. Often it is all the couple has to pass on to their children.

Under Medicaid, the home is an excluded asset, up to a maximum equity, *on application*. The 2026 maximum is $752,000. The recipient's exclusion ends on death. If there is no spouse or other protected person living in the home, then the home may be the subject of the "estate recovery" program to seek recovery of all Medicaid payments.

A home *can* be lost on "estate recovery." Here's how it works. After the death of the Medicaid recipient and spouse if there is one, the state may demand repayment of benefits. Virtually any property owned by the Medicaid recipient and spouse may be subject to payback. Because the home is the single largest "excluded" asset that is not spent down, it is the main target of estate recovery. Michigan started going after homes in July 2011. That's the bad news. The good news is that you can avoid the state's claim if you avoid probate without creating "divestment."

Even if the home and other property should go to probate some or perhaps all can be saved. However, it is better to avoid the problem in the first place. Fortunately, there are ways to protect the home and other property that transfers upon death. The solutions can range from re-titling, selling or gifting assets, converting them to income, to setting up contracts or trusts. Seek help from an experienced Elder Law attorney to help you in your planning.

Case Study No. 6 The $190,840 Mistake?

The complexity of the Medicaid rules and the frequent changes are a recipe for expensive missteps. People of ordinary means can be financially ruined by a misunderstanding of Medicaid eligibility rules. Spouses are especially vulnerable. In the prior case studies we have focused on estate planning options under the Medicaid rules. That is not the complete picture. Great care must be exercised in completing and submitting the Medicaid application.

Larry Smith is in the nursing home. His wife Patricia wanted to know how much she would have to spend before she could apply for help from Medicaid. She consulted a neighborhood lawyer who was not an Elder Law attorney.

The lawyer reviewed and listed her assets. He told her that she need not count her home or car, at this time. Then he made a list of their assets and told her which would have to be sold and spent on the nursing home.

Assets of Mr and Mrs. Smith on Entry into Nursing Home	
Excluded ASSETS (need not be spent)	
$225,000.00	Home in Dearborn Hts.
$17,500.00	2018 Ford Taurus
$32,500.00	**Excluded ASSETS,**
COUNTABLE ASSETS (To be spent down)	
$250,000.00	Cottage on Lake Huron: Mr and Mrs. Smith deeded the property to themselves and their two children and spouses in June 2009.
$93,500.00	CDs and savings at Big Bank. The accounts are joint between husband, wife and daughter (added last year).

$10,000.00	Loan to son, after he was laid off to avoid foreclosure on his home, made five years ago. The whole amount is still owing, clients have not made demand for payment.
$22,000.00	Book value, 2020 Conquerer 36 foot motor home
$353,500.00	TOTAL COUNTABLE ASSETS
$162,660.00	Minus Community Spouse Allowance
$190,840.00	**TOTAL to be spent down**

Upon completion of the list the lawyer explained that Medicaid allows only one homestead. So, the cottage would have to be sold. Mrs. Smith told him it had been listed for sale for three months, but no offers have been received. He said it is still an asset as is the motor home. They would have to be sold before Medicaid would be approved. She could keep the Ford. Finally she would have to collect from her son. The lawyer advised he would have to be sued in court if he did not pay.

In summary the lawyer said she would have to spend down her countable assets to $162,660, the maximum spouse allowance. She would have to spend $190,840! As we have seen before there are a number of ways to protect assets. But the unanswered question is "Did the lawyer make a mistake in his assessment?"

Did the lawyer make a mistake by counting the following assets?

$250,000.00	Cottage on Lake Huron
$10,000.00	Loan to son
$22,000.00	2020 Conquerer 36 foot motor home
$282,000.00	TOTAL

Maybe. He should have considered whether these were assets deemed "unavailable, non-salable or excluded." It is possible they should not be counted at all. If she consults an Elder Law attorney *she may not have to spend anything at all* on the nursing home. Mrs. Smith can choose among her options and decide how to best spend her own money and protect her family.

Conclusion

There are a number of strategies that applicants can use to qualify for Medicaid and still preserve some or all of their lifetime savings. The spouse and family can be protected.

These strategies are legal. They are moral. They are ethical. You have the right to choose which options you will use and which you will not. This is akin to the millionaire visiting his tax advisor. Nobody would expect the tax advisor to say "You have saved enough. You should pay more taxes." The millionaire would expect the tax advisor to tell him of "deductions, credits and exemptions" that he could take and save money on taxes

Nobody should tell a family of modest means that they should not save their money. The family has every right to. Medicaid is like the tax code with "deductions, credits and exemptions." Please be advised, however, that Medicaid planning requires a great deal of knowledge of the current rules and practices of the system. Work with an experienced advisor who can advise you accurately.

Now, it's up to you

We hope we have met our goal of helping you to be an informed, powerful patient advocate. You will successfully get through the Medicare process, the discharge planning process and selecting a long term care facility, and finally, arranging payment without "going broke."

We wish you the best.

Nursing Home Evaluation Checklists

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Record your observations as soon as possible, scoring your answers on a scale from Poor to Excellent or 1 to 5. Use the book as an original and make as copies as needed.

Name of Nursing Home:

____

Dates Visited Home: ________________________ Average Score :______________

The questions: Some may not lend themselves to scoring, an expected answer may be a simple yes or no. Score your impressions. Feel free to select those questions you wish to ask and to give more importance or weight to your particular areas of concern. Use the following guide for numbers: Poor = 1, Excellent = 5

A. LOCATION

1	How convenient is the nursing home's location to family members who *will* visit the resident ?	1 2 3 4 5

B. QUESTIONS FOR THE ADMISSIONS PERSON

After you have raised your questions with the admission person, test them by your observations or ask the same questions of residents and family members.

1	Are there rules in this facility? Do residents have input?	1 2 3 4 5
2	Does the facility have a resident bed-time and a wake-up time in the morning? Can residents choose what time to go to bed and wake up?	1 2 3 4 5
3	Can residents have their own belongings here if they choose to do so? What about their own furniture?	1 2 3 4 5
4	What is policy if personal belongings are missing?	1 2 3 4 5
5	Is mail delivery prompt? Does resident mail arrive unopened?	1 2 3 4 5
6	What provision does the facility make to accommodate the residents' legal rights such as voting and making an advance directive and appointing a patient advocate?	1 2 3 4 5

7	What effort does the facility make to assure privacy rights of residents?	1	2	3	4	5
8	Is there a secure area where a resident with Alzheimer's or other dementia can safely wander?	1	2	3	4	5
9	Is there a separate Alzheimer's or dementia care unit?	1	2	3	4	5
10	Does staff have training in various diseases of aging (Alzheimer’s, Parkinson’s etc.)? How often?	1	2	3	4	5
11	What is facility policy toward a staff member who is rude to residents?	1	2	3	4	5
12	Are residents involved in making decisions about nursing care, medical treatment and activities?	1	2	3	4	5
13	Do residents get permanent assignment of staff?	1	2	3	4	5
14	How good is the nursing home's record for employee retention?	1	2	3	4	5
15	What happens if a resident refuses care or treatment (such as a bath or certain medication)?	1	2	3	4	5
16	Do residents choose their own physician?	1	2	3	4	5
17	Does the facility accept Medicare <u>and</u> Medicaid?	1	2	3	4	5
18	Do residents have input into the selection of the activities offered?	1	2	3	4	5
19	Outside of the formal activity programs, are there opportunities for residents to socialize with other residents?	1	2	3	4	5
20	What method is used in selecting roommates?	1	2	3	4	5
21	Does the facility have an active family council?	1	2	3	4	5
22	Are *State Survey Results* readily available?	1	2	3	4	5
23	Have deficiencies reported in the state survey been corrected?	1	2	3	4	5

C. OBSERVATIONS AND QUESTIONS FOR RESIDENTS AND FAMILY

After you have spoken with the Admissions team, you will want to make your own observations. You will see if the reality matches their words and assurances.

1	Do corridors have handrails? Are handrails affixed to walls, intact, and free of splinters?	1	2	3	4	5
2	Is the facility free of objectionable odors and resident areas well ventilated?	1	2	3	4	5
3	Are nonsmoking areas smoke free? Are the smoking areas comfortable for residents who smoke?	1	2	3	4	5
4	Is it pest free and clean (walls, floors, drapes, furniture)?	1	2	3	4	5
5	Are housekeeping/hazards, compounds, and other chemicals stored to prevent resident access?	1	2	3	4	5
6	Is there a functioning call system in residents' bathing areas and toilet areas?	1	2	3	4	5
7	Is there room at and between tables for both residents and aides for those who need assistance with meals?	1	2	3	4	5
8	Are dining and activity rooms adequately furnished?	1	2	3	4	5
9	Are residents assisted with dining or with activities when necessary?	1	2	3	4	5
10	Is the resident equipment in common areas sanitary, orderly, and in good repair?	1	2	3	4	5
11	Are adequate accommodations made for resident privacy, during medical treatment and visiting with family?	1	2	3	4	5
12	Are rooms safe and comfortable in the following areas: Room temperature, water temperature, sound level, and lighting?	1	2	3	4	5
13	Are bedding, bath linens and closet space adequate for resident needs?	1	2	3	4	5

14	Is environment homelike, comfortable and attractive? Are accommodations are made for resident personal items and modifications?	1	2	3	4	5
15	Are residents with physical limitations (e.g. walker, wheel-chair) able to move around their rooms?	1	2	3	4	5
16	Do residents appear well groomed and reasonably attractive (e.g. clean clothes, neat hair, free from facial hair)?	1	2	3	4	5
17	Does staff treat residents respectfully and listen to resident requests?	1	2	3	4	5
18	Is staff is responsive to resident requests and call bells?	1	2	3	4	5
19	While staff are giving care, do they include resident in conversation or do staff talk to each as if resident is not there?	1	2	3	4	5
20	Is the Administration responsive to the Family Council?	1	2	3	4	5
21	Is information about Medicare, Medicaid and contacting advocacy agencies posted?	1	2	3	4	5

D. Comments / Observations / Persons Spoken With

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Selected Medicare Regulations on Skilled Care

42 *Code of Federal Regulations* (CFR) 409.31 Level of care requirement.

(a) Definition. As used in this section, *skilled nursing* and *skilled rehabilitation services* means services that:

(1) Are ordered by a physician;

(2) Require the skills of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

(3) Are furnished directly by, or under the supervision of, such personnel.

(b) Specific conditions for meeting level of care requirements.

(1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

(2) Those services must be furnished for a condition–

(i) For which the beneficiary received inpatient hospital or inpatient CAH services; or

(ii) Which arose while the beneficiary was receiving care in a SNF or swing-bed hospital for a condition for which he or she received inpatient hospital or inpatient CAH services.

(3) The daily skilled services must be ones that, as a practical matter, can only be provided in a SNF, on an inpatient basis.

Restoration Potential Not the Determining Factor
42 CFR. 409.32 (c) The *restoration potential of a patient is not the deciding factor* in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in 42 CFR. 409.33.

42 CFR. 409.33 Examples of skilled nursing and rehabilitation services.

(a) Services that could qualify as either skilled nursing or skilled rehabilitation services-

(1) Overall management and evaluation of care plan.

(i) When overall management and evaluation of care plan constitute skilled services. The development, management, and evaluation of a patient care plan based on the

physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient's needs, promote recovery, and ensure medical safety. Those activities include the management of a plan involving a variety of personal care services only when, in light of the patient's condition, the aggregate of those services requires the involvement of technical or professional personnel.

(ii) Example. An aged patient with a history of diabetes mellitus and angina pectoris who is recovering from an open reduction of a fracture of the neck of the femur requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, an exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his or her condition or complications resulting from restricted, but increasing, mobility. Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. Since the nature of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. Under these circumstances, the management of the plan of care would require the skills of a nurse even though the individual services are not skilled. Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be ensured only if the total care is planned, managed, and evaluated by technical or professional personnel, it is appropriate to infer that skilled services are being provided.

(2) Observation and assessment of the patient's changing condition-

(i) When observation and assessment constitute skilled services. Observation and assessment constitute skilled services when the skills of a technical or professional person are required to identify and evaluate the patient's need for modification of treatment or for additional medical procedures until his or her condition is stabilized.

(ii) Examples. A patient with congestive heart failure may require continuous close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication(s) that serve as indicators for adjusting therapeutic measures. Similarly, surgical patients transferred from a hospital to an

SNF while in the complicated, unstabilized postoperative period, for example, after hip prosthesis or cataract surgery, may need continued close skilled monitoring for postoperative complications and adverse reaction. Patients who, in addition to their physical problems, exhibit acute psychological symptoms such as depression, anxiety, or agitation, may also require skilled observation and assessment by technical or professional personnel to ensure their safety or the safety of others, that is, to observe for indications of suicidal or hostile behavior. The need for services of this type must be documented by physicians' orders or nursing or therapy notes.

(3) Patient education services-

(i) When patient education services constitute skilled services. Patient education services are skilled services if the use of technical or professional personnel is necessary to teach a patient self-maintenance.

(ii) Examples. A patient who has had a recent leg amputation needs skilled rehabilitation services provided by technical or professional personnel to provide gait training and to teach prosthesis care. Similarly, a patient newly diagnosed with diabetes requires instruction from technical or professional personnel to learn the self-administration of insulin or foot-care precautions.

(b) Services that qualify as skilled nursing services.

(1) Intravenous or intramuscular injections and intravenous feeding.

(2) Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day.

(3) Nasopharyngeal and tracheostomy aspiration;

(4) Insertion and sterile irrigation and replacement of suprapubic catheters;

(5) Application of dressings involving prescription medications and aseptic techniques;

(6) Treatment of extensive decubitus ulcers or other widespread skin disorder;

(7) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by nurses to adequately evaluate the patient's progress;

(8) Initial phases of a regimen involving administration of medical gases;

(9) Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment, e.g., the institution and

supervision of bowel and bladder training programs.

(c) Services which would qualify as skilled rehabilitation services.

(1) Ongoing assessment of rehabilitation needs and potential: Services concurrent with the management of a patient care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders;

(2) Therapeutic exercises or activities: Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the patient, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the patient and the effectiveness of the treatment;

(3) Gait evaluation and training: Gait evaluation and training furnished to restore function in a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;

(4) Range of motion exercises: Range of motion exercises which are part of the active treatment of a specific disease state which has resulted in a loss of, or restriction of, mobility (as evidenced by a therapist's notes showing the degree of motion lost and the degree to be restored);

(5) Maintenance therapy; Maintenance therapy, when the specialized knowledge and judgment of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic reassessment of the patient's needs, and consistent with the patient's capacity and tolerance. For example, a patient with Parkinson's disease who has not been under a rehabilitation regimen may require the services of a qualified therapist to determine what type of exercises will contribute the most to the maintenance of his present level of functioning.

(6) Ultrasound, short-wave, and microwave therapy treatment by a qualified physical therapist;

(7) Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool; Hot pack hydrocollator, infrared treatments, paraffin baths, and whirlpool in particular cases where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgment of a qualified physical therapist are required; and

(8) Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing.

(d) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in § 409.32(b). Personal care services include, but are not limited to, the following:

(1) Administration of routine oral medications, eye drops, and ointments;

(2) General maintenance care of colostomy and ileostomy;

(3) Routine services to maintain satisfactory functioning of indwelling bladder catheters;

(4) Changes of dressings for noninfected postoperative or chronic conditions;

(5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

(6) Routine care of the incontinent patient, including use of diapers and protective sheets;

(7) General maintenance care in connection with a plaster cast;

(8) Routine care in connection with braces and similar devices;

(9) Use of heat as a palliative and comfort measure, such as whirlpool and hydrocollator;

(10) Routine administration of medical gases after a regimen of therapy has been established;

(11) Assistance in dressing, eating, and going to the toilet;

(12) Periodic turning and positioning in bed; and

(13) General supervision of exercises which have been taught to the patient; including the actual carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function do not require the skills of a therapist and would not constitute skilled rehabilitation services (see paragraph (c) of this section). Similarly, repetitious exercises to improve gait, maintain strength, or endurance; passive exercises to maintain range of motion in paralyzed extremities, which are not related to a specific loss of function; and assistive walking do not constitute skilled rehabilitation services.