

# JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

## Nursing Facility Resident Rights in Medicare “Short-Stay” Rehabilitation

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Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ+ individuals, and people with limited English proficiency.

# Housekeeping

- All on mute. Use Questions function for substantive questions and for technical concerns.
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- Find materials for this training and past trainings by searching the [Resource Library](https://justiceinaging.org/resource-library), [justiceinaging.org/resource-library](https://justiceinaging.org/resource-library). A recording will be posted to [Justice in Aging's Vimeo page](https://www.vimeo.com/justiceinaging) at the conclusion of the presentation, [vimeo.com/justiceinaging](https://www.vimeo.com/justiceinaging).
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# Justice in Aging's Commitment to Advancing Equity

To achieve Justice in Aging, we must:

- [Advance equity](#) for low-income older adults in economic security, health care, housing, and elder justice initiatives.
- Address the enduring harms and inequities caused by systemic racism and other forms of discrimination that uniquely impact low-income older adults in marginalized communities.
- Recruit, support, and retain a diverse staff and board, including race, ethnicity, gender, gender identity and presentation, sexual orientation, disability, age, and economic class.

# Looking for Input

- Webinars like this four times a year.
- Your suggestions welcome – respond to survey at end of webinar.
- We're listening, e.g., length of webinar.

# Advocacy Guide

- [Free advocacy guide](#) provides step-by-step instructions to residents, families and others.
- Calls out false statements and myths.



# Today's Advocacy Warning #1

- Facilities and others may assume that “short stay” and rehabilitation facilities have right to force residents to leave after a few weeks.
- **Not True!** (as we'll discuss)

# Today's Advocacy Warning #2

- Necessary therapy shouldn't be limited to Medicare-reimbursed stays.
- Under federal law, facility must
  - Provide services resident needs "to attain or maintain the highest practicable physical, mental, and psychosocial well-being."
  - Provide services without regard to payment source, including not discriminating against Medicaid-eligible residents.
    - 42 C.F.R. §§ 483.10(a)(2); 483.15(b)(1); 483.35; 483.65(a).



# Medicare Coverage Basics

# Medicare Coverage for Nursing Facility Care

- Designed for post-acute care.
- Must have prior 3-night stay in hospital as inpatient.
- Nursing care must be related to hospitalization.
- Maximum of 100 days of coverage in nursing facility.
  - First 20 days paid in full.
  - Days 21-100 have daily co-payment of \$204 (in 2024).
    - 42 C.F.R. § 409.61(b).

# Level of Care Requirement

- Level of care requirement means that Medicare will cover from zero to 100 days, depending on care needs.
- Resident must need skilled nursing services, or skilled rehabilitation services, on an every day or almost-every-day basis.
  - 42 C.F.R. § 409.30- 409.36.

# Skilled Nursing Services

- Beyond medication administration and other routine tasks.
  - **Specific services.**
    - E.g., Intravenous injections or feeding.
    - Treatment of extensive pressure ulcers.
  - **Other nursing services, but only when nurse involvement is particularly extensive.**
    - E.g., Management and evaluation of care plan, or
    - Observation and assessment of resident's changing condition.

# Skilled Rehabilitation Services

- Most commonly physical therapy, but also speech therapy, occupational therapy, and other types of therapy.
- Performed by licensed therapist.

# Facility's Advance Medicare Notice (1 of 2)

- Facility must give Advance Beneficiary Notice of Non-Coverage if facility does not intend to bill Medicare for care which Medicare usually could cover.
- Notice gives resident choice:
  - Receive care and require that Medicare be billed.
  - Receive care without billing Medicare.
  - Decline care.

# Facility's Advance Medicare Notice (2 of 2)

- If resident chooses to seek Medicare coverage, facility can't bill until Medicare makes decision.
- If facility fails to give notice, resident can be excused from payment, since they didn't know that Medicare wouldn't pay.

# Terminations and Appeals: Fee-for-Service Medicare

- Resident must be given Notice of Medicare Non-Coverage at least two days before end of coverage.
- Resident can request expedited appeal from Quality Improvement Organization.
  - Must make request by noon of day prior to termination.
- Further appeals possible, but
  - Resident bears financial risk, and
  - Appeal useful only if qualifying care (e.g., therapy) actually provided.

# Terminations and Appeals: Medicare Advantage

- Can request reconsideration by health plan, with quick turnaround if plan or MD determines that wait would threaten health.
- Next level is Independent Review Entity, with 72-hour turnaround upon showing that health is at risk.
- Further appeals possible but, again,
  - Resident bears financial risk, and
  - Appeal useful only if qualifying care actually provided.

# General Advocacy Tips

- Successful appeal requires
  - (For therapy) Physician order for therapy.
  - Actually receiving relevant services (otherwise there's nothing for Medicare to cover).
- Physician and (especially) therapist can be ally.
  - Like resident, therapist will hate premature coverage termination.



Supposed "Lack of Progress"

# Continuing Medicare Coverage: Falsehood and Truth

- False: Medicare won't pay because you've plateaued in your therapy.
- True: Improvement not required; deciding factor is whether therapy is appropriate.

# Medicare Coverage Does Not Require “Improvement”

- E.g., Doesn't matter if resident has “plateaued.”
- *Jimmo* litigation emphasizes regulatory right.
  - “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 C.F.R. § 409.32.

# Beware Quick Findings of “No Progress”

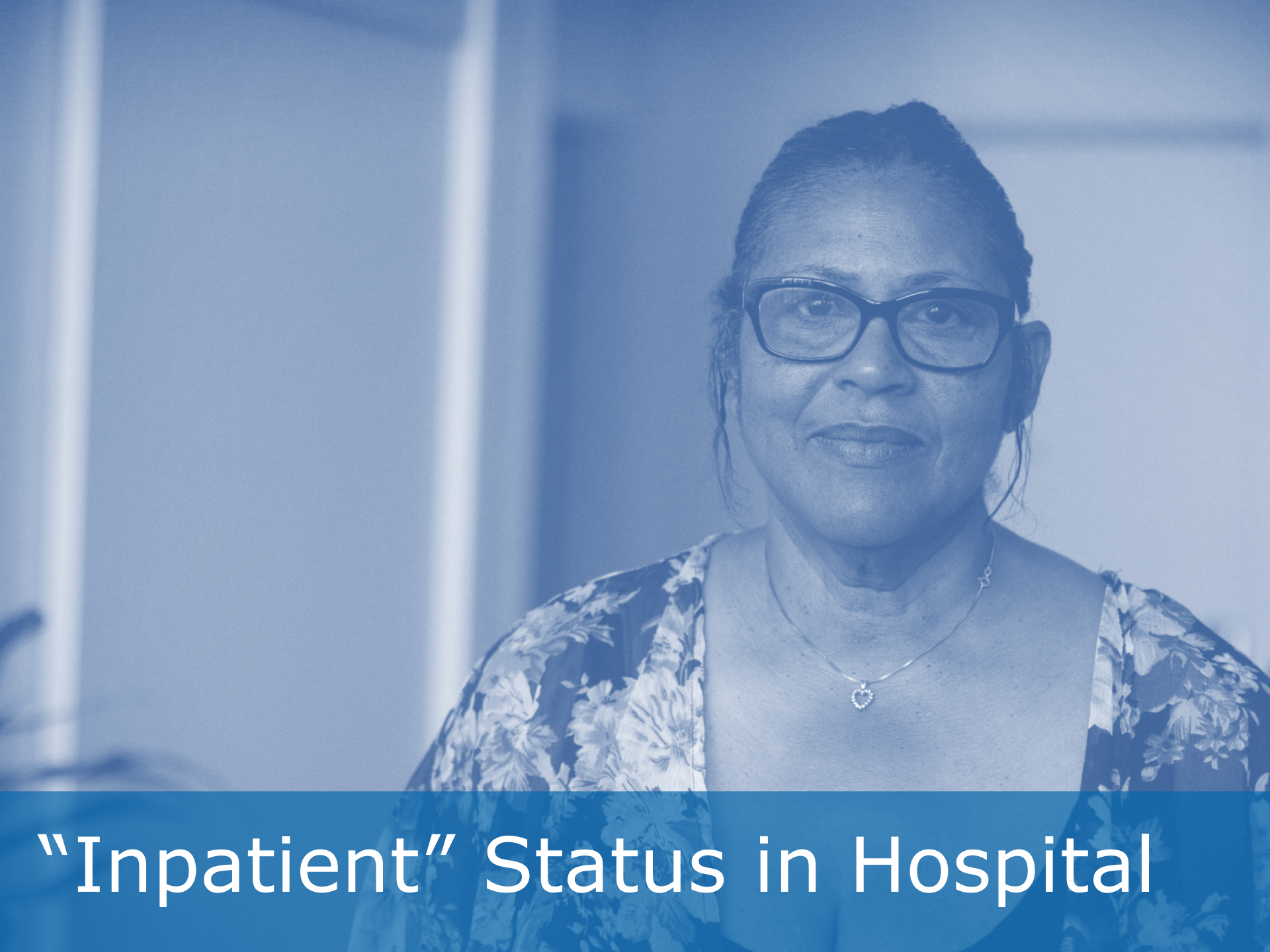
- Therapy will have some ups and downs, particularly given the age of most nursing facility residents.

# Seeking Additional Days of Medicare Coverage

- Enlist support of therapist and physician.
- Cite Jimmo info from websites of
  - CMS &
  - Center for Medicare Advocacy.

# *Jimmo v. Sebelius* Resources

- CMS *Jimmo* website
  - <https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html>
- [\*Jimmo v. Sebelius\* Settlement Agreement Fact Sheet](#)
- [\*Jimmo v. Sebelius\* Settlement Agreement Program Manual Clarifications Fact Sheet](#)



“Inpatient” Status in Hospital

# Inpatient v. Observation Status

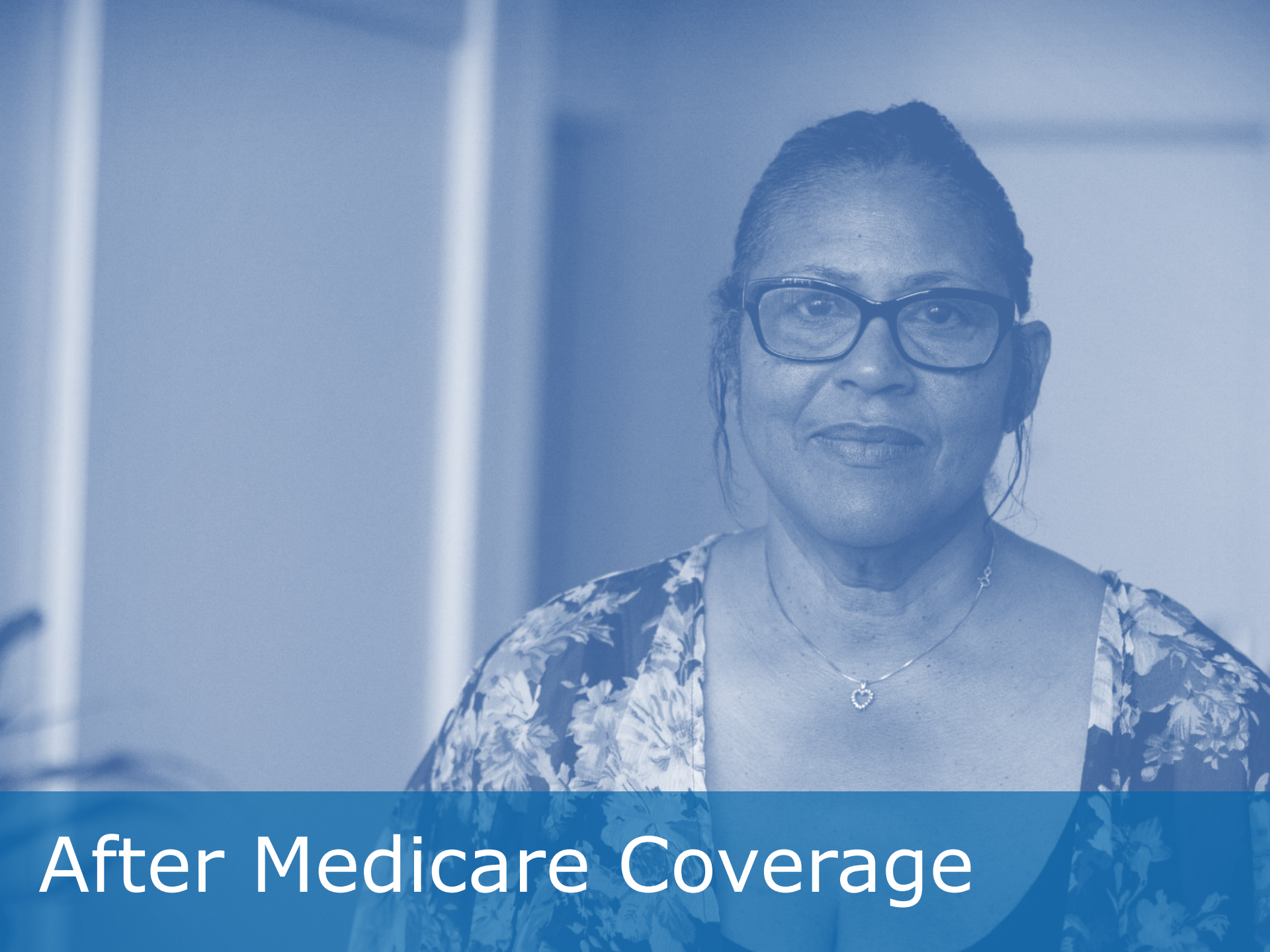
- Medicare coverage requires that 3-day hospital stay be on inpatient status.
- Hospital must issue Medicare Outpatient Observation Notice if outpatient services (i.e., observation status) last more than 24 hours.

# Rights to Appeal “Observation Status” Determination

- Federal court rules:
  - No right to appeal initial determination by physician to place resident on observation status.
  - But right to appeal if resident was initially admitted as inpatient but had status changed to “observation” by utilization review committee.
    - *Alexander v. Azar*, 2020 WL 1430089, 2020 U.S. Dist. LEXIS 50636 (D. Conn. 2020); *Barrows v. Becerra*, 24 F.4th 116 (2nd Cir. 2022).

# Appeal Procedures Under Development

- Appeal procedures not yet available.
- CMS released proposed regulations in late 2023.
  - 88 Fed. Reg. 89506 (Dec. 27, 2023).



# After Medicare Coverage

# The Danger

- Some facilities, focused on reimbursement levels, attempt to force out residents when their Medicare ends.
  - E.g., Claiming that facility is only for short-stay or rehabilitation.
  - Claiming that resident must leave room (or entire facility) because they cannot remain in “Medicare room.”

# “Medicare Beds”: Falsehood and Truth

- False: “Medicare payment has ended, so you must leave your ‘Medicare bed.’”
- True: “Medicare beds” are not limited to Medicare-reimbursed residents.

# Medicare Certification

- Medicare certification may be
  - Entire facility, or
  - “Distinct part” of facility.
- Medicare certification does not prevent room from being used by resident paying out-of-pocket or through Medicaid.
  - But note potential problem if state allows for limited Medicaid certification also (this is only minority of states).

# Limits on Transfers within Facility

- Resident can refuse intra-facility transfer if purpose is:
  - To move the resident out of a Medicare-certified room.
  - “Solely for the convenience of staff.”
    - E.g., according to surveyor’s guidelines, putting residents together because they have similar care needs.
- Facility must give written notice, including reason for change, before change in room or roommate.
  - 42 C.F.R. § 483.10(e)(6), (7).

# End of Medicare Reimbursement: Falsehood and Truth

- False: You must leave the nursing facility when your Medicare payment ends.
- True: Facility must give notice and wait for hearing.

# Important: Two Types of Notices

- Medicare notices (as we've discussed) govern Medicare coverage.
- Eviction from facility requires entirely different notice and appeal procedures.

# Six Justifications for Eviction

1. Resident needs higher level of care.
2. Resident doesn't need nursing facility care.
3. Resident endangers others' safety.
4. Resident endangers others' health.
5. Nonpayment.
6. Facility is going out of business.
  - 42 C.F.R. § 483.15(c).

# Notice

- Written notice generally at least 30 days prior to date of proposed transfer/discharge.

# Contents of Notice

- Reason.
- Effective Date.
- Location of new residence.
- Appeal rights.
- Contact info for ombudsman or other relevant advocacy organization.

# Facility-Initiated Eviction After Medicare-Funded Rehabilitation

- Residents should not be forced out when Medicare-funded rehabilitation is ending, because resident could stay under Medicaid or private pay.
- If facility tries to end residence, facility must issue written eviction notice (in addition to Medicare notice).

# Eviction Defense Rule #1

- Don't move out!!!

# Appeal Hearings

- In these cases, facilities generally are counting on forcing resident out through bluffing/intimidation.
- If resident holds firm and stays in facility, resident has extremely strong position in appeal hearing, because facility likely doesn't have grounds for eviction.



# Questions?

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