Nursing Facility Resident Rights in Medicare "Short-Stay" Rehabilitation

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Eric Carlson, D...: Welcome everyone to today's webinar focusing on Medicare eligibility and some residents rights related to that in nursing facility settings. I'm Eric Carlson from Justice in Aging. Justice in Aging is a nonprofit that focuses on using our legal expertise to benefit and protect older Americans, particularly those of limited financial means. The logistical issues I'm sure are well familiar to all of us at this point, maybe I've mentioned the chat is I believe disabled, and so to communicate with us, what you want to do is to use the questions button and we will be fielding some questions at the end of this session. Also of note, closed captioning is available, so just select CC from the Zoom control panel.

To get Justice in Aging materials, you can join our network. If you go to the website, there's a sign up button I believe in the upper left or also send an email to info@justiceinaging.org. Organizationally, we are focused on advancing equity. That includes the advocacy work that we do and it also means how we organize our work internally, both amongst our staff and amongst the board of directors. So turning to this particular webinar, we plan to do webinars like these focused on day-to-day advocacy issues in long-term care four times a year roughly. Very much welcome your suggestions. This session is based significantly upon suggestions that we received at the end of the last webinar.

When the webinar closes, you'll get an opportunity to fill out the survey. It should take you just a minute or two and really ask that you do that because we do pay attention to it. Just of note, at the beginning of this year, I had the bright idea to try to do webinars in 30 minutes rather than an hour to be more respectful of people's time and it was okay, but I certainly got some comments back saying 30 minutes, too limited, too much material in too short a time. So that's an example of we are listening and so today's webinar and future webinars will be an hour. Not to say that we'll use it all, but we'll have that as available to us and have the time to explore the issues adequately and also to field some questions at the end.

Want to make a note that on these type of advocacy issues in a nursing facility, Justice in Aging has a free advocacy guide available that covers 25 common nursing home problems, how to address them, and for each of those problems, giving step-by-step advice that's very much focused to the very best of our ability on how things play out in nursing facilities, the false statements that residents and family members and others will hear in nursing facilities and how to respond to those false statements with the relevant law and with successful advocacy strategies. Again, available for free on the Justice in Aging website.

So in the same spirit of trying to give useful advocacy information and recognizing that in a great number of these situations, you don't have to be a Supreme Court justice, you just have to have a couple principles in your mind and also a little bit of determination to dig in a bit and maintain the argument even with some pressure from the nursing facility for others. So the first point here is that in these nursing facility situations focused on Medicare eligibility, oftentimes there seems to be a general understanding amongst people at the facility that of course you're here under Medicaid, you'll just be here for a couple of weeks, then you'll leave. That's what this facility does. It just brings people in for a short period of time and then they got to go. That is not necessarily true as we'll discuss.

So that's the first advocacy point. It is not true that in these type of facilities or these situations necessarily that the resident is just there for a week or two and then is forced to leave. Not true. The resident has some options. Then the second advocacy point is that you don't want to buy into this idea that the quality of care, specifically the availability of rehabilitation services, is solely based on Medicare reimbursement. That oftentimes in nursing facilities you'll have the situation where people are getting intensive physical therapy, let's say, seven days a week, significant physical therapy provided by a licensed therapist, and then the Medicare coverage ends, and then foop, the therapy just evaporates. There's none. It completely disappears. That is not correct.

The human body doesn't work like that, right? It's not that you needed an hour a day and then all of a sudden because of a Medicare decision that you don't need any attention whatsoever on that front. So not true for a couple specific legal reasons, the citations are here. First of all, under the Federal Nursing Home Reform law, the facility has an obligation to provide the services that the resident needs, to get the resident to the highest practicable level of functioning. That's the obligation, separate from any concerns of who's paying what and how much.

Then secondly, there's another provision of the Federal Nursing Home Reform law that specifically says there should not be discrimination based on payment source. Again, I understand, easier said than done, but that's a foundational legal requirement under the Federal Nursing Home Reform law. So whenever you hear a statement from a nursing facility that says, "Oh, we can't do X because your client is covered by Medicaid as opposed to being private payer or

Medicare reimbursed." Just want to immediately question that because on its face it violates this provision. There shouldn't be payment source discrimination. The standard should be that the resident gets the care that the resident needs regardless of the particular form of reimbursement.

So with that, let's start with some Medicare coverage basics. The basics will set us up for a discussion of the specific problems. First of all, the Medicare coverage is designed for post-acute care. It's linked to hospital care. So Medicare, this is part A reimbursement, is only going to pay after a prior three-night stay in a hospital as an inpatient, not as an outpatient, but as an inpatient in a hospital, and then the nursing care is related to the hospitalization, which is almost certainly the case in any case. You're in the nursing facility for the same reason that you were in the hospital.

Then if those conditions are met and you need a specific level of care, which we'll discuss in a second, the Medicare program can pay up to a maximum 100 days of coverage. The first 20 days are paid in full, and then days 21 through 100 have a daily copayment. The copayment goes up a little bit each year. In 2024, it's $204. Now we go to the level of care requirement, which I just mentioned. It's really, to a certain extent, a little bit confusing to think about it as 100-day benefit because it's not in most cases. The average period of coverage for individuals is more in the range of 27 or 28 days at a time.

The reason for that is that Medicare will only cover in a nursing facility if those conditions that we just discussed were met, but also if the person needs what's considered a skilled level of care. So you're going to need skilled nursing facilities, skilled nursing services, or skilled rehabilitation services on an everyday basis or almost everyday basis. On the nursing services side, sometimes people are confused by a discussion of skilled nursing services and they think, "Well, all of this is skilled, right? People talk about skilled nursing facilities, there's nurses there, there's registered nurses doing nurse tasks. These must be skilled nursing facility services."

That's not accurate under Medicare. We're talking, for the Medicare standards, a particularly intense level of nursing services. So for example, the regulations call out some specific services like intravenous injections or feeding or treatment of extensive pressure ulcers or some other, you see them listed on this slide, some other nurse work of evaluation and management and monitoring conditions but not run of the mill evaluation, but the kind of evaluation and monitoring, adjusting of services that requires a particularly extensive and active participation of a nurse. That is not true of the vast majority of nursing facility residence even after a hospital inpatient stay.

So as it plays out, most of the Medicare coverage under part A in a nursing facility following a hospital stay relates not to the skilled nursing services but to the skilled rehabilitative services. Most commonly physical therapy, but other kinds of therapy as well, speech therapy, occupational therapy, and all provided

by a licensed therapist pursuant to a physician's order. There's certain procedural requirements here. There's some certain notice requirements that people should be aware of. The first is the facility's requirement to notify the person if the facility does not intend to bill Medicare essentially. So you understand the practical reason for this.

Somebody might assume that of course Medicare is going to cover this and to make sure that the patient has knowledge in situations when Medicare might be expected to cover it, but the facility doesn't intend to bill. The facility has to give out this notice that gives the resident an option that says you want the qualifying care, the rehabilitative services, for example, and you want us to bill Medicare. Number two, want the qualifying services but don't bill Medicare, or then number three, don't want the services. If the resident chooses to have Medicare billed, then the bill is submitted and the facility can't bill a resident for those services on a private pay basis until there's a determination made regarding the Medicare claim.

Also, if the facility fails to give the notice, the resident has a claim that the facility can't bill privately because the resident says that he or she didn't know. He assumed it was covered by Medicare. As a practical matter, it's unclear oftentimes how this might play out or who would make the ruling that the facility isn't in a position to bill. I know back aways, I mean when I was doing direct service, I know at one point as part of a Medicare claim, I got back a determination that even though Medicare wasn't going to cover it, there was a ruling that the facility couldn't bill regardless because they had failed to give the required notice. So just you should be conscious of that.

Like I said, how it might play out in practice is sometimes unclear absent a formal administrative ruling, but the law's there and you can understand the righteousness of the resident's cause at that point, again, the argument being, "I didn't know. The facility was required to give me a notice notifying me that they didn't intend to bill Medicare and they failed to do so." There's a second kind of notice if an existing Medicare coverage is going to stop. In these situations, the resident has to give a notice of Medicare coverage at least two days before the termination of coverage and then the resident has a right to request an expedited appeal from the quality improvement organization.

Then beyond that, there's the typical progression of Medicare appeals through federal administrative agencies and then eventually federal court. Although at that point that's obviously a bigger... The initial appeals are much easier. You get a quick determination, you can push it. But beyond that, it's a slower process and the facility has a right to bill for services while the appeals are being adjudicated. Also the appeal, we'll discuss this I think multiple times during our discussion today, that in these kind of appeals there's only something to appeal if the resident actually gets the services. So in these types of situations, if for example, the therapy is never provided, you make an appeal on that basis, no

one's going to issue a ruling down the road that says, "Oh, you should have gotten the services at that time because there's nothing really at issue."

So for as a practical matter, for there to be a subject for the appeal, you've got to be able to convince the physician and the therapist initially to go forward with the therapy, for example, assuming that the basis is therapy, and then pursue the appeal for coverage of those services subsequently through the various appeal processes. The situation is similar but not identical for managed care. As folks on this webinar no doubt know that a great number of Medicare beneficiaries have essentially signed their Medicare coverage over to be administered by Medicare Advantage plans, and in those situations, of course the benefit is administered by the managed care plan. The initial appeal is a request for reconsideration by the health plan, and then there's again an outside agency.

After that, it's required to make a relatively quick determination as to the coverage, and then at that point, the appeals go to essentially the same process that the Medicare fee for service appeals go to, the agencies within the federal government, the Medicare appeals, and then eventually a federal court. The same discussion that I just had a minute ago with you is again applicable that the resident has some financial risk here and that you only have grounds for appeal if the services were provided at the front end.

Some tips here, some thoughts. I think I essentially alluded to this a second ago that a lot of the advocacy or significant part of it is communication with the facility, the physician and the therapist at the front end because you need to have the physician on board to continue to order, we'll just talk about this in the context of therapy, to continue to order the therapy services. You can be really knowledgeable. I mean, I can be knowledgeable about these situations, but you and I aren't doctors and we don't have the authority to order these services. Also, working with and discussing these issues with a physician can be really helpful and particularly discussing it with the therapist as well.

I'll note that the physician in some cases, and the therapist probably in many of these cases, may share some of your antipathy towards these coverage determinations, particularly the therapist. They do therapy because it's good work and they take pride in it and they want to be able to provide services and to help people. They may be as frustrated as you or your client when the facility decides to not bill Medicare or whether the managed care plan decides to stop the coverage. So they can be an ally here. You want to have these discussions with them. You want to share, for example, some of these advocacy tips or legal citations and work with them to the extent possible because they oftentimes will act as an ally and have interests that are reasonably consistent and congruent with the interests of the resident.

So with that as a background, what we can do now is talk about these particular incidents, right? We know something about the Medicare coverage, we know

something about the appeals process, and so we can apply that knowledge to some of these specific factual situations that frequently arise in real life. One extremely common is this idea that Medicare coverage should end if the resident isn't making progress, oftentimes expressed as the resident having plateaued and it's wrong. First of all, just make the practical, the medical argument here, before you even get to the law, sometimes the facilities or a therapist pushed by coverage determinations but still are too quick in finding a lack of progress.

What does that mean? Does it mean for one day the person was only able to walk as far unassisted as they could the day before or two days in a row? Again, therapy is a more complicated process than that, and it's not necessarily all on an upward trajectory. It's not that people just gradually get better from day 1 to 2 to 3 to 25 to 30, there's going to be ups and downs and some setbacks and maybe some plateaus as well for a period of time. It doesn't mean that there's not progress, it just means that the processes can be more erratic than that. But secondly, just assume for the sake of the discussion on the law that there really is a plateauing, that the person isn't progressing, that they're just maintaining at that particular point. That does not mean that the Medicare coverage should and improvement isn't required. The deciding factor is whether the therapy is appropriate and it could be appropriate for maintenance of the person's condition.

So there's multiple mentions within these couple of slides here to the Jimmo litigation. It's Jimmo v. Sebelius. It was a case brought by the Center for Medicare Advocacy and some legal services partners, and it focused on this issue and was settled in a way there was a win for residents and their interests. It was based on this regulation, which has always been in play. So Jimmo didn't create new rights. What Jimmo did was recognize that those rights had always been there under the federal regulations, but these rights had oftentimes been ignored by the federal government and others in the system in the administration of the program. You can see that from this regulatory language right on this particular slide. This has been the applicable regulatory language for decades long before Jimmo and long after the settlement. You can read it here. It's pretty straightforward.

The restoration potential is not the deciding factor. So even if full recovery or medical improvement is not possible, patient may need skilled services to prevent further deterioration or preserve current capabilities. Don't need improvement, even supposed plateauing is okay. The standard should be whether the services are appropriate based on medical considerations. So people need to be, however you want to think about it, your spidey senses are tingling. It's a red flag, however you prefer to think about it. When you hear these statements about plateauing or lack of progress, you want to be ready to push back, because as I mentioned just medically, it may be that somebody's going up and down and it's just the reality of recovering, particularly if you're in

your seventies, eighties, or nineties of recovering from a stroke or a broken hip or what have you.

But secondly, given Jimmo, given the regulatory language, restoration potential is not the standard. So take this information to the physician, to the therapist. There's information specifically on this issue related to the Jimmo case on the CMS website and also the website of the Center for Medicare Advocacy. I've listed some citations here. You see the URL for the Jimmo website, and then within that there's some relevant documents, including the documents that I've listed here, the fact sheet, the program manual clarifications. All of this has been incorporated into the Medicare manuals, and you can find that information on the Jimmo website that I've cited here.

So moving from that, there's a second issue that's been related to litigation. Again, the Center for Medicare Advocacy, co-counsel includes Justice in Aging, and it deals with inpatient status in the hospital. The problem here has been that the Medicare coverage in the nursing facility, if you remember we talked 10 minutes ago about this requirement of a three-night stay. It's oftentimes referred to as a three-midnight stay. You've got to be in the nursing facility over at least three midnights in order for the inpatient stay to be long enough to qualify the person for subsequent Medicare coverage in the nursing facility. This has to be inpatient.

People have been surprised over the years because they've been in the hospital for three midnights, but then find that Medicare is not in a position to cover the nursing facility stay because, again, without their knowledge, they were actually not there as an inpatient. They sure seemed like an inpatient, I'm sure to them, because they were in the hospital for three midnights running, but they had been classified as an outpatient or under observation status, and so their stay then didn't qualify them for the subsequent Medicare coverage. Now, under a relatively recent change, there has to be a notice given. The acronym is MOON, right? M-O-O-N, Medicare Outpatient Observation Notice. If the observation status lasts for more than 24 hours, that's a little bit of [inaudible 00:29:17]. At least you know, I mean I'll talk about appeal rights in a second, so at least you know, but that hasn't solved all the problems.

So there's been significant litigation in this area over the past decade, maybe a little bit more at this point, initially arguing that Medicare was obligated to include observation status days rather than limited to inpatient days. That challenge was unsuccessful. In this most recent case, there was a ruling related to appeal rights. So the argument is that residents should have some right to appeal the determination of their hospitalization as being inpatient or outpatient. The result of that litigation is that going forward there will be an appeal right, but it'll be a bit limited. Again, we're talking about the future, this is going to go into effect a year or two from now, but it won't apply to the original determination as to whether the person is there as an inpatient or as an inpatient, but it will apply to situations when the resident was initially admitted

as an inpatient, but then had his or her status changed to observation by a utilization review committee.

As I said, it's in the works right now. The litigation was successful on this issue. CMS put out some proposed regulations just four or five, six months ago. So we think we expect the appeal process to be finalized possibly sometime in the next calendar year. Before we move on from this topic, let me just talk about the advocacy realities. There will be an appeal process, but I think what people should be aware of, in the interim and even after that appeal process is finalized, is that they should be conscious of these things, they should ask if there's any ambiguity about whether the person is an inpatient or an outpatient, have that discussion earlier. Just routinely ask the physician, ask the hospital, get some clarity there.

Even if there's not a formal appeal right, for example, it doesn't prevent anyone from talking to the doctor and advocating to make sure that the stay in the hospital is classified as inpatient rather than outpatient. So again, I've mentioned the administrative protections that now are in place or will be in place, that the notice that you get after 24 hours and that the appeal process that will be available during reclassification. But in addition to that, residents, family members, advocates of various types should be aware of the issue and be prepared to have that discussion with the physician in the hospital early rather than being blindsided subsequently because it's a significant difference, right?

If you think you have the ability to get Medicare coverage and all of a sudden you don't, you're in the hospital, you assume you're going to be entitled to post-acute coverage, and so you want to be conscious of this and make those arguments informally, without a formal appeal process, but just through informal advocacy, talking with hospital and physician and doing everything you can to make sure that the resident, the patient at that point is being treated as an inpatient rather than an observation status outpatient. So that's the hospital considerations.

Now, we'll move on a little bit later in the process actually to the post-Medicare period of the resident's nursing facility stay. So if you remember 20 minutes ago we talked about the appeal process, you have a right if the facility or the managed care plan says Medicare is not going to cover this anymore, you have appeal rights to push that. As we discussed, there's advocacy to be done with the facility, both formal and informal, with the facility and the physician and or the therapist. So we're assuming now at this point that the Medicare coverage has ended or that maybe the appeals are ongoing, but this is a separate issue.

I think we're assuming here that the Medicare coverage has ended, or may likely will end, and the facility then is telling the resident, "Okay, Medicare's over. You're not Medicare covered anymore and so you have to leave." That's articulated in a variety of ways. I've listed a couple here. The facility says, "You've got to move to a different room or you have to move out of the facility

entirely based on arguments that, well, we're a Medicare facility, we're a short stay facility, that's our specialization. So either that that's what we require or what Medicare requires." You hear it stated sometimes that the person is "Medicare room", and so if they aren't covered by Medicare, then they've got to leave. I mean, I'll tell you how long this problem's been going on.

Really the first nursing home problem that I can remember handling, and this is in the '90s, it's been a while, was exactly the situation. This woman called me up and said her husband's Medicare had ended and the facility was telling him to get out because he was in a Medicare bed. So as they described it, if he wasn't eligible for Medicare anymore, they didn't have a choice and they were giving her 24 hours notice. This has been a long ingrained problem, this attitude, and it comes of course from this financial discrimination that's illegal, that Medicare pays the highest, that's the preferred reimbursement source for facilities.

So there is some financial incentive for a cold-blooded facility to churn through Medicare people, bring in somebody under Medicare, keep them for as long as their Medicare lasts, two weeks or four weeks or six weeks, depending on their particular person. Then again, if you're being cold-blooded from the facility's point of view, force them out and then bring in somebody else under Medicare. But that is not consistent with the law as we'll describe. People have a right to stay. It's not about maximizing the facility's revenues, it's about treating people like human beings and providing them with necessary care regardless of the reimbursement that they happen to be bringing in.

So look at the false statements that you or the resident of the resident families might hear. The facility claims Medicare has ended. Let's assume the 100 days are up. There's no arguments. I don't want to hear from you Mr. or Ms. Legal aid attorney about these appeal rights and improvement and whatnot, that 100 days is 100 days. This is day 101. This person has to leave because the resident's in a "Medicare bed". That is not true. That just because a bed or room is certified for Medicare doesn't mean that it can't be used for other reimbursement types as well, Private payer or Medicaid.

Talk about certification for a second. That facilities do have a right to... They certify some rooms for Medicare. It's a separate certification process and the facility has the right to certify only a limited number of rooms in the facility for Medicare. So the facility may be telling the truth to a certain extent, right? If you've got 100 beds, we'll say, in a facility, it's possible that only a third of those or a half of them or two-thirds of them is Medicare certified. It's possible that 100% of them are as well. But it is legal for a facility to pursue distinct parts certification here. But just because a particular room is certified for Medicare doesn't mean that that room is exclusively for people under Medicare certification. It's not.

It's certainly available for somebody paying out of pocket and it is likely available for somebody paying through Medicaid as well. Although a little bit of

a caveat here, that in a limited number of states, that those states allow a facility to pursue distinct part Medicaid certification as well. So it is possible in those states that the room may not be among the rooms in the facility certified for Medicaid. So in those states, you got to be a little more methodical about figuring this out. But in most states, the state has across-the-board certification, if you're certified, the facility is 100% certified, then you don't have to worry about this. But there's a limited number of states that allow for distinct parts certification.

In those states you may run into a little bit of a problem. It is a possible, at least in those states, that the particular room may be Medicare certified but not Medicaid certified. But again, even in those states, it doesn't mean that the residents to leave the facility, it means that the resident may just have to go to a Medicaid certified bed within the facility. There's a specific resident right that addresses this problem and it's listed here. A resident has a right under the Federal Nursing Home Reform law to refuse a transfer within the facility. I refuse, right? I could just veto this. If the purpose of the transfer within the facility is to move the resident out of a Medicare certified room or if it's solely for the convenience of staff.

So people should take advantage of that. There is not a formal administrative appeal process. So it's a little ambiguous how an adjudication might be done. There is a requirement that a facility give written notice. So in those situations, the resident rather would want to explicitly say, "I refuse. You've given me this notice. It said I should be moving to this other room. I decline. I have a right to refuse under this particular federal regulation and I'm notifying you that I'm asserting that." Then from there, enlist the help of the the long-term care [inaudible 00:42:30] rep for that facility or make a complaint to licensing. Or you can imagine at some point it would end up in court if it got really contentious, but the initial step is just to dig in your heels and say, "I'm not going, I have this right and I'm asserting it."

Then related to that is the desire of the facility, not just to move the resident down the hall, but to get them out of the facility entirely. As I mentioned, the first case I did these many years ago, that was exactly the situation is this resident was told his Medicare ended and he just had to go to a different facility because supposedly it was impossible, inappropriate for him to stay where he was. That is a false claim by the facility. The one thing, the first thing to note here is that here there is an administrative appeal process because it's not just a movement within the facility, it's an effort to essentially evict the person. There is a separate notice and appeal process for evictions in addition to the Medicare appeals processes.

So sometimes I think the facilities may think or claim that they think that they've done what they need to do if the Medicare-related notices have been issued, the ones that we discussed now half an hour ago, their determination of coverage determinations from the facility or from the managed care plan, but

that's just a notification as to Medicare coverage. That isn't a determination as to whether the resident has a right to stay in the facility. So in these kind of situations, there should be compliance with both notice requirements, the notice requirements that relate to the Medicare coverage, and then this entirely separate set of requirements that relate to an eviction from a nursing facility.

It's important to note that eviction from a nursing facility can only happen under six conditions and they're listed here. The resident needs a different level of care, either higher or lower, than a nursing facility. The resident is endangering the safety or health of others. So that covers one through four. Then number five, the resident has failed to pay, and number six, the resident has gone out of business. Those are the only justifications to force a resident against his or her will out of the facility. There needs to be a written notice. The written notice generally has to be given 30 days prior to the proposed transfer discharge, although there is an exception if the resident has been in the facility for less than 30 days, which may be the case under some of these Medicare coverage situations.

So in that case it's not 30 days, it's a practical period of time, but which still should be long enough to be practicable so that the resident can make an appeal request and have his or her appeal heard. In these situations, the notice has to include the reason and the facility's going to have to come up with a reason. In these situations they should be unable to come up with a legitimate reason because they're still being paid. The worst that happens maybe is that going forward, they're going to get paid under a private pay or Medicaid rate rather than a Medicare rate, but that's not non-payment. Then the notice also has to list the date, 30 days in the future, location of new residence, appeal rights, ombudsman contact, and then if you request an appeal, you get an administrative hearing.

The processes will vary a little bit from state to state, but in general, the federal regulations say that the same rules that apply to Medicaid eligibility, Medicaid fair hearings apply in these situations. So that means an administrative law judge and the right to present testimony, the right to do some cross-examination of your opponents, the right to admit evidence. So it's administrative appeal process, less formal than a court obviously, but still with some level of formality but with also greater accessibility in which it helps certainly to be represented by legal counsel, but it's not necessary.

So in these situations, let's say that all these really the most important thing is just to not be intimidated right out of the bat, that most residents in all of these determinations, but particularly these eviction situations, they don't lose because of some sort of sophisticated legal calculation. They lose just because capitulate, they give up. They believe the lies that they're being told and don't pursue coverage or just pick up and go when the facility says get out. In talking about this, I always want to give two messages.

First is some sort sense of empathy that it's a lot easier for me as a lawyer to sit here in my office and say, "You got to be really strong and don't give up," which I think is the right answer, but I get it. It's easier as an academic matter than it is as acting as a human being if you're in a facility and thinking, "Well, if they don't want me, maybe I shouldn't stay here," and feeling the pressure of getting into a dispute with the people who are providing you nursing facility care. So some level of empathy. But also, as someone who has gone through a lot of these sort of disputes over the years as a representative of residents, I can tell you, I can tell them that the right thing to do is to stand firm, that people do well, picking up and leave, just may well put you in a worse situation and put you in a position of weakness.

Even in situations where, again, people are a little bit squeamish about staying in facilities where they're getting some hostility, but again, I've been involved in a lot of those and the residents win, and they're treated with more respect. Usually, it's not about the staff. The staff isn't necessarily, it's maybe the administration has some issues about this, but oftentimes it's not the nurse aides or the nurses that are in this dispute. It's the business office of the facility, not the care staff. But even assuming that the care staff has somehow taken it personally, the right thing to do is to stay in and to win.

If you do win and you do stay and the facility recognizes that you're not to be trifled with and you handle yourself appropriately all the way through, you do fine, you do better and certainly much better than just being driven this way and that by false statements by nursing facility representatives and others. So in these situations, you get a lot of really quick and wrong eviction in these Medicare-related situations where residents are given the impression that they have to go as soon as their Medicare coverage ends, just the way that the operation messages the whole process, and that is wrong. People absolutely have a right to stay and they should leave under their own terms.

If people want to stay, either you're paying out of pocket or Medicaid is paying. If you feel like you don't need to stay anymore, then you don't obviously and you make that determination. But ideally, you're making those decisions because that's the decision that's best for you and not because you feel like you're being jerked around this, that or the other way. So in the situations you need to stay put, force the facility to go through the process. If the facility is trying to essentially pursue an eviction, they've got to go through the process, they've got to give a notice, they've got to cite a reason. It is very likely in these situations they don't have a legitimate reason because their only problem is that they want to accept only Medicare rather than some other reimbursement source, and that is not a legitimate claim for eviction.

Which brings us all the way to eviction rule number one, you just don't move out, don't panic, hang tough, say no, cite the law and then put the ball back in the facility's court. They are oftentimes used to just intimidating people and they may not have a plan B. If intimidation fails, it is just as likely as not that the

facility will see reason and then follow the process appropriately and allowing the resident to make decisions to stay or not stay on his or her own terms. Again, the resident should win appeals because the resident is right and the facility doesn't oftentimes have a leg to stand on of these sort of disputes.

So with that, indeed these presentations are more appropriate for an hour than a half an hour because here we are at 53 minutes, which feels about right. Gelila has monitored their questions during this presentation and we'll see what we can answer in our remaining time together today.

Gelila Selassie...: Yeah, lots of good questions. One question was, is the Medicare nursing facility 100-day limit an annual limit or a lifetime?

Eric Carlson, D...: The 100-day limit is per benefit period. It's not lifetime. The benefit period, I think it resets in 60 days if you're not receiving the qualifying care. it is not lifetime. It resets. It's per benefit period.

Gelila Selassie...: Then another question was, are facilities required to inform residents of their coverage options when Medicare ends? Because a lot of them get very intimidated of when they get the notice that Medicare is ending.

Eric Carlson, D...: No, there's a broader obligation to notify people of the Medicaid rights. So there's a residence rights provision, but in most cases facilities can comply with it by just having some general information within the admission agreement. So the shorter answer is no. There's nothing at the time that says the Medicare notice just says Medicare is not covered anymore. It doesn't say Medicare is not covering anymore and you may consider your options are paying out of pocket or Medicaid and this is how Medicaid works. It's the notice obligations at that particular point are just limited to Medicare-related issues.

Gelila Selassie...: Then sort of related to that, if an individual decides to get on Medicaid after their covered Medicare ends, is the facility responsible for completing the Medicaid application or the resident?

Eric Carlson, D...: The facility's not obligated. Again, there's some general legal obligation to notify people of their rights under Medicaid, but the message today should be don't count on the facility making that stuff happen. They don't have a particular legal obligation to handle it. It's in their interest to facilitate those sort of things oftentimes, and social workers at facilities will do it and sometimes they'll go beyond that, particularly in situations where the resident just because of medical limitations or cognitive limitations is not in the position to handle it. The short answer is they may be of help. Their legal obligation to work in that area is limited. People should not assume that the facility is just going to handle those things, because ultimately it's the obligation of the resident to arrange for his or her eligibility.

Gelila Selassie...: Then we had a couple questions about observation status. If a hospitalized patient is found to need placement in a nursing home and nursing home level care, but they're waiting for that nursing facility bed to open up, is that period that they're waiting for a bed considered an observation status?

Eric Carlson, D...: Not necessarily. It's just a question of how it's... So no, it's a question of the care that they're getting in the hospital. Obviously, there's some, to a certain extent, from a cold-blooded point of view, it's an administrative question of how it's handled. But if you look at the standards, you can imagine the medical determinations under observation standard, not my area of expertise as a lawyer or as a doctor, which I'm not, that observation status is, "Yeah, we're checking, we're observing. Things are in limbo a little bit." This is just a tentative process to consider options, whereas a inpatient is a more formal initiation of a particular course of treatment.

So my sense is if someone ends up staying a couple extra days in a hospital and maybe that's motivated a bit by the fact that there aren't available options for him or her at that point, I would not assume that it wouldn't necessarily be observation status and that wouldn't necessarily make sense that you'd be all of a sudden observing somebody after having provided active care for at least three days and nights.

Gelila Selassie...: I think one last quick question is, are these rules regarding Medicare coverage in nursing homes the same under original Medicare and Medicare Advantage plans?

Eric Carlson, D...: The original Medicare sets a floor. So if we're talking about the level of care, the skilled care, for example, and those type of distinctions, the managed care plans, for example, can do better than that. They can offer 150 days as opposed to 100 days, and they do. I believe that they would have some authority to go above and beyond in some other circumstances as well, but they're obligated in a minimum, and as always, that's how advantage plans work, at a minimum, they have to give you what fee-for-service original Medicare would do, but they have some discretion to go beyond that if they choose to do that to make the coverage more attractive to people.

Gelila Selassie...: I think it's top of the hour, so I'll turn it back over to you.

Eric Carlson, D...: All right then. So thanks, Gelila. Thanks everybody. As I mentioned, you will be offered a survey in about 10 seconds, and if you will fill it out, we would greatly appreciate it. Thank you much and goodbye.