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Twenty Common Nursing Home Problems and the Laws to Resolve Them

By Eric Carlson

[Editor's note: This article is adapted from Eric Carlson’s Twenty Nursing Home Problems, and How to Resolve Them, a consumer guide published in December 2005 by the National Senior Citizens Law Center with funding from The Commonwealth Fund. The guide is available at www.nsclc.org.]

The average consumer knows much more about cars (or apartments, or cell phones) than about nursing homes.¹ For example, a tenant who is told by her landlord that she has to move out within forty-eight hours because she is too “difficult” likely will have some idea of her legal rights and will object. The law generally will be on her side. But consider a nursing home resident who is told to leave because she is “too difficult.” Will she know her rights?

As explained in the discussion of problem 19 below, being “difficult” never is enough to justify eviction from a nursing home, and evictions from nursing homes generally require thirty days’ notice. These eviction rules are set by the federal Nursing Home Reform Law and apply across the country. However, if a nursing home tells a resident that she must leave within forty-eight hours on account of being “difficult,” the resident may panic and move out.

Twenty Problems and How to Resolve Them

Too frequently, nursing homes follow standard operating procedures that violate the Nursing Home Reform Law and harm residents. In this article I discuss some of the most common but illegal practices and explain the law that can be used to avoid or reverse these illegal procedures.

¹Nursing homes also are commonly known as convalescent hospitals or care centers. The term used by federal law is “nursing facility” or “skilled nursing facility.” See 42 U.S.C. §§ 1395i-3, 1396r (2005).
The Nursing Home Reform Law applies to every nursing home that is certified to accept payment from Medicare or Medicaid even if the resident involved is not eligible for either program and is paying privately. 2 Because Medicare and Medicaid are major sources of payment, over 95 percent of nursing homes are governed by the Reform Law. The law’s cornerstone is the requirement that each nursing home provide the care that residents need to reach their highest practicable level of functioning.3

1. Discrimination Against Medicaid-Eligible Residents

What Your Client Hears: “Medicaid does not pay for the service that you want.”

The Facts: A Medicaid-eligible resident is entitled to the same level of service provided to any other nursing home resident.

The Nursing Home Reform Law prohibits discrimination based on a resident’s Medicaid eligibility. A nursing home “must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State [Medicaid] plan for all individuals regardless of source of payment.”4

Nursing homes have a love–hate financial relationship with Medicaid. On the one hand, approximately two-thirds of nursing home residents are Medicaid-eligible, and the Medicaid program accounts for approximately one-half of nursing homes’ total revenues. On the other hand, Medicaid rates tend to be the lowest—lower than private-pay rates, and much lower than the rates paid by Medicare.

A Medicaid-eligible resident should resist any attempt by the nursing home to give her second-class treatment. She should emphasize the federal law (quoted above) that prohibits a nursing home from discriminating against Medicaid-eligible residents.

Nursing home staff members are quick to claim—generally without proof—that the nursing home loses money on each Medicaid-eligible resident. A resident or advocate should avoid getting drawn into a discussion of the nursing home’s financial status.

A better strategy is to assume that the nursing home’s finances are irrelevant as, indeed, they are in this situation. By seeking Medicaid certification, a nursing home promises the federal and state governments that it will give Medicaid-eligible residents the care guaranteed by the Nursing Home Reform Law. A nursing home is being completely hypocritical if it accepts Medicaid reimbursement for a resident’s care and then turns around and tells the resident that the care will be inadequate because Medicaid payment rates are low.

Providing Care

Problems 2 through 8 focus on quality of care.

2. Care Planning Without Resident or Family Participation

What Your Client Hears: “The nursing staff will determine the care that you receive.”

The Facts: The resident and resident’s family have the right to participate in developing the resident’s care plan.

A nursing home must complete a full assessment of a resident’s condition within fourteen days after admission and thereafter at least once annually and after a significant change in the resident’s condition. More limited assessments must be done at least once every three months.5

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2 The Nursing Home Reform Law is contained in two almost identical statutes, Sections 1395i-3 and 1396 of Title 42 of the United States Code. Section 1395i-3 applies to Medicare-certified nursing homes, and Section 1396 applies to Medicaid-certified nursing homes. Regulations applicable to both types of certification are found in Section 483 of Title 42 of the Code of Federal Regulations. For a comprehensive explanation and discussion of the Nursing Home Reform Law, see ERIC CARLSON, LONG-TERM CARE ADVOCACY (2005).


Assessments are used to develop a comprehensive care plan, which must be prepared initially within seven days after completion of the first full assessment. Care plans must be reviewed every three months and, if necessary, revised. Also, a care plan can be reviewed and revised at any time as necessary.6

The care plan is prepared by a team that includes the resident’s doctor, a registered nurse, and other appropriate nursing home staff members. Most important, the team should include the resident or the resident’s legal representative or a member of the resident’s family or all three.7

The resident or family member should attend all care plan meetings. (In this discussion, “family member” includes the resident’s legal representative.) If the nursing home fails to give notice of the meetings, the resident or family member should ask when the meetings will be held and to be included.

Before a care plan meeting, the resident or family member should think creatively about what the resident might want or appreciate. There is no reason to be timid. A nursing home is paid thousands of dollars monthly to care for a resident and should be expected to provide personalized care. Also, the Reform Law requires that a nursing home address a resident’s particular needs and preferences.8

A resident or family member often feels intimidated by care plan meetings. “Who am I,” a family member might think, “to tell a nurse what should be done for my dad in a nursing home?”

The resident or family member should resist any sense of intimidation. In most cases, care planning decisions do not involve complicated medical issues. Instead the optimal plan of care is relatively obvious, and the issue is whether the nursing home will commit to providing that care.

3. Not Honoring Resident Preferences

What Your Client Hears: “We don’t have enough staff to accommodate individual schedules. You will be woken up every morning at 6:00.”

“Because of our scheduling, your bath always will be at 9:00 a.m.”

“If you don’t like the meal entrée, your only option is a peanut butter sandwich.”

The Facts: A nursing home must make reasonable adjustments to honor resident needs and preferences.

Freedom of choice is a vital part of a resident’s quality of life. A nursing home should feel like a home rather than a health care assembly line. Accordingly the Nursing Home Reform Law requires a nursing home to make reasonable adjustments to meet resident needs and preferences. For example, a resident has the right to “[c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care.”9

The resident or resident’s representative should not feel bound by a nursing home’s standard operating procedures. That the nursing home, for example, never has allowed residents to sleep past 6:00 a.m., or has refused to serve Chinese food, does not necessarily matter. If a requested change in procedure is reasonable, the nursing home must make the change.

Of course, the $64 million question is “what is reasonable?” But this question has no clear answer. Because the definition of “reasonable” is not precise, residents, family members, and advocates must be prepared to explain why the benefit from a proposed change is worth any inconvenience or expense.

More enlightened nursing homes are realizing the benefits—both to residents and to the nursing homes—of giving

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8 See problem 3.
more control to residents and to individual staff members. The goal is to change nursing home culture so that care is more resident-centered. By implementing this culture change, nursing homes across the country have improved resident care and customer satisfaction and have done so while making a profit.10

4. Claiming Inability to Provide Necessary Services

What Your Client Hears: “We don’t have enough staff. You should hire your own private-duty aide.”

The Facts: A nursing home must provide all necessary care.

The foundation of the Nursing Home Reform Law is the previously discussed requirement that each nursing home provide the care that a resident needs to reach the highest practicable level of functioning.11 That requirement is obviously being violated if the nursing home is expecting or encouraging the hiring of private-duty aides.

The resident, family member, or advocate should make clear that the legal responsibility to provide necessary care is the nursing home’s and that a claimed shortage of staff or money is no excuse for failure to provide that care. The specific request should be made in writing with the relevant law, if necessary, included as support. The need for the specific care might be shown by such documents as a doctor’s order, the assessment, or the care plan.

5. Use of Physical Restraints

What Your Client Hears: “If we don’t tie your father into his chair he may fall or wander away from the nursing home. There’s just no way we can always be watching him.”

The Facts: Physical restraints may not be used for the nursing home’s convenience or as a form of discipline.

A physical restraint is a device that restricts a resident’s freedom of movement. Perhaps the most common physical restraint is a vest or belt that ties the resident into his wheelchair or bed. A seat belt is a physical restraint, as is a chair that is angled back to prevent the resident from standing up. Bed rails are another common type of physical restraint.

Under the Nursing Home Reform Law, a physical restraint may be used only to treat a resident’s medical conditions or symptoms. Restraints never may be used for discipline or the nursing home’s convenience.12

The use of physical restraints has dropped drastically over the past fifteen years, and many facilities now function completely restraint-free. Part of this decline certainly is due to the Reform Law’s restriction on the use of physical restraints. A growing medical consensus that the use of restraints harms residents both physically and psychologically, rather than protecting them, has also contributed to the decline.

Like any medical intervention, physical restraints may be used only with the resident’s consent or—if the resident lacks the mental capacity to consent—his representative. If the resident’s doctor recommends use of restraints, the resident or resident’s representative may choose to accept or reject that recommendation but should do so with knowledge of restraints’ negative consequences. The nursing home must suggest less restrictive methods of managing the problem for which restraints are being recommended.

6. Use of Medication to Modify Behavior

What Your Client Hears: “Your mother needs medication in order to make her more manageable.”

The Facts: Medication may be used to modify behavior only when a diagnosed

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10 Helpful information about nursing home culture change and resident-centered care is available from the Pioneer Network, www.pioneeretwork.net.


illness, such as depression, for which a specific medication is needed for treatment, causes the behavior.

Under the Reform Law, a behavior-modifying medication—also called a “psychoactive” medication—may be used only to treat a resident’s medical conditions or symptoms. Behavior-modifying medication may not be used for discipline or for the nursing home’s convenience.13

Like any medication, behavior-modifying medication may be administered only with the resident’s consent or, if the resident lacks mental capacity to consent, with the consent of the resident’s representative. If the resident’s doctor recommends behavior-modifying medication, the resident or resident’s representative must be told what condition or illness is being treated and then allowed to accept or reject the recommendation.

Note that behavior-modifying medications may be used when appropriate to treat various psychological and emotional conditions—schizophrenia, paranoia, or depression, for example. In deciding whether use of a particular medication is advisable, consider as a good rule of thumb whether the medication is intended for the resident’s benefit to treat a specifically diagnosed health problem or is meant for the nursing home’s benefit to keep the resident more manageable.

The central point with behavior-modifying medications is the right of the resident or (more likely) the resident’s representative to decide whether to use them. If a resident’s representative feels that the use of such medication would be unwise, premature, or excessive, he should feel free to say “no.”

7. Use of Feeding Tubes

What Your Client Hears: “We must insert a feeding tube into your father because he is taking too long to eat.”

The Facts: The use of a feeding tube should be a last resort.

Under the Nursing Home Reform Law, a nursing home must assist a resident in maintaining his ability to eat. Federal guidelines mention specific steps that a nursing home might take, including

- prompting the resident to eat;
- providing therapy to improve swallowing skills;
- providing foods in a more easily eaten form (pureed in a blender, for example);
- providing assistive devices (such as eating utensils with easy-to-grip handles); or
- simply feeding the resident by hand.14

For a resident unable to take food via mouth, nutrition can be provided through a feeding tube into the stomach. A nasogastric tube enters the stomach through the nose and the nasal passages; a gastrostomy tube enters the stomach directly.

A study comparing tube feeding with careful hand feeding found that the tube feeding did not increase the length of survival of residents with dementia. In other research, tube feeding was not shown to reduce the risk of aspiration (inhaling food into the lungs). A further disadvantage of tube feeding is that it often is accompanied by restraint use, to prevent the resident from pulling the tube out.15

Tube feeding in a nursing home should be done only if absolutely necessary. The Reform Law’s regulations state: “A resident who has been able to eat enough alone or with assistance is not fed by [a] tube unless the resident’s clinical condition demonstrates that use of a … tube was unavoidable.”16

A resident’s slowness in eating is not reason enough for insertion of a feeding tube.

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15 See “Quality Matters” website maintained by Texas, at mqa.dhs.state.tx.us/qmweb/TubeFeeding.htm.

tube. Neither is a nursing home’s shortage of staff. To provide needed assistance is the nursing home’s responsibility. If necessary, the nursing home should increase its staffing or stagger its meal-times.

On occasion a nursing home may claim that a resident must be tube-fed because otherwise the nursing home will be penalized by government inspectors for the resident’s loss of weight. This claim is wrong because (as discussed above) adequate nutrition generally can be provided even without tube feeding and because inspectors will not penalize a nursing home for following a treatment choice made by a resident or resident’s representative.

8. Limiting Visiting Hours

What Your Client Hears: “Your children may visit you only during visiting hours.”

The Facts: A resident’s family member may visit at any time of the day or night.

Under the Nursing Home Reform Law, a nursing home should be as homelike as possible. Consistent with this philosophy, a nursing home may not limit visiting hours for “immediate family or other relatives.”17 For a late-night visit, federal guidelines suggest that the visit take place outside the resident’s room—in the nursing home’s dining room, for example—to avoid disturbing other residents’ sleep.18

There are good reasons why a family member may want to visit outside “normal” visiting hours. The family member may not get off work until visiting hours are over. Or the resident may have a lifelong habit of staying up late. An off-hours visit may also give a family member a better opportunity to check up on a nursing home. Naturally a visit may only be made with the resident’s agreement. If a resident does not want to see a visitor, the visitor has no right to visit.

If a resident lacks mental capacity, the resident’s representative may make decisions regarding visitors. In most cases, the appropriateness of a visit is obvious because the resident of course wants visits from family members and friends.

9. “Responsible Party” Provisions in Admission Agreements

What Your Client Hears: “We can’t admit your mother unless you sign the admission agreement as a ‘responsible party.’”

The Facts: A nursing home may not require anyone but the resident to be financially responsible for nursing home expenses.

The Nursing Home Reform Law prohibits a nursing home from requiring a family member or friend to become financially liable for nursing home expenses.19 The signature of a family member or friend may be required only if the family member or friend is signing on the resident’s behalf.20

Some nursing homes use “responsible party” signatures to trick a family member or friend into becoming financially liable. Usually the “responsible party” signature line does not explain what the term means. As a result, family members are likely to believe that a “responsible party” is merely a contact person.

A son or daughter might think: “I should be the ‘responsible party’ so that the nursing home will let me know what’s going on. After all, I certainly don’t want to be irresponsible.”

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18 Centers for Medicaid and Medicare Services, supra note 14, Surveyor’s Guideline to 42 C.F.R. § 483.10(j).
What the son or daughter does not realize is that a paragraph in the middle of the admission agreement defines responsible party as someone who is fully liable financially for nursing home expenses. Generally the definition paragraph claims, falsely, that the responsible party understands that she is not required to be financially liable for nursing home expenses but nonetheless is volunteering to take on that liability. This language represents a strategy by nursing homes to evade the Reform Law. As noted, the Reform Law prohibits a nursing home from requiring a family member or friend to become financially liable for nursing home expenses. Nursing homes claim that this prohibition does not apply to “responsible party” provisions because (according to the nursing homes) the responsible parties are volunteering to become financially liable.

The nursing homes’ arguments are wrong. For three reasons, “responsible party” provisions are illegal and unenforceable. First, the provisions often are used to require guarantees, in direct violation of the Reform Law. In the example at the beginning of this section, the nursing home is requiring the resident’s daughter to sign as responsible party.

Second, “responsible party” provisions are deceptive. Generally a family member or friend believes that a responsible party is merely a contact person.

Third, neither the resident nor the responsible party receives any benefit from the responsible party signature. Under general contract rules, a contract is enforceable only if each party to the contract benefits. When a family member or friend signs as a responsible party, however, only the nursing home benefits. From the point of view of the resident and the responsible party, the only possible benefit is the resident’s money. The Reform Law says that admission decisions may not depend on a family member or friend becoming financially liable.21

Some nursing home admission agreements claim that a responsible party is not guaranteeing the resident’s financial obligations but instead is promising to take all necessary steps (including the filing of a Medicaid application) to arrange for payment of the resident’s nursing home bills. In practice such language is used by nursing homes as an illegal financial guarantee. If the resident’s bill is unpaid at some point, the nursing home likely will claim that the responsible party is at fault and will sue the responsible party for all money allegedly owed by the resident.

A family member or friend who is asked to sign as a responsible party should not hesitate to refuse, assuming that the resident already occupies her room in the nursing home. Once the resident has moved in, only six reasons may cause the resident’s eviction (see problem 19), and a refusal by a family member or friend to sign as responsible party is not one of those six reasons. If the resident has not moved into the nursing home yet, the situation is more precarious. If the family member or friend refuses to sign as responsible party, the nursing home possibly will refuse admission.

In this situation I recommend that the family member or friend consider refusing to sign as responsible party, with a polite but firm explanation of why “responsible party” provisions are illegal and unenforceable. A family member or friend who is the resident’s agent may sign as an agent whose sole responsibility under the admission agreement is to make payments to the nursing home from the resident’s money.

The nursing home staff member probably will be too embarrassed or confused to object and will continue with the resident’s admission. Of course, there is a risk that the nursing home will refuse admission, but avoiding that risk generally is not worth signing an illegal and unfair admission agreement. Also, refusing to sign is an important step in educating nursing homes and their staff on the inappropriateness of “responsible party” provisions.

What if a family member or friend signed as a responsible party and now is being sued for payment by the nursing home?

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As explained above, the lawsuit is defensible on multiple grounds. Furthermore, depending on state law, a counterclaim may be an excellent way to turn the tables on the nursing home.\textsuperscript{22}

10. Arbitration Agreements

What Your Client Hears: “Please sign this arbitration agreement. It’s no big deal. Arbitration allows disputes to be resolved quickly.”

The Facts: There is no good reason for a resident (or resident’s representative) to sign an arbitration agreement at the time of admission.

The arbitration process generally is not a good option for residents. It often is more expensive than a state or federal lawsuit because the parties are responsible for paying the arbitrator by the hour. Also, arbitrators often are less sympathetic to residents’ concerns than judges or juries are, and nursing homes commonly write arbitration agreements in a way that favors the nursing home over the resident.

In any case, a resident need not agree to arbitration at the time of admission, when neither party has any idea whether a dispute will arise or what a dispute might involve. If for some reason arbitration might be a good option, the decision (for or against arbitration) should be made after the dispute will have arisen.

If at all possible, a resident or resident’s representative should not sign an arbitration agreement. In most cases, the nursing home will process the admission anyway. If a nursing home employee raises a question, the resident or representative can explain that there is no need to commit to arbitration at the time of admission.

As with the “responsible party” situation discussed in problem 9, a refusal to sign is not risky at all when a resident already has been admitted. Refusal to sign an arbitration agreement is not one of the six reasons for eviction under the Reform Law. (See problem 19.)

If the resident has not yet been admitted, the resident or representative still has some leverage. In some states, a nursing home may request but may not demand the signing of an arbitration agreement. Also, if the resident is eligible for payment of his nursing home care through Medicare or Medicaid, federal law prohibits the nursing home from asking any more from the resident than the payment of any copayment or deductible authorized by law.\textsuperscript{23} Arguably these laws prohibit a nursing home from requiring a resident to sign an arbitration agreement.\textsuperscript{24}

A signed arbitration agreement may not be binding, depending on state law, the language of the agreement, and the circumstances surrounding the signing. Unconscionability is the most common defense.\textsuperscript{25} Also, as discussed above, an agreement to arbitrate may be improper consideration under Medicare and Medicaid law.

Medicare Issues

Problems 11 through 14 raise issues related to Medicare.


11. Medicare Reimbursement

What Your Client Hears: “Medicare can’t pay for your nursing home care because we have determined that you need custodial care only.”

The Facts: A resident may insist that the nursing home bill Medicare—the nursing home does not have the last word on whether the resident’s condition qualifies for Medicare reimbursement.

Medicare is not a comprehensive health insurance program. One common limitation is that Medicare payment often depends on a tie to hospital care. In the case of nursing home care, Medicare payment is limited to situations in which the resident enters the nursing home within thirty days after a hospital stay of at least three nights.26

At most, Medicare will pay in full for only twenty days of nursing home care. For the next eighty days—days 21 through 100 of staying in the nursing home—the resident must pay a daily copayment of $119 (for 2006).27 This copayment is covered by most Medicare Supplement (“Medigap”) insurance policies.28

One additional limitation keeps most residents from qualifying for Medicare payment for nursing home care. Medicare will not pay for care that is only “custodial care”—for example, medication administration. Rather, payment under Medicare is possible only if the resident needs skilled nursing services or skilled rehabilitation services. These skilled services generally must be provided every day, although an exception allows for Medicare payment even if rehabilitation services are provided only five days per week.29 “Skilled” services require the active and direct participation of a nurse or licensed therapist. That a nurse oversees the resident’s care is not enough.30

If a resident is a Medicare beneficiary, a nursing home must give the resident written notice whenever the nursing home decides that it will not bill Medicare for the resident’s care. Thus this notice may be given when the resident first is admitted or may be given later if Medicare already has paid for nursing home care for a certain period.31

The important fact is that the resident is not bound by a nursing home’s decision not to bill Medicare. The resident may insist that the nursing home submit a bill to Medicare. The written notice of a decision not to bill Medicare that the nursing home must give the resident should include a box for the resident to check asking that Medicare be billed. The resident may trigger the request by returning the notice to the nursing home. If the nursing home fails to give the required notice, the resident may submit his own written request that the nursing home submit a bill.32

While Medicare is considering a submitted bill, the nursing home may not charge the resident for any amount that Medicare subsequently might pay. If Medicare refuses to pay, the resident may appeal. However, the resident is financially liable for the bill while the appeal is pending.33 If the resident also were eligible for Medicaid, of course, the nursing home would be prohibited from charging any more than the

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27Id. §§ 1395d(a)(2)(A), 1395e(a)(3); 42 C.F.R. § 409.61(b) (2005).
28These benefits renew themselves in each benefit period. A new benefit period starts when a resident has not used Medicare payment, either for hospital care or nursing home care, for at least sixty days. 42 U.S.C. § 1395x(a)(2) (2005); 42 C.F.R. § 409.60(b) (2005).
32Centers for Medicaid and Medicare Services (CMS) Form 10055.
33Medicare Claims Processing Manual § 30-70.6.1.3 (2005).
Medicaid monthly patient pay amount (also called the “share of cost”).

These issues most commonly arise in relation to therapy. Assume that a resident is recovering from a broken hip. He wants therapy to regain the ability to walk. In such cases, receiving timely therapy is crucial.

Counterbalancing the resident’s need for therapy is Medicare’s frequent reluctance to pay. Nursing homes receive pressure from Medicare not to submit bills, or to cease billing for residents whose nursing home care Medicare previously covered. Nursing homes often pass this pressure onto doctors and therapists, encouraging them to discontinue therapy services.

The resident must combat such pressure on two fronts—compelling the nursing home to submit a bill to Medicare and convincing the doctor (or therapist) to continue ordering (or recommending) therapy services. Battle on the first front is relatively easy—as noted, the resident may require the nursing home to bill Medicare.

But, of course, submitting a bill will prove futile unless the resident actually receives the therapy services that would qualify him for Medicare payment for nursing home care. The resident (or resident’s representative) should encourage the doctor or therapist to initiate or continue appropriate therapy services and to focus on medical considerations, leaving the Medicare issues to the resident or resident’s representative. In certain cases, the resident may want to switch to a different doctor if the second doctor is more aware of the resident’s need for therapy.

If a doctor orders therapy, the nursing home must provide it. A nursing home always must follow doctors’ orders (assuming that the resident or resident’s representative consents).

12. Discontinuing Therapy When Resident Is Not Making Measurable Progress

What Your Client Hears: “We must discontinue therapy services because you aren’t making progress.”

The Facts: Therapy may be appropriate even if the resident is not making measurable progress. Accordingly Medicare may pay for therapy services even if progress has stalled.

A nursing home sometimes moves to stop therapy prematurely. The nursing home commonly claims that the resident has “plateaued”—in other words, that he is no longer making progress.

Most likely the real reason for the termination is part medical and part financial. The resident’s progress may have slowed or temporarily stopped. But due to pressure from Medicare, the nursing home may have been too quick to terminate therapy even when the resident still can benefit.

A resident or resident’s representative should keep in mind that recovery from an illness or injury is not always steady. If, for example, a resident is recovering from a broken hip, understandably he would have good days and bad days.

Under the Nursing Home Reform Law, as discussed above, a nursing home resident must be given medically necessary care. Thus therapy should be provided if the therapy improves or maintains the resident’s condition or slows the condition’s decline.\(^\text{34}\)

If the termination of therapy is blamed on Medicare rules, two rebuttal points may be made. First, as explained in problem 1, a nursing home must provide the same high quality of care, whether the care is funded through private funds, Medicare, or Medicaid. Second, Medicare may must pay for therapy services even if, for the time being, no progress is being made.\(^\text{35}\)

The resident or advocate should follow the two-pronged approach recommended for problem 11: forcing the nursing home to submit a bill to Medicare and convincing the doctor or therapist that therapy is the right thing to do. The point is that a lack of progress is not a reason for automatically terminating therapy.

\(^{34}\)See 42 C.F.R. § 483.25(a) (2005).

\(^{35}\)Id. § 409.32(c).
13. Discontinuation of Therapy After Medicare Reimbursement Ends

What Your Client Hears: “We can’t give you therapy services because your Medicare reimbursement has expired, and Medicaid doesn’t pay for therapy.”

The Facts: Therapy should be provided whenever medically appropriate, regardless of the resident’s source of payment. Therapy should not be discontinued just because a resident has reached the end of his 100 days of Medicare coverage for the two reasons already discussed: a resident is entitled to receive medically necessary service, and services for a resident should not depend on his source of payment. Specifically a Medicaid-eligible resident is entitled to the same level of service provided to other residents. (See opening paragraphs and problem 1 for discussion of these two issues.)

Federal guidelines explicitly require that therapy services be provided even if the nursing home is entitled to no more than the typical Medicaid rate. In some states, depending on the reimbursement mechanism in place, a nursing home may be entitled to extra Medicaid payment for therapy services.

14. Discontinuing Stay in Medicare-Certified Bed After Medicare Payment Ends

What Your Client Hears: “Because you are no longer eligible for Medicare reimbursement, you must leave this Medicare-certified bed.”

The Facts: A resident whose care is not being reimbursed through the Medicare program may nonetheless occupy a Medicare-certified bed.

Understanding this issue requires understanding how nursing home beds are certified by Medicare. A nursing home may seek Medicare certification for all or some of its beds. A bed must be Medicare-certified for the nursing home to bill Medicare for care given the resident assigned to that bed.

Medicare certification does not mean that the bed is reserved exclusively for residents whose care is being paid for by Medicare. A Medicare-certified bed may be occupied by a resident who is paying privately, or through private insurance. A resident who pays through Medicaid may also occupy a Medicare-certified bed if the bed is certified for Medicaid reimbursement as well.

Because Medicare generally pays more per day than any other source of payment, nursing homes prefer to use Medicare-certified beds for residents whose care is being reimbursed through Medicare. Once a resident is no longer eligible for Medicare payment of his nursing home expenses (see problems 11 and 12 for more details), the nursing home has an incentive to move that resident out of a Medicare-certified bed and use the bed for a resident who is eligible for Medicare payment.

Shuttling a resident around in this fashion, although it may make financial sense for a nursing home, can be detrimental to a resident accustomed to his original room. Also, because Medicare reimbursement is available only to residents who need skilled nursing or rehabilitation services, the nursing care provided in the Medicare-certified beds may be better than that available in the rest of the nursing home.

To protect residents, the Nursing Home Reform Law gives them the right to veto a transfer within the nursing home if the purpose of the transfer is to move the resident out of a Medicare-certified bed. This right provides a counterbal-

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37. 42 U.S.C. § 1395i-3(a) (2005); 42 C.F.R. § 483.5(b) (2005).
ance to the Medicare program’s transfer-encouraging financial incentives.\(^{39}\)

When a resident refuses a transfer from a Medicare-certified bed, the nursing home often complains that such transfers ultimately will cause all of the nursing home’s Medicare-certified beds to be occupied by residents who are ineligible for Medicare payment. In response, the resident should point out that the nursing home always is free to certify additional beds for Medicare reimbursement.\(^{40}\)

**Medicaid**

Problems 15 and 16 raise issues related to Medicaid.

15. **Unavailability of Medicaid-Certified Beds**

What Your Client Hears: “Even though you’re now financially eligible for Medicaid payment, we don’t have an available Medicaid bed for you.”

The Facts: A nursing home can certify additional beds for Medicaid payment.

As mentioned in the discussion of problem 14, some states allow a nursing home to certify only a percentage of its beds for Medicaid payment. Such partial certification creates a particular problem when a resident initially pays privately for her nursing home care but later becomes eligible for Medicaid payment after spending her savings down to Medicaid limits.

If, at that point, the resident is not in a Medicaid-certified bed, and the nursing home does not have a Medicaid-certified bed available, the nursing home likely will claim that it cannot accept Medicaid payment on the resident’s behalf. This may lead to nonpayment and then eviction because the resident will have spent down her savings and will be unable to pay the private-pay rate.

A resident or advocate must understand that a nursing home in this situation has the option of certifying additional beds for Medicaid payment. Nursing home employees often give the inaccurate impression that partial Medicaid certification is forced upon the nursing home. However, even in the states that allow partial certification, a nursing home is free to seek certification for every bed.

Resolution of this problem requires early action. Ideally information regarding a nursing home’s Medicaid certification should be obtained before admission—when choosing the nursing home. As soon as possible, the resident (or resident’s representative) should determine whether the nursing home accepts Medicaid payment and, if it does, whether the Medicaid certification is full or partial. After admission the resident should determine whether her current bed is Medicaid-certified.

If a resident foresees herself in the situation of being financially eligible for Medicaid but in a bed not certified for Medicaid, she should, as soon as possible, ask the nursing home to seek Medicaid certification for her bed. She should best do so four to six months before she becomes financially eligible for Medicaid.

In so requesting, the resident puts the nursing home on notice that she will need to use Medicaid reimbursement. In most cases, in order to avoid disputes, the nursing home takes the necessary steps to have the resident’s bed certified for Medicaid payment. If it does not, and instead tries to evict the resident for nonpayment when the resident becomes Medicaid-eligible financially, the resident will have a good argument in an eviction hearing that the nonpayment is the nursing home’s fault.

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39 A resident who will rely on Medicaid reimbursement should be sure that the bed is Medicaid-certified. In some states, Medicaid certification is an all-or-nothing proposition: if the nursing home has Medicaid certification, every bed is Medicaid-certified. Other states allow nursing homes to certify only a portion of their beds for Medicaid. General information about a nursing home’s certification is available at the federal government’s Nursing Home Compare website, www.medicare.gov/NHCcompare/home.asp. More detailed information about the certification of particular beds should be available at the state agency that inspects, certifies, and licenses nursing homes (often part of the state’s health department). The nursing home may or may not be able to give accurate information on the Medicaid certification of particular beds.

40 Centers for Medicaid and Medicare Services, State Operations Manual § 32028.
16. Denying Readmission from Hospital

What Your Client Hears: “We don’t have to readmit you from the hospital because your bed-hold period has expired.”

The Facts: A Medicaid-eligible resident has the right to be readmitted to the next available Medicaid-certified bed, regardless of the length of the hospital stay.

When a nursing home resident is hospitalized, state law generally requires the nursing home to hold the bed for a week or two if the resident so desires. If the resident is paying privately, she will be responsible for paying for the bed hold. If the resident is Medicaid-eligible, Medicaid generally will pay.

The Nursing Home Reform Law establishes a readmission right for Medicaid-eligible residents. Even if a bed-hold period is exceeded (or if state law does not require a bed hold), a nursing home must admit a Medicaid-eligible resident to the next available Medicaid-certified bed, regardless of the length of hospitalization.41 A bed is not considered available if the hospitalized resident and the proposed roommate are not of the same gender.

A Medicaid-eligible resident should not hesitate to assert her right to be readmitted to the next available Medicaid-certified bed. The resident should be persistent if the nursing home claims that it does not have a vacancy. If the nursing home is led to believe that the resident will keep checking for the next available bed, the nursing home will be more likely to accept the inevitable and readmit the resident.

17. Requiring Payment of Unauthorized Charges

What Your Client Hears: “You must pay any amount set by the nursing home for extra charges.”

The Facts: A nursing home may assess only extra charges authorized in the admission agreement.

Some nursing homes charge separately for various items and services—for example, catheter supplies, diapers and other incontinence products, and wound dressings. These separate charges are inappropriate if Medicare or Medicaid is covering the resident’s care because the nursing home must accept payment from these sources as payment in full. The resident’s only financial obligation is to pay the deductibles and copayments authorized by law.42

Such separate charges also are inappropriate if they were not authorized in the admission agreement, whether or not the resident’s care is covered by Medicare or Medicaid. Federal regulations implementing the Nursing Home Reform Law require a nursing home, during the admission process, to notify residents of any extra charges.43 Also, standard principles of contract law require a nursing home to limit its charges to the amount authorized by the admission agreement.

18. No Available Space for Resident and Family Councils

What Your Client Hears: “We have no available space in which residents or family members could meet.”

The Facts: A nursing home must provide a private meeting space for a resident council or family council.

Under the Nursing Home Reform Law, residents and their family members have the right to form resident councils and family councils, respectively. If such a council is formed, a nursing home must offer a private meeting space and must designate an employee as a liaison with the council. A nursing home must seriously consider and respond to all complaints or recommendations made by a resident or family council.44

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43 Id. § 483.10(b)(6).

Evictions

Problems 19 and 20 address grounds for eviction.

19. Eviction Threatened for Being “Difficult”

What Your Client Hears: “You must leave the nursing home because you are a difficult resident.”

The Facts: Eviction is allowed only for six reasons.

The Nursing Home Reform Law specifies only six legitimate reasons for eviction:

1. The resident fails to pay.
2. The resident no longer needs nursing home care.
3. The resident’s needs cannot be met in a nursing home.
4. The resident’s presence in the nursing home endangers others’ safety.
5. The resident’s presence in the nursing home endangers others’ health.
6. The nursing home is going out of business.

Thus being “difficult” does not justify eviction. Nursing homes exist to care for people with physical and mental problems, and most nursing home residents are “difficult” in one way or another.

Some nursing homes attempt to evict residents who, for example, tend to wander aimlessly or have severe dementia and make howling sounds during the night. These evictions almost always are improper because such residents belong in a nursing home. The fact that they are arguably “difficult” does not mean that they should be evicted. In most cases, evicting a resident from one nursing home merely so he can be transferred to another is pointless.

A nursing home may cite reason 3, arguing that it cannot meet the needs of the supposedly “difficult” resident. This argument is wrong because reason 3 applies only if the resident’s needs cannot be met in a nursing home generally—for example, if the resident needs placement in a subacute unit or a locked psychiatric ward. The federal government prohibits a nursing home from using its own inadequate care to justify eviction under reason 3.

To evict a resident, a nursing home must give written notice of the reason for the eviction and the facts that allegedly support the eviction. The notice must give the telephone number of the state agency that inspects and licenses nursing homes and instructions on how the resident can request an appeal from the agency. Generally the notice must be given at least thirty days before the date of the proposed eviction.

Upon receiving the notice, the resident or resident’s representative should appeal to the state agency, which should schedule a hearing. The hearing generally takes place at the nursing home, with a state hearing officer presiding. The resident’s representation by an attorney or other advocate is preferable but not essential. The hearings tend to be relatively informal.

At the hearing, the resident and advocate should emphasize that nursing home care is appropriate for the resident. In most cases, they can show that the nursing home did not plan adequately for the resident’s care and instead tried to evict the resident when a difficulty arose. Often the nursing home proposes to transfer the resident to another nursing home—good evidence that nursing home care is appropriate.

20. Eviction Threatened for Refusing Medical Treatment

What Your Client Hears: “You must leave the nursing home because you are refusing medical treatment.”

The Facts: Refusal of treatment, by itself, is not an allowable reason for eviction.


A nursing home resident, like any other individual, has a constitutional and common-law right to refuse medical treatment. For that reason, an eviction may not be based solely on a resident’s refusal of treatment.

As discussed above, eviction is allowed only for one of six specified reasons. Federal nursing home guidelines state: “Refusal of treatment would not constitute grounds for transfer, unless the [nursing home] is unable to meet the needs of the resident or protect the health and safety of others.”

On occasion, a resident refuses treatment because he is terminally ill and does not want to take steps to extend his life. This is his right, and he should not be forced to move from the nursing home for this reason.

A small number of nursing homes, mostly affiliated with religious denominations, require life-sustaining treatment under all circumstances. A nursing home may follow such a policy only if state law allows the policy and it is described in considerable detail during admission.

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48 Centers for Medicaid and Medicare Services, supra note 14, Surveyor’s Guideline to 42 C.F.R. § 483.12(a)(2).