Top 10 Things Skilled Nursing Facilities Don’t Want You or Your Clients to Know

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Philip P. Lindsley, CELA*, CLS**
*Certified Elder Law Attorney
**Certified Legal Specialist, Estate Planning, Trust and Probate

San Diego Elder Law Center
www.sandiegoelderlaw.com
(619) 235-4357

#Tip 1: Spousal Protection Rules in Long Term Care Medi-Cal Eligibility Determinations

Long Term Care Medi-Cal

- Not a "poverty based" program. Substantial protection for middle class.
- No income test. Share of cost only.
- Cannot be discharged for change of payment
- Special “Spousal Impoverishment Rules.”
  - Congressional History: MCCA 1988
  - Divorce vs. Spousal Protection
  - Special Asset and Income Protection
  - Since 1988 Divorce almost never best option (30 years!)
Spousal Protection Rules
- There is both an asset protection rule and an income protection rule
  - CSRA – Community Spouse Resource Allowance. 2018 = $123,600
  - Share of Cost Calculation
  - After acquired property

MEDI-CAL ASSET LIMITATIONS
- WELL SPOUSE
  - $123,600 CSRA
  - + exempt property
  - - home
  - - retirement accts
  - - qualified annuities
  - - personal property
  - - business property
  - *Can be increased

- ILL SPOUSE (or single)
  - $2,000
  - + exempt

INCREASE CSRA?
- Definitions
  - CSRA (Community Spouse Resource Allowance) 2018 = $123,600
  - MMMNA (Minimum Monthly Maintenance Needs Allowance) 2018 = $3,090
- CSRA Appeal
  - Well Spouse is entitled to increase his/her CSRA in an amount sufficient to generate enough income to make up any difference between MMMNA and their actual income.
**COMPUTATION FOR CSRA INCREASE**

- MMMNA - actual income = shortfall
- Shortfall x 12 months = annual shortfall
- Annual shortfall divided by average 1 year CD interest rate
- Equals amount in CSRA necessary to generate income to meet MMMNA

**EXAMPLES OF CSRA EXPANSIONS**

(Assumes 1 year CD at 2.5%)

<table>
<thead>
<tr>
<th>Spouse’s Income</th>
<th>Expanded CSRA</th>
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<tbody>
<tr>
<td>$2,000</td>
<td>$491,040</td>
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<tr>
<td>$1,500</td>
<td>$731,040</td>
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<tr>
<td>$1,000</td>
<td>$971,040</td>
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**Often via Prob. C. 3100**

- Increase Community Spouse Resource Allowance
- Spousal Support Orders to Minimize Share of Cost
- Asset Transfers
- Transmutation for “Well Spouse” Estate Planning

Bottom Line: If spouse’s Social Security and pension income totals less than $3,000, their spouse in skilled nursing almost certainly can qualify for Long Term Care Medi-Cal benefits.
If Community Spouse’s income is less than the current Monthly Maintenance Allowance $3,090, the formula used by Administrative Law or Superior Court Judges will almost always result in eligibility for Long Term Care Medi-Cal.

Bet you didn’t know that!

Tip 2: Know About the Nursing Home Reform Act of 1987

- “A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care”
  - 42 USC 1396r(b)(2)
- This plan must be developed with family and/or legal representative within 14 days of admission, and is subject to review.

Regulations for the Nursing Home Reform Act of 1987

- Source for 3-Phase updates and analysis
  - “Medicare and Medicaid Programs: Reform Requirements for Long Term Care Facilities”
  - Federal Register 10/4/2016
There are ONLY 6 Lawful Reasons for Discharge

1. The resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility (42 C.F.R. §483.15(c)(1)(B); R Dr.
2. It is necessary for the resident’s welfare and the resident’s needs cannot be met in the facility (42 C.F.R. §483.15(c)(1)(A)); R Dr.
3. The health of individuals would otherwise be endangered (42 C.F.R. §483.15(c)(1)(D));
4. The safety of individuals is endangered (42 C.F.R. §483.15(c)(1)(C)); Dr.
5. The resident has failed, after reasonable and appropriate notice, to pay (42 C.F.R. §483.15(c)(1)(E));
6. The facility ceases to operate (42 C.F.R. §483.15(c)(1)(F)).
What Aren't Grounds for Discharge?

- "We don't have any 'custodial' beds."
- "Medicare isn’t paying any more"
- Conversion to Medi-Cal
  - Can’t even change room (W&I 14124.7)
- Difficult, demanding, problem residents
  - (Advanced dementia, howling at night, etc.)

What Aren't Grounds for Discharge?

- Wandering
  - May have grounds if not secured perimeter and wandering outside, but is that really what's happening? What does chart say about other efforts? Behavioral? Social? Wander alerts? Would it be different elsewhere?
- Beware of “Lateral” transfers.
- Refusal of treatment

Tip 4: Proper Discharge Planning

- Vast majority of discharges are voluntary.
- "A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care" 42 USC 1396r(b)(2)
- This plan must be developed with family and/or legal representative within 14 days of admission, and is subject to review.
- Make sure the facility knows from the start any limitations on ability of family to provide needed care at home.
Proper Discharge Planning

- Reasons for discharge must be adequately documented in chart (remember 6 grounds)
- Must be sufficient orientation and preparation
- SNF must provide orientation and post-discharge plan of care, developed in consultation with family and/or representatives (42 CFR 483.21)
- Discharge Plan must assist resident to adjust to his or her new living environment. (42 CFR 483.15(c))

More on Discharge Planning

- If transfer to assisted living or board and care, you may want to consider, or demand, trial visits and opportunity to orient new facility staff
- This is the time for you to question plan if you are uncertain about ability to be properly cared for at home or lower level of care.

Discharge Notice Requirements

- 30 day written notice can be waived only:
  - When health and safety of individuals in facility would be endangered;
  - Where there is a medical emergency;
  - Where health has improved sufficient to go home;
  - When resident has been in facility less than 30 days.
- In all such situations, notice must be given “as soon as practicable.”
Help Your Clients Learn to Say “NO!”

- Often, if you simply say “no,” they will back down. If not, be ready to assist your client in appealing.
- If necessary, immediately request Discharge Appeal Hearing with the Department of Health Care Services.
- Department of Public Health Lic. and Cert. for matters other than discharge and bedholds

Summary….

- If appropriate facts, just say “No,” and convert process from voluntary discharge to involuntary
- Or at least “Well, wait a minute. I have some questions…”

Tip 5: Know Hospitalization and Bed-Hold Issues

Federal Authority: 42 CFR 483.12 (b); see also State Operations Manual Guidelines; State Authority: 22 CCR 72520; Cal Health & Safety Code 1599.1(h) & 1599.79
**Beware of “Discharge by Hospitalization”**

- Health & Safety Code Sec. 1599.79
  - 7 day bed-hold and immediate readmission to same bed
  - You are entitled to readmission to next available bed,
    - If on Medi-Cal and more than 7 days
    - If facility failed to give written notice of bed hold rights.

**Bed-Hold Notice**

- Written notice of bed-hold policies at admission. Must include readmission rights.
- Again at time of transfer. Notice must:
  - State duration and terms of bed hold consistent with state plan and facility standards
  - Provide information on post bed-hold return rights
- Minimum bed-hold is 7 days
- Patient or representative has 24 hrs. to exercise notice

**Bed-Hold Return Rights**

- Refusal to readmit during bed-hold period is an involuntary discharge with all the notice and appeal rights. After stays longer than 7 days, facility must still re-admit to next available bed if:
  - Patient is on Medi-Cal, or
  - Facility failed to meet any of the notice requirements
Bed-Hold Appeal Rights

- Failure to adhere to bed hold requirements regarding notice or readmission is treated, as a matter of law, as an involuntary discharge with identical appeal and hearing rights.
- If Medi-Cal resident files such an appeal, hospital must hold patient pending hearing. MC will pay administrative day rate.
- Other residents can stay if have method of payment. If no method of payment, hearing must be held within 48 hours.

Tip 6: Right to Choose Personal Attending Physician

42 USC 1395i-3(c)(1)(A)(i);
42 CFR 1396r (c)(1);

Rights to Choose Doctor

- Not subject to facility veto or approval.
- Can put control of discharge and treatment considerations back into hands of patient, patient’s family or legal representative.
  - Involuntary discharge for “patient’s welfare” requires patient’s physician.
  - Cooperative doctor invaluable to good plan of care.
  - Therapy discontinuation issues.
  - Johnson v. Rank.
  - HMO Issues.
Tip 7: The "Improvement Standard" is a Myth

- Authority: 42 CFR Sec. 409.32. Jimmo v. Sebelius

The "Improvement Standard" is a Myth

Under the settlement in Jimmo v. Sebelius, the Federal government has agreed that Medicare will pay for covered individuals for skilled services needed to "maintain the patient's current condition or prevent or slow further deterioration," even if the patient's condition is not expected to improve.

Jimmo v. Sebelius

- The coverage of services necessary to "maintain the patient's current condition" has been required by law for some time now. However, for many years the operations manuals indicated coverage is only available if the patient shows a likelihood of medical or functional improvement. This has been known as the "Improvement Standard."
- The settlement of the class-action lawsuit (supposedly) resolved this discrepancy between the law and the administrative guidelines, and required CMS to re-write the Medicare Manual to remove any reference to an improvement requirement for Medicare coverage for skilled services. CMS required to educate providers, too.
- An overview of the class-action may be found at: medicareadvocacy.org/hidden/highlight-improvement-standard/
Jimmo Reality Check

- Despite CMS directives and training, many providers have largely ignored Jimmo. People are frequently told by providers skilled therapy is stopping due to a failure to improve.
- Be prepared to encourage your clients to appeal any determination of discontinued services based on “failure to improve” or having “reached their plateau.”
- Great self-help tools on website of Center for Medicare Advocacy: www.medicareadvocacy.org

Jimmo & Medicare Coverage of Therapy: Process

- If you can show skilled therapy needed to help maintain current capabilities or prevent further deterioration, Medicare should pay
- “Demand Billing” may be a prequel
- Appeals
  - First and Second Stage appeals (Intermediaries)
  - Third Stage (ALJ)
- Medi-Cal and Johnson v. Rank possible alternative.

Skilled Therapy vs. “Restorative Care Plan.”

Skilled care can end if proper plan to segue to “restorative care plan.” Skilled therapist can train staff to implement, and SNF staff should do so without charge. Under this scenario, Medicare may properly stop paying for skilled therapy.
Tip 8: SNF Treatment Obligations

- SNF must provide or arrange needed therapy services regardless of who is paying. 42 USC 1396r(c)(4)(A). (remember NHRA!)
- This includes PT, OT, Speech Therapy and Mental Health rehabilitation services.
- Specialized rehabilitative services are to be provided to Medi-Cal patients without charge. Surveyor’s Guideline to 42 CFR 483.45(a), appendix PP to CMS manual.

Tip 9: Johnson v. Rank

- Skilled care can end if proper plan to segue to “restorative care plan.” Should train staff to implement, and staff should do so without charge.
- Monitor file for compliance!

Tip 9: Johnson v. Rank

- Resident or representative can deduct from the Medi-Cal share of cost expenses of non-covered services and supplies if they are prescribed by physician in the patient’s medical records/Plan of Care at the facility
- Authority: Johnson v. Rank; ACWDL 85-59 and 89-54
Example: Jasper resides in Happy Trails SNF on Medi-Cal. He needs dental care after years of neglect, and is incontinent. Jasper’s Dr. authorizes a specific procedure recommended by the dentist, and prescribes “Depends” and other incontinent supplies. All this is noted in the facility chart.

Estelle, Jasper’s daughter, arranges for a dental procedure and pays $1,400 for it from Jasper’s account. She also pays for $200 of Depends that month, for a total of $1,600. First of next month, Estelle, instead of writing $2,000 check for share of cost, gives Happy Trails $400 and copies of the invoices. Happy Trails is completely baffled by this, but eventually realizes there is a form they can fill out and that Medi-Cal will reimburse them the $1,600.

In addition to dental, also helpful for vision, hearing aids, and other issues not covered by Medi-Cal.

Treatment Authorization Requests (TARs) for PT and other skilled therapies.

Solvable Johnson v. Rank problems:
- Problem: Facility never heard of this, freaks out, and says you cannot do this
- Solution: Educate them with copies of Medi-Cal regs and procedures
**Johnson v. Rank**

- **Solvable Johnson v. Rank problems**

  Problem: Dr., who does a lot of business for Happy Trail residents, will not cooperate. Usually based on “no way to pay for it.”

  Solution: Educate or replace Doctor. Federal law prohibits treatment discrimination based on form of payment. Tell him not to worry about payment, just clinical issues (!). If still balks, get another Doctor to write the prescription. If still a problem, evoke right to fire and replace that Doctor.

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**Johnson v. Rank (Cont.)**

P.S.….Did I say that Happy Trails will freak out?

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**Tip10: Filing Complaints & Appeals is Easy!**

- Know your client’s rights, and how to file complaints and appeals.
- Appeals are to DHCS and for discharge and bed-hold issues
- Complaints are to DPH use also for bed-hold, and all other matters concerning rights and care other than discharge
- Complaints are very simple and confidential. Appeals are not complicated, and the hearings informal.
And, a Great Resource….
CANHR’s “Outline of Nursing Home Rights”

http://www.canhr.org/factsheets/nh_fs/html/fs_outline_resrights.htm

- Admission rights
- Transfer and discharge rights
- Rights within facility
- Other rights

Also, Google “State Operations Manual Appendix PP.” (Surveyor’s Guidelines)
From CANHR list…

To Surveyor’s Guidelines…

- A “Find” search for 483.15(c)(5) found “TAG 622”
- Look at handout materials for TAG 622 and the reach source of advocacy and cross-references.

Bonus Tip 11: It’s not hard to find a Certified Elder Law Attorney

- www.nelf.org
- www.naela.org
  - National Academy of Elder Law Attorneys. Largest organization for promotion and education on elder and special needs law issues. Lists members, in “attorney finder” and identifies those that are CELAs
- www.canhr.org
- www.sandiegoelderlaw.com
Thank You!

- More questions?
- www.canhr.org
- www.naela.org
- www.sandiegoelderlaw.com